



SCHOOL HEALTH TOOLKIT

Resources and Recommendations
to Support K-12 School Health Programs

2026

VDH VIRGINIA DEPARTMENT OF HEALTH

EDITORS

Joanna Pitts, BSN, RN, NCSN
School Health Nurse Consultant
Virginia Department of Health

Tonishia Short, M.Ed.
Special Projects Manager
Virginia Department of Health

Tracy White, MA, RN
School Health Specialist (Retired)
Virginia Department of Education

Sherry Winant, MHA, BSN, RN, NCSN
School Nurse, Warren County Public Schools
Master of Health Administration
George Mason University

Abigail Barden, B.A.
Political Science
James Madison University

Special Acknowledgement To Consulting Editors

Anne McMillan
Graphic Designer
Virginia Department of Health

Janet B. Wright, BSN, RN, NCSN
Independent School Nurse Consultant
School & Adolescent Health Specialist, Virginia Department of Health (Retired)

Tia Campbell, MSN, RN, NCSN, FNASN
Coordinator, Chesterfield County Public Schools (Retired)

Mary Kay Jessen, MSN, RN
Independent Nurse Contractor

School Nurses are an invaluable asset to the school communities they serve. Through their unique vantage point of merging health and education, School Nurses are able to nurture the whole child, including personal health & wellness, academic performance, and social/emotional well-being.

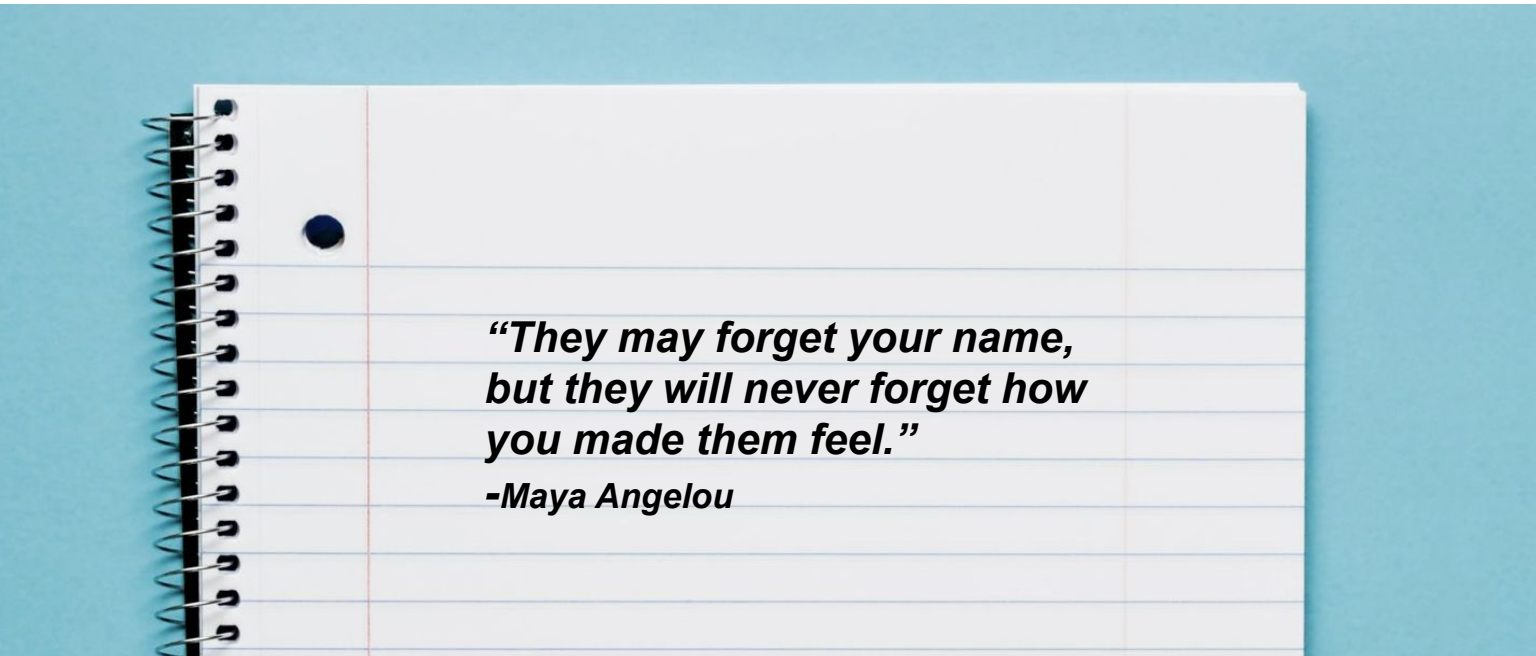
For some students, a pop-in visit to the School Health Clinic may be their only opportunity to access a licensed healthcare provider. One student's visit to share a recurring toothache, or to express difficulty seeing the whiteboard in class, could serve as the launching pad for a School Nurse to communicate with families and recommend follow-up care.

Through the School Nurse's support, the student having difficulty seeing the board is able to purchase a pair of low-cost glasses from a community organization. Another student experiencing chronic tooth pain is able to attend a school-based dental clinic to receive proper oral health treatment from a licensed dental health professional. School Nurse's ability to assess health needs, recommend services, and connect students, staff, and families to community resources and affordable healthcare providers, not only improves student's overall health and wellbeing, but also fosters a spirit of collaboration that enhances academic performance.

We here at the Virginia Department of Health, along with our partners at the Virginia Department of Education, understand the importance of your role as a School Nurse. The **School Health Toolkit: Resources and Recommendations to Support K-12 School Health Programs,** in conjunction with, the latest edition of the **Virginia School Health Guidelines** is a compilation of resources, recommendations, and guidance, to support School Health Teams and their respective school communities, with ensuring every student in the Commonwealth reaches their optimal level of health for learning. Thank you for all you do to support our students. We are honored to serve alongside you.

Yours In Service,
Office of Family Health Services
Division of Child and Family Health
Virginia Department of Health





The Virginia Department of Health is pleased to present the *Virginia School Health Toolkit*, a resource intended to provide guidance to school administrators, school nurses, teachers, and other school personnel on the care of students with special health needs. Guidelines present current, practical health information and recommendations for the development of local programs and policies related to school health care services.

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 Toolkit are advised to confirm federal, state, and local laws, regulations, and policies when using this manual to plan, implement, and evaluate school health programs.

Searchable Database
A searchable database of the Code of Virginia is available 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 a phrase (example: comprehensive physical examination) into the screen's search window and press submit. The Code of Virginia contains the laws passed by the General Assembly and signed by the Governor for the Commonwealth of Virginia. *Updated July 1 to reflect the legislation passed during the previous session.*

Intended Audience
This document is intended to enhance the educational process by providing guidance and resources for: school administrators, school nurses, teachers, community partners, healthcare providers, and other school staff personnel, on the development, implementation, and evaluation of a comprehensive school health program.

Support Services
According to § 22.1-274. School health services, the school board shall provide pupil personnel and support services in compliance with § 22.1-253.13:2. A school board may employ school nurses, physicians, physical therapists, occupational therapists, and speech therapists.

Shared Responsibility

The purpose of the **Virginia School Health Toolkit** is to provide guidance, procedures, and protocols for school health staff, parents/guardians, and community providers to ensure all students reach their optimal level of health and well-being for learning.



Every student, every day.

FAMILY EMPOWERMENT AND COMMUNITY ENGAGEMENT

School health advisory councils, coalitions, community organizations, new initiatives, and broadly-based constituencies for school health are essential to a successful school health program. These unique partnerships can build support and aide with implementation. Click the titles below to learn more.



Promoting Healthy Schools: A Guide For School Health Advisory Boards



Whole School, Whole Community, Whole Child Model (WSCC)



Involving Parent and Teacher Groups (PTA)



Division of Multicultural Health and Community Engagement

ENHANCING SCHOOL HEALTH PROGRAMS THROUGH

COMMUNITY PARTNERSHIPS



Together, we can shape a healthier school community!

"Community partnerships are essential for enhancing K-12 School Health programs, bringing together resources, expertise, and support from various stakeholders. This collaborative effort significantly benefits our students' health and well-being."

Karrell Smith, RN, NCSN, Nurse Specialist
Richmond City Public Schools

Community organizations assist School Nurses with connecting families to equitable resources, coordinating school-based wellness clinics, and much more. Check out the resources below to get started!

01 **Bridge2Resources (VA-AAP)**
Connecting families to community resources right in their zip code!

02 **Federally Qualified Healthcare Centers**
A database of federal healthcare centers by state.

03 **Virginia Medical Reserve Corps (MRC)**
Current and retired healthcare professionals, volunteering to improve the overall health/wellness of local communities.

04 **Local Health Department Locator**
Collaborate with your local health department to host vaccine clinics.

05 **Immunize Virginia**
Achieving and maintaining full immunization protection through education, advocacy, collaboration, and equity.

06 **Virginia Oral Health Catalyst**
Providing access to comprehensive health care by creating positive system changes through education, advocacy, and partnership.

MEETING THE HEALTHCARE NEEDS OF *EVERY* CHILD, *EVERY* DAY.

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For additional guidance and recommendations on administering emergency medications, refer to the ***Virginia School Health Guidelines.***

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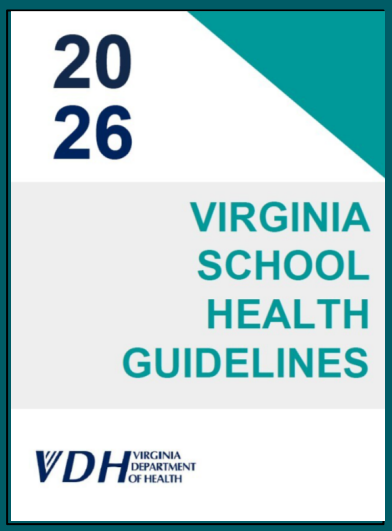
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Seeking guidance on policy, procedures, and procurement for administering emergency medications?

Refer to the latest edition of the **Virginia School Health Guidelines** *for specific guidance and recommendations on administering emergency medications.*

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The resources found within this section are stand alone documents. Title pages are listed below.

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Helpful Hints for Coordinating School-Based Vaccination Clinics……**164**
(22 pages)

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School Entrance Checklists
"This Is Quitting" Flyers (Vaping Resources)
Department of Behavioral Health and Developmental Services (DBHDS) Resources



The #988Lifeline is here to support you. No matter what's on your mind or when you want to reach out. Connect with someone who is ready to listen and support you. Call or text 988 or chat at 988Lifeline.org.



Eight Key Components of School Health Programs

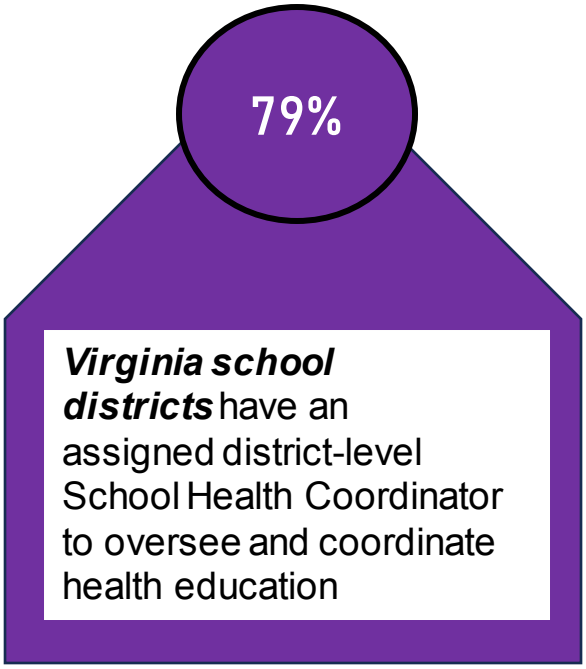
The eight-component coordinated school health model is outlined below. Each of the components works to help promote the health and well-being of both students and staff, working together to provide a coordinated effort in achieving health promotion in the schools.

- **1: 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.
- **2: 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.
- **3: 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.
- **4: 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.
- **5: 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.
- **6: 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.
- 7: **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.
- **8: 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.

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Developing A School Health Program: Planning, Implementation, and Evalution

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.



SCHOOL HEALTH COORDINATORS AT A GLANCE

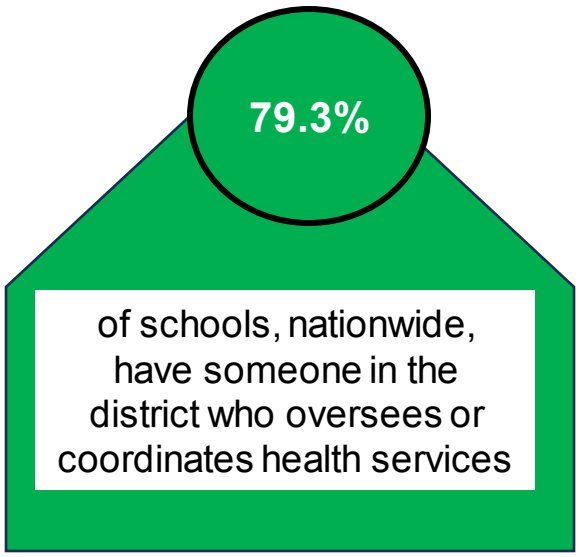
- **79%** of Virginia districts had a district-level school health coordinator who oversees the district's health and safety policies and activities

VDOE School Health Data Survey, 2022-2023

- **79.3%** of states have someone who oversees or coordinates health education for the district

Results from School Health Policies and Practices Study, 2016

SHPPS : School Health Policies and Practices Study : trends over time, 2000-2016



In addition, all eight components of school health programs 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.

Whole School, Whole Community, Whole Child

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".

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.

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



SCHOOL HEALTH PROGRAMS

Recommendations for Implementation

The following essential elements should be considered in program design and implementation of school health programs:

- **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).

Implementation of School Health Programs

A variety of resources are available at the **national, state, and local levels** 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 a different needs, gaps in services, and programs already in place. It Is recommended new programs, organizations, and interventions be tailored to meet the needs of individual schools and their unique communities.

There are six key steps to implementation of CSH programs. Each step encompasses components at the ***national, state, and local level.***

Six Steps of Launching A School Health Program	
1	Establish a school health planning team.
2	Assess health problems and service needs.
3	Set goals and objectives.
4	Develop an action plan.
5	Implement school-health program components.
6	Continual evaluation of effectiveness.

Local, State, and National Resources To Support School-Health Programs

LOCAL INFRASTRUCTURE. A formal organization with broad representation compromised of community leaders, school nurses, teachers, business owners, faith-based leaders, students, parents/guardians, should be established in every school district, to anchor the infrastructure from national, state, and local levels to the community or district level.

Local Nonprofits and Health Organizations

Several national or state agencies have a smaller organization which operates at the local level. Below are a list of organizations found in several Virginia localities. **You can narrow your options by searching for a program near your school's city and/or zip code.**

- **United Way of Virginia:** www.unitedway.org/local/united-states/virginia
- **Virginia Medical Reserve Corps:** www.vdh.virginia.gov/mrc
- **Boys & Girls Club, Inc:** www.bgca.org
- **YMCA:** vaymca.org
- **Communities In Schools:** cisofva.org
- **VDH Local Health Districts:** www.vdh.virginia.gov/local-health-districts
- **American Academy of Pediatrics, Virginia Chapter:** www.virginiapediatrics.org
- **Virginia Health Catalyst:** vahealthcatalyst.org

SCHOOL INFRASTRUCTURE. A school-level committee facilitated by the School Nurse, comprised of administrators, faith-based leaders, community members, teachers, custodians, food service workers, students, and parents/guardians to develop, coordinate, and organize school-health programs that develop the whole-child.

School Resources

Developing a quality school-health program encourages you to get creative with your most valuable resources: **people, money, and time.** Developing new initiatives that are practical, sustainable, and innovative will create an environment where students can have their academically, social, emotional, and physical health needs met.



Parent/Teacher Association (PTA)
Partner with PTA to plan school-wide events, vaccine clinics, health fairs, and build community partnerships with local businesses



Health Fairs
Collaborate with Public Health Nurses, or the local health department, to host health fairs or wellness clinics at your school.



Clubs and Committees
Launch a small committee or club of teachers, students, and families to organize assemblies and community events.



School Health Hub
With the help of the IT specialist, develop a School Health hub to serve as a resource for families, students, and teachers to access health-related information, updates, and documents.

STATE INFRASTRUCTURE. As noted in **School & Health: Our Nation's Investment**, 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 and indemnity insurers. For example in 1992, Virginia created the **Virginia Maternal and Child Health Council** to improve health for Commonwealth's mothers and children. A *subcommittee* was formed to make additional recommendations. State infrastructure is important to meet universal needs of student's in your school division.

Key Child-Health Related State Agencies

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. *To learn more about the state agencies and their focus areas, please follow the below links.*

Virginia Department of Education (VDOE)	Viriginia Department of Health (VDH)
Virginia Department of Deaf and Hard of Hearing (VDDHH)	Viriginia Department of Conservation and Recreation (DCR)
Virginia Department of Medical Assistance Services (DMAS)	Viriginia Department of Social Services (VDSS)
Virginia Department of Agriculture and Consumer Sciences (VDACS)	Viriginia Department of Behavioral Health and Developmental Services (DBHDS)
Virginia Department of Criminal Justice	Viriginia Department of Blind and Visually Impaired (DBVI)

NATIONAL INFRASTRUCTURE. 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.

- Center for Disease Control (CDC)
- Alliance for A Healthier Generation: Healthy Schools Program
- American Academy of Pediatrics (AAP)American School Health Association (ASHA)
- American Cancer Society, Health for Success
- Education Development Center (EDC)
- Society of Health and Physical Educators – SHAPE America
- Association of State and Territorial Health Officials (ASTHO)
- National Association of School Nurses (NASN)
- National Association of State School Nurse Consultants (NASSNC)
- National Association for Chronic Disease Directors (NACDD)
- Education Development Center (EDC)
- Robert Wood Johnson Foundation

SCHOOL HEALTH TEAM
FREQUENTLY ASKED QUESTIONS

How do I use the Code of Virginia to establish a School Health Team?

Using Code of Virginia, Section 22.1.274, schools can develop robust, interdisciplinary team to solve complex problems of students with varying medical, social, and emotional health needs. The team, representative of the community and individual disciplines of need, work in collaboration to develop a comprehensive school health program.

1

How do I select a School Nurse to lead the School Health Team?

When developing a position description for a School Nurse to lead School Health Program, school divisions should consider:

- scope of responsibilities
- supervision received
- supervision given
- licensure qualifications
- school health services rendered

2

How do I choose additional members for the School Health Team?

The basic school health team consists of parents/guardians, primary health care provider, school physician, or public health medical director, community leaders, and school nurse. Ideally this group will collaborate with administrators, teachers, guidance counselors, legal services, child welfare services, and therapists to keep parents/guardians informed of resources available to them.

3

How do I form school health teams at smaller school divisions?

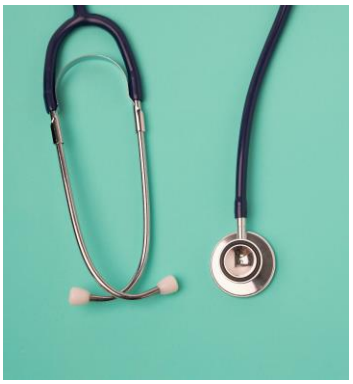
Interdisciplinary team membership may vary among school divisions. Smaller districts are more likely to have personnel who are assigned multiple roles. The key to a successful interdisciplinary approach is to ensure specific disciplines are represented on the team that address the unique school health needs.

4

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

School Health Program Team Members

A diverse school health team can be comprised of individuals with various backgrounds and levels of expertise. It is best to have a team of 6-8 professionals who bring a unique perspective to development, planning, and implementation. Below are a list of potential team members.







- School Administrators
- Clinic Aides/Unlicensed Assistive Personnel (UAP)
- Athletic Coaches
- Food Service Managers
- Social Workers
- Physicians
- School Resource Officers
- Occupational Therapists
- Office Secretaries
- Consultants
- Faith-Based Leaders
- Law Enforcement Officers
- School Nurses
- Health Educators
- Athletic Trainers
- Guidance Counselors
- Worksite Health Promotion Directors
- Parents/Guardians
- Librarians
- General Education Teachers
- Resource/Humanities Teachers
- Custodians/School Maintenance
- Qualified Mental Health Professionals
- Special Education Teacher
- Nurse Practitioners
- Physical Educators
- Food Service Directors
- School Psychologists
- Community Leaders
- School Health Advisory Members (SHAB)
- Special Education Teachers
- Physical Therapists
- Students
- Local Health Department Representative
- Licensed Practical Nurse

Building A Diverse School Health Team

Basic school health teams consist of parents, community leaders, primary health care provider, school physician, school nurse practitioner, or public health medical director, and the school nurse. Drawing on different backgrounds, ethnicities, and levels of expertise can provide a comprehensive approach to address School health needs.

Assigning Roles. When developing a school health team, it may be customary to assign components, roles, and responsibilities based on the team members' current duties associated with their existing school health role. For example:

- A ***School Nurse*** may be assigned school health services because the school nurse is responsible for school health services as a part of their current school nurse role.
- A ***Health and Physical Education Teacher*** may oversee the physical health component of the school health program. They would oversee community partnerships that support the physical health needs of the students.
- A ***School Principal*** may oversee the healthy school environment component as they typically set the tone for the school.

Delegating Tasks. School-health programs are fluid, flexible, and fit the unique needs of their school. Members could participate in many areas, especially if they are passionate about certain components and possess a high level of expertise. 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.

Staff Participation. Successful school health programs have the full cooperation of all staff, which makes the school environmentally safe, aesthetically pleasing, and embodies a space of belonging. which makes the school environmentally safe, aesthetically pleasing, and embodies a space of belonging.

Diversity of Team. Collaboration between the school and community is vital to guide programming. Ideally, the school health team includes at least one representative from each of the eight components, who is passionate about youth, and possesses a great deal of knowledge in their area of expertise.

Primary Team Members. It is important to remember each person can bring various perspectives to their role on the School Health Team. Developing a team of individuals with unique attributes to a particular component of the action plan strengthens the school health team as a whole.

Selecting Team Members. School-health program team members who represent various disciplines foster greater dissemination of information and implementation of program initiatives. It is recommended to develop a well-versed team. Team members can share activities with their respective professional groups and foster innovate ideas. Below are a list of team members who could serve on the school health team. It is not recommended to have a large team, instead it is best practice to have a smaller team of individuals with diverse backgrounds.

Recommendations. It is not recommended to have a large team, instead it is best practice to have a smaller team of individuals with diverse backgrounds, experiences, and perspectives. This allows for constructive, solution-driven conversations to address and identify school health needs.

Setting Goals For School Health Programs

Are your goals SMART?

- ***S**pecific,*
- ***M**easurable*
- ***A**ctionable*
- ***R**elevant*
- ***T**imebound*

1 Setting Goals and Objectives

Drafting autonomous goals and measurable objectives to enhance program effectiveness.

Goals. After the needs are identified, goals are specified. Goals are broad statements that identify long term outcomes the school health program is to achieve. Goals can serve as the mission statement of the program.

***Example*:** 80% of student population will have a dental health wellness check by the end of the academic school year.

Additional Resources:
How To Write SMART Goals (ucop.edu)

Objectives. Specific objectives help achieve program goals. They are actionable, incremental, and measurable steps that must be accomplished to successful reach the goal.

***Example*:** School will collaborate with community stakeholders to host wellness clinics



2 Developing An Action Plan

Developing a strategy or blueprint for meeting the identified priority needs from the assessment

The **action plan** works to resolve the identified needs by focusing on these key strategies:

- ***analysis*** of the need.
- ***setting priorities*** for goals and objectives.
- ***identifying*** the strategies to facilitate attainment of the objectives and goals.
- ***delegating*** the specific activities needed to complete each strategy/goal.
- ***establishing*** timelines.
- ***developing*** evaluation procedures.



Assessing Health Problems and Service Needs

Use data to analyze school community health status, trends in illness, and available resources.

DATA COLLECTION ANALYSIS

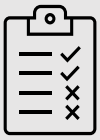


An assessment of the school community health status involves the regular collection, analysis, and sharing of information about the health conditions, risks, and resources present in a community. Assessments are needed to:

- **identify** trends in illness, injury, high-risk health behaviors, death, absenteeism, access to healthcare, and the factors that may cause these events;
- **research** available school health resources and their application
- **address** unmet needs and community perceptions about school health issues

Data can be analyzed to determine overarching school community health problems and ways to combat issues.

ASSESSMENT QUESTIONS

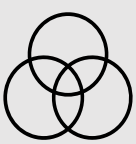


To identify the unique needs of the students in the school division, or individual school, collecting sufficient data is top priority. There are target questions to consider when collecting data:

What are major health problems affecting our community?
What are the areas of focus based on the needs of the student population?
What is the current status of programming that addresses these health problems?
Where are the gaps in needed programming?
What health issues should be addressed first?

A printable worksheet of assessment questions is available by clicking here.

METHODS & TOOLS



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

- Surveys (students, community, and parent/guardian perspective)
- Student School Health Records
- Epidemiological Data Reporting
- Social Indicator Data
- Crime reports
- School Health Profiles
- Youth Risk Behavior Surveillance System (YRBSS)
- Blue Ribbon Commission on School Health Evaluation Survey
- School Health Index (SHI): Self-Assessment & Planning Guide

Assessing Health Problems and Community Needs

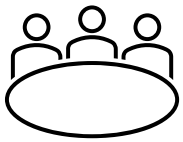
Use the template to record school health status, trends in illness, student behaviors, and available resources for your community.

Question	Findings
What are major health problems affecting our community?	
Data Collection Tool:	
What are areas of focus based on the needs of the student population?	
Data Collection Tool:	
What current level of programming exists to address the health problems?	
Data Collection Tool:	
Where are the gaps in needed programming compared to current programming?	
Data Collection Tool:	
Which health problems should be addressed first?	
Data Collection Tool:	

Community Support and Engagement

Actively involving families and the community can provide support for school health programs in the form of administrative support, personnel to staff events, program advocates, and outside funding. Many local school divisions are limited in adequate resources to successfully implement all eight components of successful school health programs. Outside avenues, like Parent Teacher Association and School Health Advisory Boards (SHAB), can play a crucial role in the development of a partnerships with community organizations, such as corporate and nonprofit agencies.

Nonprofit Agencies



A partnership could be developed with a nonprofit agency such as AmeriCorps or American Cancer Society. Both agencies can provide volunteers, educational programs, or development of educational materials, videos, posters, and handouts.

Funded Non-Governmental Organizations for Healthy Schools | CDC

Corporate Organizations



Developing a partnership with a large corporation could be beneficial for community engagement, especially if employees of the corporation have children who attend local schools. Corporate organizations could assist with funding a specific project for school health program components.

Local Organizations



Healthcare Organizations. A local healthcare organization, such as pediatric offices, can assist with managing a school-based health center or provide school-based educational resources.

Small Businesses. Owners of small business have a desire to serve their local community and are valuable, collaborative partners for school health programs. Catering of events, additional funding, and additional volunteers, are a few ways to utilize a partnership with local small businesses.

Civil Service Volunteers (Virginia Medical Reserve Corps)



Parents who work in civic service field could assist with components of school-health programs. A few examples include, but are not limited to:

- **parents/guardians with medical backgrounds** (i.e. nursing) could support hearing/vision screenings;
- **parents/guardians who work in law enforcement** could serve as guest speakers; and,
- **parents/guardians who are qualified mental health professionals** could provide a plethora of helpful resources.

Establishing and Enhancing School Health Advisory Boards

The **School Health Advisory Board (SHAB)** is an excellent vehicle to assist in the development of the school health program. 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. The Code of Virginia, Section 22.1-275.1, 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.

1

Health Forum
SHAB representatives address difficult health issues that are require presentation and consideration of multiple perspectives. SHAB representatives discuss, plan and decide on best practices to better to serve the community.

2

Membership Functions
SHAB members promote the development of health policy in the school division and the continuous evaluation of the status of school health, health education, school environment, and health services.

3

Recruitment
SHAB can strengthen communication channels between schools and outside agencies, through the coordination of community health resources that target a specific need in the school division.

4

Community Engagement
SHAB can coordinate the involvement of parent engagement, community involvement, and partner agencies to promote and advocate for high-quality community health resources using CDC's Whole School, Whole Community, Whole Child Model (WSCC).

5

Public Relations
SHAB can function as an effective public relations extension of a school division by informing the community and school personnel about aspects of coordinated health programs.

6

Innovation
SHAB can introduce new health program initiatives into the community and become a trailblazer for change within a school division.



Additional Resources:

Virginia Department of Education - Health & Medical: School Health Advisory Boards (SHAB)

Code of Virginia, Section 22.1-275.1, School Health Advisory Board

School Health Advisory Board (SHAB) Prospective Members

Potential SHAB members should include representatives from multiple disciplines and have a keen interest in improving and enhancing student's overall health and well-being. The list below are examples of potential SHAB members.





Education	Community
Teachers	Law Enforcement Officials
School Social Worker	Community Service Boards
School Nurse (RN)	Businesses/Industry
School Resource Officer	Church Leaders
Parent/Guardians	Public Health Agencies
Students	Community Youth Groups
Custodian	College/University Affiliates
School Health Coordinator	Local Government Officials
School Counselor	Transporation Coordinator
School Psychologist	Attorneys
School Administrators	Public Media Representative
Speech-Language Pathologist	Community Service Boards
School Psychologist	Healthcare providers/professionals

Establishing A School Health Team: Position Descriptions, Roles, and Responsibilities

Position	Scope of Responsibilities	Supervision Received	Supervision Given	Required Qualifications	Recommended Qualifications	Responsibilities
School Nurse: Registered Nurse (RN) Code of Virginia, Section 54.1-3000	The RN is responsible for developing, implementing, and managing a school health program for a school population as defined by the school division.	RN reports to the school nursing supervisor (if available) or local health department nursing supervisor.	RN Supervises the health aide/technician and others (LPN, school health aide, school health volunteer)	Current license to practice as a Registered Nurse in Virginia • Diploma from an accredited school of nursing • Associates degree from an accredited school of nursing • Baccalaureate degree from an accredited school of nursing Maintain certification in CPR, AED, and First Aid	Baccalaureate degree in nursing from an accredited college or university Attain National Board for Certification of School Nurses (NBCSN) Minimum of two years in a community or child health capacity before entry into school nursing practice	• Administration and Program Management of School Health Services • Physical Assessments • Delegation of Nursing Services • Nursing and School Health Services • Nursing Supervision and Training of school staff • Community Collaboration • Health Education • Community Health Planning • Continuing Education • Medicaid Nursing Services Plan of Care • First aid care and report emergencies to supervisor
School Nurse: Licensed Practical Nurse (LPN) Code of Virginia, Section 54.1-3000	The LPN is responsible for implementing a school health program for a school population as defined by the school division through direct collaboration with licensed health professionals.	LPN reports to the school nursing supervisor and receives direction from licensed medical practitioner (MD, DO, NP, PA), a registered nurse, or other licensed health professional authorized by the Virginia Department of Health Professions	Unlicensed Assistive Personnel School Staff	Current license to practice as a Licensed Practical Nurse (LPN) in Virginia Graduate from an accredited LPN program by the Virginia Board of Nursing Maintain certification in CPR, AED, and First Aid	Minimum of two years in a community or child health capacity before entry into school nursing practice	• Nursing and School Health Services • Health Education • Training of school staff • Community Collaboration • Community Health Planning • Continuing Education • First aid care and report emergencies to supervisor

Position	Scope of Responsibilities	Supervision Received	Supervision Given	Required Qualifications	Recommended Qualifications	Responsibilities
School Health Coordinator/ Supervisor: Registered Nurse	School Nurse Coordinator/Supervisor responsible for the administration and management of the local school health program, providing nursing leadership within the school system.	School Nurse Coordinator/Supervisor reports to their designated school supervisor/ administrator. If applicable may collaborate with their school medical director or local health director/ physician	School Nurse Coordinator/ Supervisor supervises all clinical staff providing services in the school health program.	Current license to practice as a Registered Nurse in Virginia • Diploma from an accredited school of nursing • Associates degree from an accredited school of nursing • Baccalaureate degree from an accredited school of nursing Maintain certification in CPR, AED, and First Aid Minimum of three years in school nursing or related field	Baccalaureate degree or Masters' degree (preferred) in nursing from an accredited college, university or school of nursing Attain National Board for Certification of School Nurses (NBCSN) Minimum of three years in a community or child health capacity before entry into school nursing practice	• Administration and Program Management of School Health Services • Delegation of Nursing Services • Nursing Supervision and Training of school staff • Community Collaboration • Health Education • Community Health Planning • Continuing Education • Medicaid Nursing Services Plan of Care • Employee Hiring and Orientation • Evaluation • Staff Development/Continuing Education
Unlicensed Assistive Personnel	Unlicensed Assistive Personnel (UAP) is a paraprofessional trained to provide care to individuals under the supervision of a registered nurse (RN) or Licensed Practical Nurse (LPN)	UAP receives supervision from the registered nurse and Licensed Practical Nurse (LPN)	None	Possess a high diploma or equivalent. Demonstrate sound judgment and clerical proficiency. Ability to communicate with verbal and written language. Maintain certification in CPR, AED, and First Aid	Post high school education Office management skills Experience in the care of the school-aged child.	Assisting in health care activities. • Vision/Hearing screening • Administer medications after receiving MAT training • First aid care and report emergencies to supervisor Perform clerical tasks as assigned. • Record health information. • Disseminates information to teachers, staff, and parents. • Complete incident and accident reports.

School Health Volunteers: The health, safety, and welfare of students are of primary concern when deciding to use volunteers in the school health setting. 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. Volunteers should not: administer medications or perform treatments unless specifically covered by local school board policy; or, have access to confidential student records**. Background checks and TB Screening per local school policy.**

Position	Scope of Responsibilities	Supervision Received	Supervision Given	Required Qualifications	Recommended Qualifications	Responsibilities
School Nurse Practitioner (NP)	NP in the school setting responsibilities may be based on their licensure according to the Virginia Board of Nursing and local school board policy. In some divisions, NP is the primary care provider for school-based health centers.	NP in the school setting responsibilities may be based on their licensure according to the Virginia Board of Nursing and local school board policy. NP may receive clinical consultation from a designated physician and the school nurse manager (when applicable).	NP may supervise licensed and unlicensed personnel with the school-based health center (SBHC) or school-based health program.	Current license to practice as an advance practice Registered Nurse Practitioner in Virginia Hold a Masters degree in nursing from an accredited college or university Possess/maintain current certification as a Nurse Practitioner Maintain certification in CPR, AED, and First Aid Per requirements of state licensure	Hold a Masters degree in nursing from an accredited college or university Doctor of Nursing Practice (DNP) 3 years in Pediatrics or school nursing Attain National Board for Certification of School Nurses (NBCSN)	Consultation with pediatrician and specialists in adolescent medicine Administration and Management of the School Health Services including care of students with chronic and acute conditions Provision of physical examinations of students and staff Provision of clinical in-service education Medicaid Nursing Services Plan of Care Training of School Staff
School Health Physician	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.	Primary care providers in a school program can serve as a liaison between child, family, and school personnel. -Primary Care Provider -School Health Physician -Medical Director of Local Health Department	Not applicable to school health setting.	Current license to practice medicine in the Commonwealth of Virginia. Knowledgeable about health needs of children and adolescents.	Board certified in pediatrics, family practice, or adolescent medicine. Masters' degree in Public Health	• Consultation to the school health program. • Lead/Participate in school health advisory board. (SHAB) • Complete health assessments for students. • Provide health education. • Coordinate with the school health team and community providers.

School Health Services
Evaluation of Services, Programs, and Procedures

Guidelines for Evaluation of School Health Services	
Criteria	**Documentation/ Comments**
I. GENERAL SCHOOL HEALTH SERVICES	
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. 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.	
B. Specific, written school health procedures are available for: 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.	
C. Responsibilities and roles of all school health personnel are clearly defined and applied.	
D. Community health resources and collaboration with local organizations are utilized as part of the comprehensive school health program. 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.	
E. A school health advisory board has been organized and is functioning effectively.	
6. Consultative services:	

Guidelines for Evaluation of School Health Services	
Criteria	**Documentation/ Comments**
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.	
H. Cumulative health records are maintained K-12 on all students and include: 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**
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] Per the *Code of Virginia* § 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]	
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.	
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. 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.	
J. Health assessments by the school nurse are: 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.	
K. School entrance physical examinations by a physician or nurse practitioner are: 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**
L. Screening programs are conducted as designated by the school nurse or other trained personnel. 1. Written procedures are available and being followed for: • 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.	
M. School personnel - nurse referrals and conferences: 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**
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.	
N. Health education and counseling is available to public, parents, and school personnel. 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.	
O. Students with special health care needs are identified in the school division. 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**
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. The school nurse is responsible for participating in the appropriate placement of students with exceptional needs. 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.	
Q. Communicable disease control is part of the school health services program. 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**
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.	
R. A school health office or adequate workspace is available in every school. 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.	

STAY CONNECTED

Subscribe to Commonwealth-wide newsletters to stay informed of special events, webinars, upcoming trainings, best practice recommendations, clinicians letters, and more!

01

Virginia Education Update Newsletter

Sign up here to receive updates from the Superintendent of Public Instruction. *(Formerly referenced as the Superintendent's Memo)*



02

VDH Healthcare Professionals Newsletter

Register for the monthly newsletter by clicking **here.**



03

VDOE Teacher Direct Weekly Newsletter

Sign up for the weekly newsletter by clicking **here**. A comprehensive resource beneficial for ***all*** school personnel, not just educators.



04

Clinician Letters

Sign up for the VDH Clinician Letters to stay in the know of important updates of public health significance.



Additional Subscriptions: NASN Weekly Digest / VASN Quarterly Newsletter



PROFESSIONAL ORGANIZATIONS

Join professional organizations to stay informed of special events, webinars, upcoming trainings, best practice recommendations, clinicians letters, and more!

- American Academy of Pediatrics
- Immunize VA
- Virginia Health Catalyst
- Epilepsy VA
- Virginia Chapter American Academy of Pediatrics
- AAP Bridge 2 Resources VA
- National Association of School Nurses (NASN)
- Virginia Association of School Nurses (VASN)
- Virginia Diabetes Council
- VCU Partnership for People with Disabilities
- Virginia Council for Private Education

JOIN THE

VIRGINIA ASSOCIATION OF SCHOOL NURSES

"When you join VASN, you are a member of VASN and the National Association of School Nurses with full benefits from both organizations." **Learn more** (VASN, 2024)

VASN
VIRGINIA ASSOCIATION OF SCHOOL NURSES

VIRGINIA PUBLIC SCHOOLS: RESOURCES AT A GLANCE

Bridge 2 Resources
Access to financial assistance, medical care, and other free or reduced-cost resources within your local area/zip code.
bridge2resourcesva.org

"54% of students in Virginia have a primary care provider."
Virginia Department of Education
School Health Data Survey, 2022-2023

"84.5% of schools in Virginia have an individualized medical plan for students diagnosed with diabetes."
Virginia Department of Education
School Health Data Survey, 2022-2023

Diabetes Management In Schools
The Center for Disease Control (CDC) has useful resources for providing reliable and accurate care to students diagnosed with diabetes.
Diabetes Medical Management Plan

Managing Diabetes at School - CDC Recommendations

Virginia Diabetes In Schools

Training required annually for all school health staff and designated school personnel to administer medication per § 54.1-3408.

Medication Administration, School Nurses Guide: A Training Manual for Unlicensed Public School Employees (2020) (Word)

Poison Control
Contact poison control immediately if you suspect a poisoning.
1-800-222-1222

"2.2 million medications are administered daily in K-12 public schools across the state of Virginia."
Virginia Department of Education
School Health Data Survey, 2022-2023

"Students in Virginia visit the school clinic at least 6 times each academic year."
Virginia Department of Education
School Health Data Survey, 2022-2023

Back To School: Healthy Schools Campaign
Virginia Department of Health offers resources for immunizations and wellness checks.

✓ **Healthy Back To School Website**
✓ **Vaccine Schedule**

RESPONSIBILITIES OF THE SCHOOL NURSE

- **Required Training**
  The Virginia Department of Education provides a comprehensive overview of required trainings (Anaphylaxis, Asthma, Bloodborne Pathogens, CPR/First Aid/AED, Diabetes, Medication Administration, and Seizure) for school health staff. Most trainings must be completed annually.
  VDOE School Health Guidance and Resources, & Required Training

- **Mandated Parent Notification Required:**
  School Nurses are required to notify parents of the following:
  - **Hearing and Vision Screening**
    § 22.1-273, 8VAC20-81-50(C), 8VAC20-250-10
  - **Scoliosis Screening**
    8VAC20-690-20, § 22.1-273.
  - **Eating Disorders**
    § 22.1-273.2.

- **Parental Empowerment**
  School Nurses encourage open communication amongst school staff, students, and parents/guardians. They make students feel safe and supported to reach their optimal level of health for learning.

- **School Health Activity Chart**
  The Virginia Department of Health provides recommendations for delegating tasks/activities to school health personnel caring for students with special health needs.
  VDH School Health Activity Chart

School Nurses are a vital resource for students, school communities, and parents/guardians. They understand both the medical and educational components of a child's overall well-being and assist students with reaching their optimal level of health for learning.



✔ New School Nurses

VDOE provides training modules for school nurse practices within the school setting. The modules are supplemental and not intended to replace orientation about school health policies and procedures at the local/school division level.
New School Nurse Orientation

✔ School Nursing Checklist

The Virginia Department of Health provides a checklist to assist nurses with setting up their school clinic, conducting mandated screenings, managing student enrollment/school entrance, immunization requirements, and end of the year wrap up.
VDH School Nursing Checklist

Resources:
VDH School Health Webpage
Forms, Action Plans, and Resources

VDOE School Health Guidance

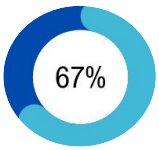
Nurturing our kids hearts and souls, as well as their minds and bodies, is educating the whole child. -Maggie Dent

School Health Staff:
Roles, Responsibilities, and Direct Supervision

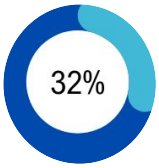
Code of Virginia §54.1-3000

Role	Scope of Responsibilities	Duties
School Registered Nurse (RN)	**The RN** is licensed nurse responsible for developing, implementing, and managing a school health program for a school population as defined by the school division. RNs report to the school nursing supervisor or local health department.	• Manage nursing and school health services. • Conduct physical assessments. • Develop health education resources. • Delegate nursing services. • Supervise and train school staff. • Establish community health partnerships and planning. • Administer emergency medication. • Provide first aid care and report emergencies to supervisor.
Licensed Practical Nurse (LPN)	**The LPN** is a healthcare professional responsible for components of a school health program for a school population as defined by the school division. LPNs report directly to licensed Registered Nurses, Physicians, and Nurse Practitioners.	• Perform nursing and school health services. • Provide health education. • Train school staff. • Establish community health partnerships and planning. • Administer medication (with RN supervision). • Provide first aid care and report emergencies to supervisor.
Unlicensed Assistive Personnel (UAP)	**The UAP** is an unlicensed paraprofessional trained to provide care to individuals. UAPs are restricted in their scope of responsibilities and perform duties assigned under the direct supervision of a registered nurse (RN) or Licensed Practical Nurse (LPN).	***Assist*** with health care activities and clerical tasks upon adequate training. ○ Conduct mandated screenings. ○ Administer medication (with RN supervision). ○ Input data for student health records. ○ Complete incident and accident reports.

School Health Activity Chart



schools staffed by a Registered School Nurse



schools staffed by a Licensed Practical Nurse **or** Unlicensed Assistive Personnel*

School Health Data Report, 2022-2023, Virginia Department of Education

- **RNs** can supervise LPNs and UAPs.
- **LPNs** may supervise UAPs.
- **UAPs** do not provide supervision.

School Health Services

Scope of Services and School Health Clinic Setup

Deciding On A Model for School Health Services

Although the primary goal of schools is education, basic school health services are an essential component of today's education program. School-based health services model typically depends on the educational preparation of the available personnel, the funding available in the particular community, the scope of services available, as well as, the attitudes and objectives of the community. A universally accepted definition of the term "school health services" has not been adopted, however the Health Is Academic: A Guide to Coordinated School Health Programs presents the following definition: *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.*

Scope of School Health Services

Most schools provide the following school-health services:

- Conducting screenings.
- Monitoring student immunization status.
- Providing first aid.
- Administering medication.
- Detection of infectious diseases.
- Providing wide range of health services for students with disabilities and individuals with special health care needs.

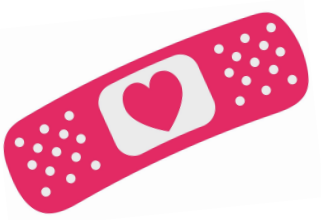
School Health Clinic Setup

The functions of a school health clinic should include the following:

Office space for managing the health of the student population.	Assessment area.	Medication dispensing area.	First aid emergency care treatment area.
Temporary isolation area for students who suspected of communicable diseases.	Rest areas for students who are ill or injured (before reporting back to class or picked up by parent/guardian).	Service area to conduct procedures such as immunization administration or mandated screenings.	Private conference space for counseling, meetings, etc.
Secure area to store student health records.	Resource center for health education materials.	Storage area for health supplies and equipment.	Secure area for medication storage.

Additional Resources

For additional guidance and information 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 information about the role of the School Nurse, refer to CDC website: School Nurses Help Keep Students Healthy.



Recommendations for School Health Clinic Supplies

Moveable Equipment	Suggested First Aid Supplies
⬜ Weight scales ⬜ Automated External Defibrillator ⬜ Bookcases ⬜ Bulletin boards ⬜ Clock (with a second hand) ⬜ Flashlight or pen light with battery ⬜ Gooseneck lamp ⬜ Magnifying light ⬜ Nebulizer ⬜ Otoscope/ophthalmoscope with battery ⬜ Physician's scale with height rod (and balanced) ⬜ Portable crisis kit ⬜ Portable first aid kit ⬜ Pure tone audiometer (calibrated annually), tympanometer ⬜ Reflex hammer ⬜ Sphygmomanometer (calibrated annually), with appropriate cuff sizes ⬜ Stethoscope ⬜ Stretcher ⬜ Tables (preferable for vision and hearing screening equipment) ⬜ Tape measure ⬜ Two-way communication device (i.e. walkie talkie) ⬜ Vision testing equipment, such as Random Dot E and HOTV tests, consistent with current standards ⬜ Wall-mounted height measuring tool ⬜ Wheelchair	⬜ Ace bandages ⬜ Airway/Ambu bags ⬜ Bandages, including adhesive (i.e. Band-Aids) and elastic of various types, materials, and sizes ⬜ Basins (emesis, wash) ⬜ Cold packs ⬜ Cotton-tip applications (swabs) ⬜ Cotton balls ⬜ CPR masks (pediatric and adult) ⬜ Dental floss ⬜ Disinfect for surfaces and fresh spills (1:10 beach salutation or disinfectant approved by the U.S. Environmental Protection Agency) ⬜ Disposable gowns ⬜ EpiPens ⬜ Eye cup ⬜ Eye irrigating bottles ⬜ 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 ⬜ Physician roll paper (optional) ⬜ Record forms (emergency cards, medication administration forms accident reports, state forms, etc.)



List retrieved from National Association for School Nurses: Emergency Resources, Equipment and Supplies List for Schools

- **EMERGENCY GO BAG**
- **FIRST AID SUPPLIES**
- **FIRST AID TEAM EQUIPMENT & SUPPLIES**
- **NON-MEDICAL RECOMMENDED SUPPLIES/EQUIPMENT**
- **FIRST AID CAMPUS EQUIPMENT**
- **SANITATION SUPPLIES**
- **FIRST AID TEAM RESOURCES**

School Health Services: Managing Illness

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.



Authorizations

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

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.

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).

- **Statewide Standing Order for Epinephrine in School Settings**
- **Albuterol Standing Order**
- **Naloxone Standing Order**

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:

- 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.
- Preventive measures to limit injuries.

STANDING ORDERS: THE WHO, THE WHAT, THE WHY

Medical Emergencies	Treating Specific Medical Issues
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.	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.
School Division Responsibility	**Orders, Rules, Regulations**
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.	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.

Student-Specific Treatment Orders

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.

Continued on next page.

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.



NURSING PROTOCOLS

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. 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.

School Division Responsibility

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.

Registered Nurse

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.

Other School Health Staff

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.



Resources

Virginia School Health Guidelines
VDH School Health website
School Health Forms & Action Plans
School Nursing Practice Framework™

School Health Services
Procedures 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.	*The first dose of any new medication should be given at home.*
4. Review Health Care Plan for documentation of any student-specific techniques that are recommended for administering the medication.	*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.*
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.	*Helps to ensure that the right medication is given to the right student.*
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.	*The person preparing the medication should be the person giving the medication.* *All pediatric liquid oral medicines should be measured and administered in millileters only, not teaspoons or other non-metric units, to ensure accurate dosing.*
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.	*By encouraging the student to assist in the procedure, the caregiver is helping the student achieve maximum self-care skills.*
Oral Medications	
1. Positioning for special situations: <u>Small students at infant developmental level</u>: • 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. <u>Large student at infant developmental level</u> • Allow student to remain in wheelchair. • Support student's head against your body. • Press on student's chin to open mouth. <u>Students with tongue thrust</u> • Medications may need to be rescued from the student's lips or chin and re-administered.	*When holding or supporting the student, it is important that the student is relaxed to prevent choking.* *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.*
2. Administering medication:	
<u>Dropper</u> • Squirt medication to the back and side of the student's mouth in small amounts.	
<u>Syringe</u> • Place syringe to the back and side of the student's mouth. • Give the medication slowly in small amounts, allowing the student to swallow.	
<u>Nipple</u> • 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
<u>Medicine Cup</u> • 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.	
<u>Tablets</u> • 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.	*It is important to check with pharmacist to see if drug action will be affected by crushing the medication.* *Division of unscored tablets may adversely affect their absorption by the body.* *Check with parents to determine how the medication is given at home.*
<u>Capsules</u> • 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.	*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.*
3. Before student leaves your presence, make sure that he/she has received and swallowed all of the medication.	*Students may hold medication in their mouth and spit it out at a later time.*
Nose Drops	
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.	*The lowered position is necessary when the student can not sniff the medication.*
2. Squeeze prescribed drops into each nostril. Student should remain in position for 1 minute to	

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.	*Keeps medication from flowing out of the ear.*
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.	*Avoid touching dropper to eye to avoid contamination of the medication.*
3. Ointment - Pull lower eyelid down, apply ointment along edge of lower eyelid from the nose side of the eyelid to the opposite side.	*Avoid touching tip of medication container to the to eye to avoid contamination of the medication.*
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.	*It is important that privacy be provided.* *Prevents quick expulsion of the medication so that the medication has adequate time to be absorbed.*

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.	*Pancreatic enzymes aid in digestion and absorption of food; therefore, they should be given prior to eating.*
2. Microspheres or microtablets should not be crushed or chewed.	*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.*
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.	*Notify parents and/or physician of any problems or side effects.*

Possible Problems	
Observations	***Reason/Action***
Incomplete dose of medication	*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.*
Incorrect medication	*Notify parents and physician immediately with name of medication and dosage given. Follow physician's orders.*

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Incorrect medication	*Notify parents and physician immediately with name of medication and dosage given. Follow physician's orders.*

Medication not given	*Report immediately to parents and/or physician. Determine when medication should be given next.*
Choking	*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.*
Response to medication	*Any side effects should be reported to the parents. If the student has an allergic reaction, the medication should be discontinued.*

Resources

American Academy of Pediatrics
Policy Statement – Guidance on the Administration of Medication in School

American Diabetes Association
Safe at School

Cystic Fibrosis Foundation

National Association of School Nurses
Medication Administration in the School Setting

Conducting Health Assessments

For Day-to-Day Health Encounters

Comprehensive 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.

01 Presence of Symptoms

Students present a range of complaints, and symptoms, from potentially life- threatening situations to more common problems, such as colds and coughs. Chronic recurrent symptoms may be associated with psychosocial problems, or abuse.
Review **COMMON HEALTH CONDITIONS ENCOUNTERED IN THE SCHOOL HEALTH CLINIC** found on *pages 45-48.*

02 Asking Open-Ended Questions

School health personnel should ask open-ended questions that encourage student to describe the problem. Take into consideration different cultural, ethnic, or socioeconomic backgrounds of students.

- "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 parent/guardian?"
- "What did they do?"
- "Are you taking any medication?"
- "Are you having problems in your classes?"
- "What class do you have now?"

03 Physical Health Assessments

School health personnel assessing the student obtains physical health assessment information about signs of an illness (e.g., vital signs and temperature) and takes appropriate measures, such as having the student rest in the health room and either returning to class or calling parent/guardian if the student is to be sent home, suggesting any follow-up with the student's health care provider, or calling emergency services.

04 Developing A Plan of Action

When assessing a student, the school nurse must skillfully explore the presenting symptom(s) 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 next steps and determine a plan of action, including referral to a health care provider, observation in the health office, and/or notifying parents/guardians.

Action Plans and Toolkits

- VDH Guidelines for Healthcare Procedures in Schools
- VDH First Aid Flipchart
- VDOE School Health Services Website
- CDC Concussion Signs and Symptoms Tool Kit
- Epilepsy Foundation Information
- Epilepsy Seizure Action Plan
- Food Allergy.org - FARE
- FARE Food and Allergy Emergency Action Plan
- ACAAI Allergy/Anaphylaxis Information
- Anaphylaxis Emergency Action Plan
- ACAAI Asthma Resource
- AAAAI Asthma Emergency Action Plan and Resources
- Virginia Asthma Action Plan
- Virginia Diabetes Council Resources
- Virginia Diabetes Council Tool Kit – DMMP and Forms

COMMON HEALTH CONDITIONS ENCOUNTERED IN THE SCHOOL HEALTH CLINIC

Headaches, Sore Throat, Abdominal Pain, and General Malaise

The focus of the school clinic visit is for the School Nurse to do an initial assessment and refer to healthcare provider for further medical management. Recommendations are based on best, 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 healthcare provider.

Headache

Initial Assessment and Intake	Plan of Action	Physical Examination	Potential Causes
Name and age of student.	Review health record.	⬜ Check temperature. ⬜ Check for tenderness or pain on motion. ⬜ Examine pupils to assess if they are equal in size. ⬜ Are there any lacerations, bleeding, bumps, or bruises? 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.	Headaches can be classified as acute, chronic, and recurrent. **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.
Has there been any recent head injury?	Examine student's head for lacerations, bleeding, bumps, or bruising.		
Where is the severity, persistence, location of the headache?	Any headaches that are characterized as severe, unilateral, or have persisted beyond 12 hours should be evaluated by a licensed health professional immediately.		
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.		
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.		
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.		

Sore Throat (Pharyngitis)

Initial Assessment and Intake	Plan of Action	Physical Examination	Potential Causes
Name and age of student.	Review health record.	⬜ Check temperature. ⬜ Neck: Are the glands in the neck swollen and/or tender? ⬜ Mouth: Does the throat appear red? Are the tonsils enlarged? Is pus or exudate present on the throat or tonsils? 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.	**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.
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.		
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.		
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.		
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.		
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.		
Has the student had recent contact with anyone who has had strep throat or impetigo (i.e., skin infection caused by Streptococcus)?	Sore throat following a recent contact with someone who had strep throat or impetigo warrants a throat culture in order to rule out Streptococcus as a cause of the pharyngitis.		

Abdominal Pain

Initial Assessment and Intake	Plan of Action	Physical Examination	Potential Causes
Name and age of student.	Review health record.	⬜ Check temperature and blood pressure. ⬜ Abdomen: Is pain localized? Does it radiate? Any signs of injury? ⬜ Is student pale? Sweaty? ⬜ Is mobility or actively severely restricted? Are there signs of guarding? 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.	**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.
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 should be referred to a licensed health professional immediately.		
Is this a new complaint? If not, how many times has the student complained of this?	If this is a common complaint for this student, it may be indicative of stress- related illness and the student could stay in school.		
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.		
For girls: Is it associated with frequency or burning on urination? Is it associated with menstruation cycle?	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.		

General Malaise: "I Don't Feel Well"

Initial Assessment and Intake	Plan of Action	Physical Examination	Potential Causes
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.	⬜ Check temperature. If positive for temperature, this may indicate nonspecific viral or bacterial disease. Refine assessment and refer for further evaluation.	**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.
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.		
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.		

REFERENCES: 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.

Communicable Diseases



Virginia Department of Health, Office Of Epidemiology

The **Disease Reporting and Control Regulations** provides important resources on clinic epidemiology, disease prevention, and immunizations. They also provide **Epidemiology Fact Sheets** for common diseases.

Overview

Communicable infectious diseases usually spread through direct skin contact, including those commonly known as head lice, impetigo, pink-eye, scabies, and ringworm. Illness can spread from person to person by direct or indirect transfer of the disease-causing organism. Communicable disease is an illness due to specific infectious 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. For additional information, check out:

Guidance/Recommendations

Communicable Disease Reference Chart for School and Child Care Facilities

Supplemental Communicable Disease Reference Chart for School and Child Care Facilities (*found on page 50*)

Virginia Reportable Communicable Disease List

COVID-19 Information for K-12 Schools & Child Care Programs

Infectious Disease Control In Schools Measures



Infectious disease control measures in schools include:

- Requiring certain immunizations.
- Identifying children who have communicable diseases.
- Preventing illnesses from spreading through mitigation strategies.
- Temporarily excluding some children who are ill.
- Reporting illnesses regulated by VDH.
- Being prepared by having policies, procedures, and trained personnel.
- Consulting with health department for continuous guidance.

Communicable Disease Resources

Communicable Disease Reference Chart

Supplemental Disease Reference Chart for School and Child Care Facility Personnel

Both charts are continued on the next 20 pages.

For the most recent resources, follow this link.

VDH VIRGINIA DEPARTMENT OF HEALTH

Communicable Disease Reference Chart for School and Child Care Facility Personnel*

DISEASE	INCUBATION PERIOD	TRANSMISSION	COMMON SYMPTOMS	RECOMMENDATIONS
Chickenpox† (Varicella)	10–21 days, usually 14–16 days. (Incubation period in persons who receive VariZIG or IVIG extends through day 28.)	By direct contact with vesicular fluid or by airborne spread from respiratory tract secretions. Infectious from 1 to 2 days before rash onset until all lesions have dried/crusted over and no new lesions appear within a 24-hour period (average is 4–7 days).	Sudden onset with slight fever, other systemic symptoms and itchy eruptions which become vesicular (small blisters) within a few hours. Lesions commonly occur in successive crops, with several stages of maturity present at the same time. Typically, vesicular rash consisting of 250–500 lesions in varying stages of development (papules, vesicles) and resolution (crusting). Communicable for as long as 5 days (usually 1–2 days) before eruption of vesicles and until all lesions are crusted (usually 5 days). Communicability may be prolonged in people with weakened immune systems.	PATIENT: Exclude from school or child care until: • Uncomplicated varicella: the rash has crusted • Immunized patients without crust: no new lesions appear within a 24-hour period • Patients with weakened immune systems: at least 5 days after eruptions first appear or until vesicles become dry Avoid exposure to women in early pregnancy who have not had chickenpox and/or varicella vaccine. CONTACTS: Check vaccination status of contacts in school and child care and recommend vaccination if needed within 3 to 5 days after exposure. For exposed contacts without immunity, airborne and contact precautions from 8 until 21 days after exposure and until 28 days after for those who received VariZIG or IVIG. On appearance of symptoms, exclude from school and child care.
Conjunctivitis (Pink Eye)	Usually 1–3 days, but variable depending on the causative agent. May be bacterial, viral, allergic, or chemical/irritant.	By contact with discharge from the conjunctivae or contaminated articles, if the cause is bacterial or viral. Allergic and chemical causes are not contagious.	Pink or red eye with swelling of the eyelids and eye discharge. Eyelids may be matted shut after sleep. May involve one or both eyes.	PATIENT: Exclude from school or child care while symptomatic or until cleared to return by a healthcare provider. CONTACTS: Exclusion not indicated. Important to wash hands thoroughly after contact with eye drainage. Also, do not share any articles that have come into contact with the eyes.
COVID-19† (Coronavirus disease 2019 caused by SARS-CoV-2 virus)	Usually 2–14 days.	COVID-19 spreads when an infected person breathes out droplets and very small particles that contain the virus. These droplets and particles can be breathed in by other people or land on their eyes, noses, or mouth. In some circumstances, they may contaminate surfaces they touch. Infected people are believed to be infectious 2 days prior to symptom onset through 10 days after symptom onset, with viral loads being higher earlier in the course of infection.	Patients may be asymptomatic. Patients who develop symptoms may have a wide variety of symptoms of variable severity: • Fever and/or chills • Cough • Shortness of breath • Headache • Runny nose • Fatigue • Sore throat • Muscle aches/body aches • New loss of taste or smell • Nasal congestion • Nausea and vomiting • Diarrhea	PATIENT: Please refer to the VDH K12 Isolation and Quarantine Guidance. Depending on severity of illness, refer to a healthcare provider, urgent care center, or emergency department for further evaluation and treatment. CONTACTS: Please refer to the VDH K12 Isolation and Quarantine Guidance. Quarantine is no longer recommended for asymptomatic contacts. VDH K12 Isolation and Quarantine Guidance: https://www.vdh.virginia.gov/coronavirus/get-the-latest-guidance/k-12-education-and-child-care/

NOTE: THESE RECOMMENDATIONS APPLY ONLY TO CHILDREN IN K-12 SCHOOLS OR CHILD CARE - A more complete discussion of these conditions and other communicable diseases may be found in *Control of Communicable Diseases Manual* (2022) published by the American Public Health Association and the *2021 Report of the Committee on Infectious Diseases* (*The Red Book*) published by the American Academy of Pediatrics. Additional information and consultation are also available through your local health department.

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Communicable Disease Reference Chart for School and Child Care Facility Personnel*

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Diarrheal Diseases† (Campylobacteriosis, *E. coli* O157:H7, Giardiasis, Salmonellosis, Shigellosis, etc.)	Campylobacteriosis: Usually 2–5 days but can be longer (1-10 days). *E. coli* O157:H7: Varies from 1 to 10 days, usually 3 to 4 days. Giardiasis: Usually 1 to 3 weeks. Salmonellosis: Usually, 6–72 hours, but periods of a week or more have been reported. Shigellosis: Varies from 1 to 7 days, typically 1–3 days.	Primarily by the fecal-oral route through direct contact or by ingestion of contaminated (or improperly cooked) food or water.	Ranges from sudden onset of fever, abdominal pain, diarrhea, nausea, and sometimes vomiting in salmonellosis, to cramps and bloody stools in severe cases of shigellosis and *E. coli* O157:H7. In giardiasis, persons may be asymptomatic or have decreased appetite and weight loss. The most common symptoms are diarrhea, abdominal pain, malaise, and fever. Stools can contain visible or occult blood. Dangerous dehydration may occur in younger children. Patients with weakened immune systems can have prolonged, relapsing, or extraintestinal infections.	PATIENT: Exclude from school and child care until stools are contained in the diaper or when continent patients no longer have fecal accidents and when stool frequency becomes no more than 2 stools above normal frequency for the patient, even if the stools remain loose. Stress importance of proper handwashing. In an outbreak setting, consult local health department for clearance to return to school/childcare setting. Please note that other resources advise no return to school until diarrhea has ceased for at least 24 hours. CONTACTS: Exclusion and stool cultures not indicated in absence of symptoms. Contacts who are symptomatic should be excluded until stools are contained in the diaper or child is continent and stool frequency is no more than 2 stools above that child's normal frequency for the time the child is in the program. Stool cultures are recommended for symptomatic contacts, and these children should be excluded from school and child care while evaluation is pending. Consult with your local health department for advice during suspected school outbreaks. Thorough hand hygiene and environmental cleaning is very important.
Fifth Disease (Parvovirus B19, Erythema Infectiosum)	Between 4–14 days but can be as long as 21 days.	By contact with respiratory tract secretions and percutaneous exposure to blood or blood products. Once the characteristic rash appears, the child is considered no longer contagious.	Distinctive rash characterized by a vivid reddening of the skin, especially of the face, which fades and recurs; classically, described as a "slapped cheek appearance." The rash can fluctuate in intensity and can recur with environmental changes, such as temperature and exposure to sunlight, for weeks to months. Mild symptoms of fever, body aches, and headache may occur 7–10 days before rash.	PATIENT: Exclusion not indicated beyond facility-based policies about fever. CONTACTS: Exclusion not indicated. Pregnant women and persons with weakened immune systems should seek medical advice.
Hepatitis A†	From 15–50 days; average 28 days. **All suspected or confirmed cases of hepatitis A are rapidly reportable to the local health department**	By the fecal-oral route through direct contact or ingestion of contaminated food or water. People with Hepatitis A virus (HAV) infection are most infectious during the 1 to 2 weeks before onset of jaundice or elevation of liver enzymes, when concentration of virus in the stool is highest. Risk	Initial symptoms begin abruptly and include fever, nausea, vomiting, anorexia, malaise, and abdominal pain or discomfort. Dark urine, pale stools, and jaundice (yellowing of the skin or eyes) might be present initially or might develop a few days to a week later. The likelihood of symptoms increases with age.	PATIENT: Patients with acute HAV infection who work as food handlers or attend or work in child care settings should be excluded for 14 days if symptomatic, or 7 days since jaundice. If the person is not a food handler or in a child care setting, exclude for 7 days after onset of symptoms. Serologic testing should be performed to confirm HAV infection in suspected cases. CONTACTS: Determine if contact is immune to HAV through immunization records and/or serologic testing (a positive Hep A IgG). Contacts who are immune do not need additional follow-

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Communicable Disease Reference Chart for School and Child Care Facility Personnel*

DISEASE	INCUBATION PERIOD	TRANSMISSION	COMMON SYMPTOMS	RECOMMENDATIONS
		diminishes and is minimal by 1 week after onset of jaundice.	Symptoms typically last less than 2 months but can extend up to 6 months.	up. Determine if contact meets criteria for HAV post-exposure prophylaxis (PEP). Childcare staff or attendees who might have been exposed to HAV in the past 2 weeks should be excluded for 7 weeks after last contact with the case during the infectious period, unless they receive PEP within 14 days of exposure or report immunity through vaccination or serology indicating previous disease. Contacts who are symptomatic and epidemiologically-linked to a laboratory-confirmed case meet the case definition and should be managed as a case, including appropriate investigation and exclusion. In a child care center, stress importance of proper handwashing. In facilities with diapered children, if 1 or more cases confirmed in child or staff attendees or 2 or more cases in households of staff or attendees, hepatitis A PEP should be administered within 14 days of exposure to all unimmunized staff and attendees. In centers without diapered children, hepatitis A PEP should be administered only to unimmunized classroom contacts of index case. Asymptomatic contacts may return after receipt of hepatitis A PEP. If questions about management of cases and/or contacts, please contact local health department.
Hepatitis B†	From 45–160 days; average 90 days.	By direct contact with infected blood or body fluids. Transmission occurs when the hepatitis B virus enters the body through broken skin or mucous membranes. The risks of HBV acquisition when a susceptible child bites a child who has chronic HBV infection or when a susceptible child is bitten by a child with chronic HBV infection are unknown.	Developing symptoms of acute hepatitis are age-dependent. The spectrum of symptoms and signs is varied and includes subacute illness with nonspecific symptoms (e.g., anorexia, nausea, or malaise), clinical hepatitis with jaundice, or fulminant hepatitis.	PATIENT: Follow advice of child's healthcare provider and/or your local health department. CONTACTS: Exclusion not indicated.
HIV Infection† and AIDS† (Acquired Immunodeficiency Syndrome)	Acute retroviral syndrome occurring in adolescents and adults following HIV acquisition occurs 7–14 days following viral acquisition and lasts for 5–7 days. Most patients are not ill enough to seek	(1) sexual transmission (vaginal, anal, orogenital), (2) percutaneous blood exposure (e.g., contaminated needles), (3) mother-to-child transmission, (4) mucous membrane exposure to contaminated blood or body fluids, (5) transfusion of contaminated	Clinical manifestations of untreated pediatric HIV infection include unexplained fevers, generalized lymphadenopathy, hepatomegaly, splenomegaly, failure to thrive, persistent oral and diaper candidiasis, recurrent diarrhea, parotitis, hepatitis, central nervous	PATIENT: Follow advice of child's healthcare provider and/or your local health department. CONTACTS: Exclusion not indicated.

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Communicable Disease Reference Chart for School and Child Care Facility Personnel*

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	medical attention. The usual age of onset of symptoms is generally 12–18 months of age for untreated infants and children who acquire HIV infection through mother-to-child transmission. Some children become ill in the first few months of life, but others remain relatively asymptomatic for more than 5 years and, rarely, until early adolescence.	blood or blood products, (6) cases of HIV transmission have been reported from contact of non-intact skin with blood-containing body fluids	system disease (e.g., encephalopathy, hyperreflexia, hypertonia, floppiness, developmental delay), lymphoid interstitial pneumonia, recurrent invasive bacterial infections, and opportunistic infections (e.g., viral, parasitic, and fungal infections).	
Influenza	Usually 1–4 days, with an average of 2 days.	Person-to-person by respiratory droplets created by coughing or sneezing. Another mode of transmission comes from contact with influenza virus from droplet-contaminated hands or surfaces, where it can remain for up to 24 hours, with transfer from hands to mucosal surfaces of the face. Airborne transmission via small-particle aerosols in the vicinity of the infectious individual also may occur. Patients may be infectious 24 hours before onset of symptoms. Viral shedding in nasal secretions usually peaks during the first 3 days of illness and ceases within 7 days but can be prolonged (10 days or longer) in young children and immunodeficient patients.	Sudden onset of fever, often accompanied by nonproductive cough, chills or rigors, diffuse myalgia, headache, and malaise. Subsequently, respiratory tract symptoms, including sore throat, nasal congestion, rhinitis, and cough, become more prominent. Less commonly, abdominal pain, nausea, vomiting, and diarrhea are associated with influenza illness. In some children, influenza can appear as an upper respiratory tract illness or as a febrile illness with few respiratory tract symptoms. In infants, influenza can produce a nonspecific sepsis-like illness picture, and in infants and young children, influenza can cause otitis media, croup, pertussis like-illness, bronchiolitis, or pneumonia. Acute myositis secondary to influenza can present with calf tenderness and refusal to walk.	PATIENT: Exclude from school and child care until at least 24 hours following resolution of fever without the use of fever-reducing medication(s). CONTACTS: Exclusion not indicated. Annual seasonal influenza vaccination for staff and children ≥ 6 months of age is strongly encouraged to prevent cases of influenza or lessen severity of illness.
Measles† (Rubeola, Red Measles)	Generally, 8–12 days from exposure to onset of symptoms. (Range of 7 to 21 days, average of 14 days between appearance	Direct contact with infectious droplets or by airborne spread through inhalation of infectious droplets when a person with measles coughs, sneezes, etc.	Characterized by fever, cough, coryza, and conjunctivitis, followed by a maculopapular rash beginning on the face and spreading cephalocaudally and centrifugally.	PATIENT: Exclude from school and child care until at least 4 days after appearance of the rash and when the child is able to participate. CONTACTS: Check immunization records of all contacts.

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DISEASE	INCUBATION PERIOD	TRANSMISSION	COMMON SYMPTOMS	RECOMMENDATIONS
	of rash among case and contacts) **All suspected or confirmed measles cases are rapidly reportable to the local health department**	Patients infected with wild-type measles virus are contagious from 4 days before the rash onset through 4 days after appearance of the rash.	During the prodromal period, a pathognomonic enanthem (Koplik spots) may be present. Sometimes the characteristic rash does not develop in patients with weakened immune systems. Koplik spots are typically 1-3mm whitish, grayish, or bluish elevations with an erythematous base typically seen on the buccal mucosa. Koplik spots are not seen in all measles cases.	Additional measures are not needed for children and/or staff who are fully vaccinated or have evidence of immunity to measles. People who have not been immunized, including those exempted from measles immunization for medical reasons, should be excluded from school, child care, and health care settings until at least 21 days after the onset of rash in the last case of measles. Discuss with your local health department. Every suspected measles case should be reported immediately to the local health department.
Meningitis, Bacterial (*H. influenzae*†, Meningococcal†, Pneumococcal)	In general, 1 to 10 days, usually less than 4 days. *H. influenzae*: 2–4 days Meningococcal: 2–10 days, usually 3–4 days. Pneumococcal: 1–4 days **All suspected or confirmed cases of invasive H. influenzae disease or meningococcal disease are rapidly reportable to the local health department**	Transmission occurs from person to person through droplets from the respiratory tract and requires close contact. Transmission can also occur by sharing beverages, utensils, and personal care products. Patients should be considered capable of transmitting the organism for up to 24 hours after initiation of effective antimicrobial treatment.	Typically, acute onset of fever, neck stiffness, neck pain, headache, light sensitivity and other neurologic symptoms or signs. In meningococcal disease, rash initially can be macular or maculopapular but typically becomes petechial or purpuric within hours. Signs and symptoms of meningococcal meningitis are sometimes indistinguishable from those associated with pneumococcal meningitis.	PATIENT: Exclude from school and child care during acute illness. Non-communicable after 24-48 hours of appropriate drug therapy. CONTACTS: Exclusion not indicated. Discuss with your local health department to determine if close contacts need **prophylactic treatment** for *H. influenzae* or meningococcal meningitis, especially contacts in a child care setting. Students and staff should be advised not to share beverages, eating utensils, or personal care products.
Mpox† (Previously known as monkeypox)	Symptoms usually start within 3 weeks of exposure to the virus. If someone has flu-like symptoms, they will usually develop a rash 1–4 days later.	Transmission occurs through direct contact with sores, scabs, or body fluids from an infected person or animal, indirect contact with contaminated items (e.g., clothes, bedding, towels), and large respiratory droplet transmission during prolonged face-to-face contact. Mpox can be spread from the time symptoms start until the rash has healed, all scabs have fallen off, and a fresh layer of skin has formed. The illness typically lasts 2–4 weeks.	People with mpox get a rash that may be located on the hands, feet, chest, face, mouth, or other locations. The rash will go through several stages, including scabs, before healing. The rash can initially look like pimples or blisters and may be painful or itchy. Other symptoms of mpox can include fever, chills, swollen lymph nodes, exhaustion, muscle aches	PATIENT: Exclude from school and child care until the rash has healed, all scabs have fallen off, and a fresh layer of skin has formed. This may take as long as 4 weeks after symptoms began. Caregivers should work with a healthcare provider and the health department to decide when the child or adolescent can return to the educational setting. CONTACTS: Exclusion not indicated in most cases. In some cases, if contact tracing may not be possible and there was a high degree of exposure, the local health department may consider limiting an individual's participation in activities. The health department will consider the age of the individual and their ability to recognize or communicate symptoms, the types of

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			and backache, headache, respiratory symptoms (e.g., sore throat, nasal congestion, or cough). Sometimes, people have flu-like symptoms before the rash. Some people get a rash first, followed by other symptoms. Others only experience a rash.	interactions in the environment, and the risk of more severe disease to others in the setting. Settings that have children or adolescents in residence, like boarding schools, overnight camps, or other residential environments, should follow considerations for congregate settings.
Mumps†	From 12–25 days, usually 16–18 days. The recommended isolation period is 5 days after onset of parotid swelling. However, virus has been detected in patients' saliva as early as 7 days before and until 9 days after onset of swelling.	Mumps is highly infectious. Transmission occurs by droplet spread or by direct contact with respiratory tract secretions or the saliva of an infected person.	Fever with swelling and tenderness of one or both parotid glands as well as nonspecific symptoms such as muscle aches, loss of appetite, malaise, headache, and low-grade fever. Asymptomatic infection occurs in about 15-20% of cases, usually in adults more than children.	PATIENT: In addition to standard precautions, exclude from school and child care for 5 days after the onset of parotid gland swelling. CONTACTS: Determination of vaccination status should be obtained for all contacts. In an outbreak setting, consult local health department regarding outbreak management and whether contacts need to be excluded from school or child care. If health department agrees, unimmunized contacts should be excluded until at least 26 days after onset of parotitis in the last person with mumps. Moreover, if the school or child care is considered to be at high risk for mumps, a recommendation may be made for students and staff who have had two doses of a mumps-containing vaccine to receive a third dose of MMR vaccine.
Norovirus	From 12–48 hours	Primarily by the fecal-oral route through direct contact or ingestion of contaminated food or water, or by touching contaminated surfaces. Transmission is also possible through direct contact with the vomit, exposure to contaminated surfaces and aerosolized vomitus of an infected person.	Sudden onset of vomiting and/or diarrhea, abdominal cramps, and nausea. Symptoms typically last from 24 to 72 hours but prolonged illness can occur. Systemic manifestations, including fever, myalgia, malaise, anorexia, and headache, may accompany gastrointestinal tract symptoms.	PATIENT: In addition to standard precautions, exclude from school and child care until 48 hours after symptoms resolve. Infants and children should be excluded from child care centers until stools are contained in the diaper or when toilet-trained children no longer have accidents using the toilet and when stool frequency becomes no more than 2 stools above that child's normal frequency for the time the child is in the program, even if the stools remain loose. Stress importance of thorough handwashing, especially when caring for diapered children, as virus may be shed in stool for weeks after symptoms resolve. CONTACTS: Exclusion not indicated. Environmental cleaning is a very important component of the response to a norovirus outbreak. A high-concentration bleach solution can be used—this solution must remain on the surface for enough time to kill norovirus. Surface must be rinsed with water to remove bleach residue.

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Pediculosis (Head Lice)	Eggs hatch in about 1 week (range 6–9 days), and reach maturity to an adult about 7 days later.	By direct head-to-head contact with hair of an infected person. Transmission can occur by the personal belongings of an infected person, but this is uncommon. Head lice occurs most commonly in children attending child care, preschool, and elementary school, and is not a sign of poor hygiene.	Severe itching and scratching, often with secondary infection. Eggs of head lice (nits) attach to hairs as small, round, gray lumps. However, many children are asymptomatic. Excoriations and crusting caused by secondary bacterial infection may occur.	PATIENT: Notify parents; inform that child has lice and should be treated. Children should not be excluded or sent home early from school or child care because of head lice, because head lice have a low contagion within classrooms. "No-nit" policies should be discouraged. CONTACTS: Household and close contacts should be examined and treated if infested. No exclusion necessary. Routine classroom or school-wide screening for lice is discouraged. Parents who are educated on the diagnosis of lice infestation may screen their own children's heads for lice regularly and if the child is symptomatic. Refer for treatment if infested.
Pertussis† (Whooping Cough)	From 5–21 days, usually 7–10 days. **All suspected or confirmed cases of pertussis are rapidly reportable to the local health department**	By direct contact with large respiratory droplets (coughing, sneezing) of an infected person by the airborne route.	The initial stage begins with mild upper respiratory symptoms of a common cold and increasingly irritating cough. The paroxysmal stage usually follows within 1 to 2 weeks. "Classic" pertussis has a duration of about 6–10 weeks. Paroxysmal stage is characterized by repeated episodes of violent cough broken by a high-pitched inspiratory whoop and vomiting. Older children may not have whoop. Convalescence may require many weeks.	PATIENT: Exclude from school and child care until 5 days after initiation of appropriate antibiotic therapy. A 5-day course of azithromycin is usually treatment of choice and is also used for post-exposure prophylaxis. Untreated individuals should be excluded until 21 days have elapsed from cough onset. If questions about pertussis treatment or post-exposure prophylaxis, discuss with your local health department. CONTACTS: PEP may be indicated for certain high-risk individuals, including infants <12 months of age and household contacts, and for all people in high risk settings (e.g. child care centers) that include infants <12 months of age and other high risk individuals. Individuals in all settings who have been in close contact with a person infected with pertussis should be monitored closely for respiratory tract symptoms for 21 days after last contact with the infected person. Close contacts with cough should have medical evaluation. Exclude on first indication of symptoms pending evaluation by healthcare provider.
Ringworm of the Body (Tinea Corporis)	Incubation period believed to be 1 to 3 weeks but can be shorter, as reported cases have occurred at 3 days of age.	By contact with lesions of infected persons, animals, soil or fomites (e.g., brushes, combs, hats, towels).	Circular, red to brown, well-demarcated lesion that can involve face, trunk, or limbs. The classic eruption displays a scaly, vesicular, or pustular border (often serpiginous) with central clearing. Small confluent plaques or papules as well as multiple lesions can occur. Itching is common.	PATIENT: Exclusion not indicated as long as lesions are covered or child is receiving treatment. CONTACTS: Exclusion is not indicated.
Rubella† (German Measles)	From 12 to 23 days, usually 17 days. **All suspected or confirmed cases of**	By direct contact or droplet spread of nasopharyngeal secretions of an infected person. People infected with rubella are most contagious when the rash is erupting.	Mild symptoms; slight fever, rash of variable character lasting about 3 days; enlarged head and neck lymph glands commonly lasting between 5 to 8 days. Joint pain may	PATIENT: Exclude from school and child care for 7 days after onset of rash. Avoid exposure to women in early pregnancy. Check immunization records of all students. Discuss with your local health department.

NOTE: THESE RECOMMENDATIONS APPLY ONLY TO CHILDREN IN K-12 SCHOOLS OR CHILD CARE - A more complete discussion of these conditions and other communicable diseases may be found in *Control of Communicable Diseases Manual* (2022) published by the American Public Health Association and the *2021 Report of the Committee on Infectious Diseases* (*The Red Book*) published by the American Academy of Pediatrics. Additional information and consultation are also available through your local health department.

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Communicable Disease Reference Chart for School and Child Care Facility Personnel*

DISEASE	INCUBATION PERIOD	TRANSMISSION	COMMON SYMPTOMS	RECOMMENDATIONS
	rubella are rapidly reportable to the local health department		occur, especially in older children and adults. Communicable for 7 days before onset of rash and at least 7 days thereafter.	CONTACTS: In outbreak setting, children without evidence of immunity should be immunized or excluded for 23 days after onset of rash of the last case in the outbreak. Pregnant contacts should be evaluated.
Scabies	Persons without previous exposure: 4 to 6 weeks. Previously infested and sensitized: 1–4 days after re-exposure.	By direct skin-to-skin contact, usually prolonged exposure. Infection from dogs or other animals is uncommon. Casual skin contact unlikely to result in transmission. Fomite transmission not likely to lead to classic scabies, but fomite transmission more likely in setting of crusted scabies since parasite burden is much higher.	Begins as itchy raised areas around finger webs, wrists, elbows, armpits, belt-line, thighs, naval, abdomen, buttocks and/or genitalia. In older children and adults, in areas such as the scalp, face, neck, palms, and soles. Scabitic burrows appear as thin, gray or white, serpiginous, thread-like lines. Extensive scratching often results in secondary infection. Crusted scabies (also known as Norwegian scabies) can occur in people who have deficiency in cellular immunity (AIDS, lymphoma, long-term steroid use, etc.).	PATIENT: Exclude from school and child care until after the first course of appropriate treatment has been completed. Children identified during the school day should not be sent home early from school or child care because scabies has a low contagion within classrooms. CONTACTS: Close contacts with prolonged skin-to-skin contact should receive treatment at the same time the infected person does. Bedding and clothing in contact with skin of infected people should be laundered.
Streptococcal Diseases (Including Impetigo, Scarlet Fever, and Streptococcal pharyngitis)	Some common Group A Streptococcal infections include (1) impetigo, (2) streptococcal pharyngitis ("strep" throat) and (3) Scarlet fever. Typical incubation periods are as follows: Impetigo: 7–10 days Streptococcal pharyngitis: 2–5 days Scarlet fever: generally occurs in conjunction with streptococcal pharyngitis	In impetigo, usually acquired by direct contact with skin lesions or their discharge from an infected person. Strep pharyngitis/Scarlet fever: By direct contact with infected persons and carriers or by contact with their respiratory droplets.	Impetigo: Multiple skin lesions usually of exposed area (e.g., elbows, legs, and knees), but may involve any area. Lesions vary in size and shape, and begin as blisters, which rapidly mature into brown crusts on a reddened base. Healing from center outward produces circular areas, which may resemble ringworm. Scarlet Fever: Fever, sore throat, exudative tonsillitis or pharyngitis. Sandpaper-like rash appears most often on neck, chest, and skin folds of arms, elbows, groin, and inner aspect of thighs. "Strep" throat: Sudden onset of fever, sore throat, exudative tonsillitis or pharyngitis, and enlarged lymph nodes. Symptoms may be absent in some cases.	PATIENT: For impetigo: Exclude from school and child care until at least 12 hours after antibiotic treatment has been started and all sores on exposed skin are covered. Close contact with other children should be avoided during this time. For Group A strep pharyngitis: Exclude from school and child care until 12 hours after appropriate antibiotic therapy has been started AND afebrile without the use of fever-reducing medications (e.g. acetaminophen or ibuprofen). CONTACTS: For impetigo: Exclusion not indicated. Stress good handwashing. For Group A Strep pharyngitis: Symptomatic contacts of a child with documented Group A Strep infection with recent or current clinical evidence of a Group A Strep infection should be medically evaluated and treated if positive. Routine lab testing or school/child care exclusion of asymptomatic household contacts is not indicated except during outbreaks or if the contact is at high risk of developing sequelae of infection. In general, in the school and child care setting, chemoprophylaxis against Group A Strep is not recommended.

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Summary of Major Changes in the February 21, 2023 Update:

- Conjunctivitis (Pink eye) – Expanded from "acute bacterial" conjunctivitis to "all causes," removed the requirement to be on antibiotics to return to school/child care, and added clearance by a healthcare provider to return while symptomatic.
- COVID-19 – Aligned transmission information with the Centers for Disease Control and Prevention (CDC). Removed information on close contacts.
- Fifth Disease (Parvovirus B19) – Added information about the characteristic rash.
- Hepatitis A – Clarified length of exclusion for patients who are food handlers and those who work in or attend child care.
- Mpox – Updated disease name from "monkeypox" to "mpox."
- Pertussis – Aligned PEP recommendations for contacts with CDC recommendations.
- Rubella – Updated exclusion of unimmunized contacts from 21 days to 23 days.
- Streptococcal Diseases – Changed exclusion criteria from 24 hours of antibiotics to 12 hours of antibiotics for impetigo, and to 12 hours of antibiotics AND afebrile for strep pharyngitis.

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Bites, Bed Bugs *(Cimex lectularius)*	• Slightly swollen or red skin • Insomnia • Anxiety • Skin irritation • Itching • Severe allergic reaction (rare)	Bite marks appear between 1–14 days after initial exposure. Bed bugs fit into small spaces and are easily transported from location to location as people travel.	Visible bugs in mattresses; bite marks on face, neck, arms, hands, or other body parts	Routine inspections for signs of bed bug infestation	Not reportable	**School Exclusion Guidelines:** Bed bugs are not a medical or public health hazard as they do not spread disease. School exclusion is not indicated if they feel well enough to attend. **Treatment:** Avoid scratching the infected area and apply antiseptic creams or lotions. Take an antihistamine. Excessive scratching can increase the chance of a secondary skin infection.	School health personnel (e.g., school nurses, consulting physician, and administrators), in consultation with the LHD should determine whether some or all parents/guardians should be notified of a person with bed bug bites within the school
Bites, Human	• Visible bite marks on skin • Pain • Tenderness • Bleeding • Swelling	Spread of infectious disease is rare but possible if there is a break in the skin and/or an exchange of blood or body fluids	History, physical examination, and blood work to check for certain blood-borne pathogens	Identify the behaviors and develop a plan with the student's parents to prevent future occurrences	Not reportable	**School Exclusion Guidelines:** School exclusion is not indicated if the person is well enough to attend school **Treatment:** Should be cleaned thoroughly with soap and water for five minutes. Additional treatment will depend on the size/location/severity of the bite, nature of the bite, and the presence of potential infectious/communicable diseases.	Parents/guardians of the affected child should be notified and referred for treatment, as necessary, according to school policy
Candidiasis, Oral (Thrush)	• White patches on the inside of cheeks, gums, and tongue • Redness or soreness • Pain with eating	Lives in mouth, throat, digestive tract; antibiotics or a weakened immune system can cause yeast overgrowth. Common in infants.	Physical examination; occasionally the healthcare provider will take a scraping and look under microscope	Good oral hygiene; rinse the mouth or brush teeth after using inhaled corticosteroids	Not reportable	**School Exclusion Guidelines:** School exclusion is not indicated if the person is well enough to attend school **Treatment:** Prescription antifungal medication	Suspected oral thrush should be reported to the parents/guardians who can seek treatment from a healthcare professional
Cytomegalovirus (CMV)	• Fever • Sore throat • Swollen glands • Fatigue • Asymptomatic (most cases)	From mother-to-baby during pregnancy, direct contact with virus-containing fluid or secretions, sexual contact, breastmilk to nursing infants, transplanted	Blood tests	Exercise universal precautions for contact with bodily fluids; good hand hygiene, especially with diapered children	Not reportable	**School Exclusion Guidelines:** School exclusion is not indicated.‡ **Treatment:** Usually, no treatment is needed; for immunocompromised individuals, special treatment is available	Notify pregnant personnel and immunocompromised staff and students who may be in contact with persons infected with CMV; encourage the contacts to reach out to their healthcare providers for counseling

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		organs, and blood transfusions					about the potential risks of exposure
Diphtheria (*Corynebacterium diptheriae*)	• Sore throat • Weakness • Mild fever • Swollen glands in the neck • Thick, gray coating in nose, tonsils, and throat	Person-to-person spread through direct contact with respiratory secretions (e.g., coughing, sneezing); occasionally through raw milk	Cultures from nose, throat, and any lesions	Follow immunization compliance per code § 22.1-271.2 and § 32.1-46	Suspected or confirmed cases must be reported **immediately** to the LHD †	**School Exclusion Guidelines**: Exclusion from school is mandatory until documentation of two cultures 24 hours apart and 24 hours after completion of antibiotics do not grow diphtheria -OR- 14 days after completion of antibiotics if cultures are not practical. All close contacts should have swabs taken of nose and throat, receive postexposure prophylaxis, and be kept under surveillance for 7 days. **Treatment:** Diphtheria is treated primarily with antitoxin (single dose) and antibiotics (14-day course)	School health personnel (e.g., school nurses, consulting physician, and administrators), in consultation with the LHD should determine whether some or all parents /guardians should be notified
Hand, Foot, and Mouth Disease (Coxsackievirus)	• Fever • Mouth sores • Sore throat • Skin rash, commonly found on palms and soles • Eating and drinking less	Person-to-person spread through direct contact with respiratory secretions, stool, or contaminated surfaces	History, physical examination	Proper hand washing protocols, personal hygiene practices, and particular attention to cleaning/ sanitation efforts	Not reportable	**School Exclusion Guidelines:** Virus is most contagious the first week of symptoms. School exclusion is not indicated if the person is well enough to attend school and has no uncontrolled drooling with mouth sores.‡ **Treatment:** No specific antiviral treatment is available. Care is supportive, including hydration and over-the-counter pain and fever reducers.	School health personnel (e.g., school nurses, consulting physician, and administrators), in consultation with the LHD should determine whether some or all parents /guardians should be notified
Hepatitis C Virus (HCV)	• Asymptomatic • Fever • Fatigue • Jaundice • Dark urine or light-colored stools	Spread through contact with blood of infected person	Testing blood for antibodies and RNA	Exercise universal precautions for contact with blood or bodily fluids	Suspected or confirmed cases must be reported within **three days** of diagnosis†	**School Exclusion Guidelines:** School exclusion is not required **Treatment:** Oral antivirals for 8-12 weeks	Parents/guardians should be encouraged to notify the school nurse if their child has HCV

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Hepatitis E Virus (HEV)	• Asymptomatic • Fever • Fatigue • Loss of appetite • Nausea • Dark urine or light-colored stools • Jaundice	Spread by the fecal-oral route, including drinking contaminated water or eating undercooked or raw pork, venison, wild boar meat, or shellfish	Testing blood for antibodies and RNA	Good sanitation, availability of clean drinking water, properly cooking meat, hand washing protocols, personal hygiene practices	Suspected or confirmed cases must be reported within **three days** of diagnosis†	**School Exclusion Guidelines:** Persons diagnosed with HEV should be excluded from school until symptoms have resolved. School exclusion is not indicated for contacts. **Treatment:** There is no anti-viral medication available for the treatment of HEV. Care is supportive.	School health personnel (e.g., school nurses, consulting physician, and administrators), in consultation with the LHD should determine whether some or all parents /guardians should be notified
Herpes Simplex Virus (HSV-1 and HSV-2)	• Asymptomatic • Painful blisters or ulcers at the site of infection (may be oral or genital) • Fever	Contact with an infected person's blister or ulcer, mucosal surface, or genital or oral secretions	History, distinctive appearance of blisters or sores, and HSV nucleic acid amplification tests or culture	Exercise universal precautions for contact with blisters or bodily fluids	Not reportable	**School Exclusion Guidelines.** Blisters on the body should be covered with clothing or a bandage, if practical. Do not exclude students or staff with mouth sores or blisters that are crusted over. Students or staff with open, oozing skin sores or blisters should not attend school.‡ **Treatment.** Infection is lifelong; antivirals can prevent or suppress symptoms	None
Lyme Disease (*Borrelia burgdorferi*)	• Target-shaped rash • Fever, chills • Fatigue • Swollen lymph nodes • Muscle and joint pain • Headache	Bite from infected blacklegged tick (deer ticks); no person-to-person spread	History, physical examination, exposure to ticks, and sometimes laboratory tests	Using insect repellent, removing ticks promptly, applying pesticides, and reducing tick habitat	Suspected or confirmed cases must be reported **within three days** of diagnosis†	**School Exclusion Guidelines:** School exclusion is not indicated **Treatment:** Early diagnosis and antibiotic treatment (for 2–4 weeks) is important and helps prevent late Lyme disease. Most patients recover completely; 5-10% have prolonged symptoms of fatigue, body aches, or difficulty thinking.	Suspected Lyme Disease (target-shaped rash) should be reported to the parents, who can seek treatment from the child's healthcare professional
Methicillin-resistant *Staphylococcus aureus* (MRSA) Skin Infections	• Redness • Warmth • Pain • Pus • May look like an insect or spider bite	Person-to-person spread through contact, usually from hands or contaminated surfaces	History, physical examination, and sometimes laboratory testing	Properly sanitize shared toys and other objects; discourage sharing of personal items; diligent hand and	Not reportable	**School Exclusion Guidelines:** School exclusion is not required, unless wound drainage cannot be covered and contained with a clean, dry bandage or they cannot maintain good personal hygiene. However, they may be advised to remain home while feeling ill or limit participation in daily activities.	Suspected MRSA (red or draining skin lesions) should be reported to the parents, who can seek treatment from the child's healthcare professional

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				personal hygiene		**Treatment:** Many skin infections, including MRSA, can be treated with wound care; antibiotics may also be used for treatment.	
Molluscum Contagiosum	• Small, raised, white, pink, or flesh colored bump with a dimple or pit • Anywhere on the body • Sometimes red, itchy, or sore	Person-to-person spread via close contact, or through the sharing of inanimate objects, such as towels, clothing, pool toys, or bath sponges	History, physical examination	Properly sanitize shared toys, objects; discourage sharing of personal items; diligent hand/personal hygiene	Not reportable	**School Exclusion Guidelines:** School exclusion not required; visible lesions should be covered while participating in close contact sports, and/or water sports. **Treatment:** Usually goes away on its own in a few months (although may take as long as 4 years) as the person develops antibodies to the virus	None
Mononucleosis, Infectious (Epstein-Barr virus)	• Asymptomatic • Extreme fatigue • Sore throat • Fever • Body aches • Enlarged lymph nodes • Swollen liver or spleen • Rash (rare)	Person-to-person spread primarily through saliva (i.e., kissing, sharing cups or toothbrushes, sexual contact)	History, physical examination, and antibody testing	Properly sanitize shared toys and other objects; discourage sharing of personal items; encourage diligent hand washing and personal hygiene	Not reportable	**School Exclusion Guidelines:** 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.‡ **Treatment:** Symptomatic care including rest, hydration, and over-the-counter medications for pain and fever. May return to contact sports or heavy lifting upon the recommendation of their healthcare provider.	None

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Mosquito-Borne Diseases (Arboviral diseases include Zika virus, West Nile virus, dengue, Chikungunya virus, and malaria)	• Asymptomatic • Fever • Headache • Body aches • Joint pain • Nausea • Vomiting • Rash • Red eyes (Zika) • Serious, sometimes fatal, neurologic illness	Spread through the bite of an infected mosquito; no person-to-person spread	History, physical examination, blood tests	Use insect repellent; empty standing water that can attract mosquitoes; secure windows to prevent mosquitoes from getting indoors	Suspected or confirmed cases must be reported **within three days** of diagnosis†	**School Exclusion Guidelines:** 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. **Treatment:** Treatment is dependent on the exact virus, symptoms, and severity of illness. There are no vaccines, and most treatment is supportive in nature.	None
Otitis Externa (Swimmer's Ear)	• Ear pain with tugging • Itchiness • Redness and swelling in the ear • Drainage	No person-to-person spread	History, physical examination	Dry ears thoroughly after swimming or showering; do not put objects in ear (e.g., cotton swabs)	Not reportable	**School Exclusion:** Staff and students with otitis externa should not be excluded from school, unless they pose a risk to others due to uncontrolled drainage from the ear canal **Treatment:** Antibiotic ear drops	None
Otitis Media (Middle Ear Infection)	• Ear pain • Fever • Fussy, irritable • Difficulty sleeping • Drainage (if ear drum is ruptured)	No person-to-person spread	History, physical examination	Immunization compliance per code § 22.1-271.2 and § 32.1-46, avoid secondhand smoke exposure	Not reportable	**School Exclusion:** Staff and students with otitis media should not be excluded from school, unless they pose a risk to others due to uncontrolled drainage from the ear canal **Treatment:** Oral antibiotics (if necessary), pain medication, and rest	None

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Pinworm Infection (Enterobiasis)	• Perianal itching • Disturbed sleep • Irritability • Abdominal pain • Secondary infections of skin	Direct transfer of infected eggs from anus to mouth of the same person or another person, or indirectly through clothing, bedding, food, or other contaminated articles	Worms can sometimes be seen at night when laying their eggs on perianal skin. A healthcare provider can perform a "tape test" exam for pinworms.	Diligent hand hygiene after toileting, changing diapers, and before handling food. Infected people should not bathe with others while infected.	Not reportable	**School Exclusion.** Students and staff should be excluded from school until 24 hours after treatment is started **Treatment.** Prescription medications (pyrantel pamoate, albendazole, or mebendazole) given in a single dose and repeated in 2 weeks. In some cases, entire families may be treated for pinworms at once.	School health personnel (e.g., school nurses, consulting physician, and administrators) in consultation with the LHD should determine whether some or all parents /guardians should be notified so they may watch for symptoms
Pneumonia (Nonspecific, may have bacterial, fungal, viral causes)	• Cough • Fast, difficult breathing • Fever • Muscle aches • Loss of appetite • Lethargy	Direct or close contact with mouth and nose secretions and touching contaminated objects (for viral and some bacterial causes)	History, physical examination, and possibly a chest X-ray	Immunization compliance per code § 22.1-271.2 and § 32.1-46, annual influenza vaccine, diligent hand and personal hygiene	Refer to the Virginia Reportable Disease List† as some causes require immediate reporting or reporting within 3 days	**School Exclusion Guidelines:** School exclusion is not indicated unless the individual is not feeling well enough to participate. The contagious period depends on the causal organism.‡ **Treatment:** Antibiotics, antivirals, or antifungal medications (if indicated), and supportive care (rest, hydration, over-the-counter fever medications)	Suspected pneumonia should be reported to the parents, who can seek treatment from the child's healthcare professional
Polio (Poliomyelitis)	• Asymptomatic (most) • Mild illness: fever, sore throat, fatigue, headache, abdominal pain, nausea • Meningitis • Paralysis • Death	Very contagious: fecal-oral from contaminated hands, food, water, or other objects; through droplets from an infected person's throat from a sneeze or cough (less common)	History, physical exam, laboratory testing on samples (stool, throat, blood, urine, spinal fluid), and MRI	Follow immunization compliance per code § 22.1-271.2 and § 32.1-46; perform diligent hand hygiene	Suspected or confirmed cases must be reported **immediately** to the LHD†	**School Exclusion Guidelines:** Exclusion is recommended. Most infectious 7–10 days before and two weeks after symptom onset.‡ Secreted in stool for weeks or months. Exposed persons should have their immunization records checked by a healthcare provider and follow recommendations for vaccination if needed. **Treatment:** No specific antiviral therapy; care is supportive	School health personnel (e.g., school nurses, consulting physician, and administrators), in consultation with the LHD should determine whether some or all parents /guardians should be notified
Rabies	• Initial symptoms: flu-like illness, prickly or itching sensation at site of bite	Direct contact (through broken skin or eyes, mouth, or nose) with saliva or brain/nervous system tissue	Humans: special tests performed on blood, spinal fluid, and brain; diagnosis may	Avoid contact with wildlife (especially bats) and stray animals; ensure pets are vaccinated	Suspected or confirmed cases must be reported **immediately** to the LHD.† Animal bites	**School Exclusion Guidelines:** The infected person should be excluded. School exclusion is not indicated for contacts. Casual contact with an infected person (e.g., by touching a person with rabies) or contact with non-infectious fluids	When a student is bitten or scratched by an animal, school personnel should notify the student's parent/guardian, the LHD, and local animal

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	• Rapidly progressive • Anxiety • Confusion • Hallucinations • Fear of water • Insomnia • Death	from an infected animal or person; often through a bite from a rabid animal	not be confirmed until after death Animals: brain tissue can be tested	properly; seek care immediately for any bites, scratches, or potential exposures	should be reported to the local animal control office.	or tissue (e.g., urine or feces) does not alone constitute an exposure. **Treatment:** Once symptoms have developed, no drug or vaccine improves the prognosis. Postexposure prophylaxis with RIG (rabies immune globulin) and rabies vaccine (HDCV, RVA, or Rabovert) is recommended for a person bitten by a wild or domestic animal. Ensure exposed individual is up to date on tetanus vaccine.	control office. Parent/guardian should be advised to contact a healthcare provider for evaluation of the exposure.
Respiratory Syncytial Virus (RSV)	• Runny nose • Cough • Decreased appetite • Sneezing • Fever • Wheezing	Direct or close contact with mouth or nose secretions, kissing the face of a child with RSV, or contaminated surfaces, such as a doorknobs. Most common in winter and early spring but can occur year-round.	History, physical examination, laboratory testing	Encourage diligent hand washing and personal hygiene. RSV immunizations are available for pregnant women, infants, some toddlers, and older adults.	Not reportable	**School Exclusion Guidelines:** The person should stay home until at least 24 hours after both occur: 1) symptoms are improving, 2) fever is gone, without the use of fever-reducing medicine ‡ **Treatment:** There is no specific treatment and most children will recover on their own with supportive care	None
Rocky Mountain Spotted Fever (RMSF) *(Rickettsia rickettsia)*	• High fever • Severe headache • Nausea, vomiting • Swelling around eyes and hands • Rash (extremities then trunk) • Muscle pain	Most often by the bite of an infected American dog tick, but the Rocky Mountain wood tick and brown dog tick may also cause disease; no person-to-person spread	History, physical examination, blood testing	Daily tick checks, remove ticks right away, use insect repellants	Suspected or confirmed cases must be reported **within three days** of diagnosis†	**School Exclusion Guidelines:** School exclusion is not indicated **Treatment:** Prompt antibiotic treatment within the first 5 days of illness may decrease the chance of developing serious illness and death	Suspected RMSF (fever, headache, rash, swelling of eyes and hands) should be reported to the parents, who can seek treatment from the child's healthcare professional immediately
Roseola (Roseola Infantum, Sixth Disease)	• High fever for 3-5 days • After fever goes away,	Spread by person-to-person contact with saliva, through	History, physical examination	Properly sanitize shared toys and other	Not reportable	**School Exclusion Guidelines:** Students may attend school when the fever is gone;	School health personnel (e.g., school nurses, consulting physician, and administrators), in

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†**Virginia Reportable Disease List:** https://www.vdh.virginia.gov/content/uploads/sites/134/2023/03/VIRGINIA-REPORTABLE-DISEASE-LIST.pdf

VDH VIRGINIA DEPARTMENT OF HEALTH

Supplemental Disease Reference Chart for School and Child Care Facility Personnel

The decision to exclude an ill child from school should be made in collaboration with the local health department (LHD).
School divisions may develop local policies for condition-specific recommendations.

DISEASE	COMMON SYMPTOMS	TRANSMISSION	DIAGNOSIS*	PREVENTION	REPORTING REQUIREMENTS	RECOMMENDATIONS	NOTIFICATION GUIDELINES
	rash appears (faint red, flat spots) on chest and abdomen spreading to face, arms	sharing a cup or utensils or coughing and sneezing; also in the saliva of healthy people who have had it in the past		objects; encourage diligent hand washing and personal hygiene		the illness is no longer contagious when the rash appears‡ **Treatment:** Supportive care only	consultation with the LHD should determine whether some or all parents /guardians should be notified
Rotavirus (Rotavirus Enteritis)	• Severe watery diarrhea • Vomiting • Fever • Abdominal pain • Dehydration	Fecal-oral; by putting hands in the mouth, touching contaminated objects, and eating contaminated food	Stool testing	Follow immunization compliance per code § 22.1-271.2 and § 32.1-46, encourage diligent hand and personal hygiene	Not reportable	**School Exclusion Guidelines:** Exclude from school and childcare until stools are contained in the diaper or when continent patients no longer have fecal accidents and when stool frequency becomes no more than 2 stools above normal frequency for the patient, even if the stools remain loose. Please note that other resources advise no return to school until diarrhea has ceased for at least 24 hours. Refer to local school division policy.‡ **Treatment**: No specific medication is available. Treatment includes supportive care with oral hydration and sometimes hospitalization for intravenous fluids.	School health personnel (e.g., school nurses, consulting physician, and administrators), in consultation with the LHD should determine whether some or all parents /guardians should be notified
Sexually Transmitted Diseases (STD) (Including chlamydia, genital herpes, genital warts, gonorrhea, HIV/AIDS, syphilis, and trichomoniasis)	• Symptoms vary based on specific disease	Unprotected sexual intercourse or other intimate physical contact. Newborns can be infected during birth.	History, physical examination, microscopic exam of genital secretions, laboratory testing	Follow immunization compliance per code § 22.1-271.2 and § 32.1-46, educate families and students on STD prevention measures	Refer to the Virginia Reportable Disease List† as some STDs require immediate reporting or reporting within 3 days	**School Exclusion Guidelines**: Students should be referred to a healthcare provider or the LHD for diagnosis and follow up care. Do not exclude from school. **Treatment**: Treatment varies by specific disease but may include antibiotics or antivirals. Sexual abuse must be suspected in children with STDs.	None

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Shingles (Herpes Zoster)	• Painful, itchy rash on one side of face or body • Pain, itching, or tingling may occur prior to rash onset • Blisters	Occurs when varicella-zoster virus, the cause of chickenpox, reactivates in a person after they have already had chickenpox. Less contagious than chickenpox but can spread from a person with shingles to a person who has never had chickenpox or the chickenpox vaccine.	History, physical examination	Follow immunization compliance per code § 22.1-271.2 and § 32.1-46; good hand hygiene	Not reportable	**School Exclusion Guidelines:** Covering the rash can lower the risk of spreading it to others. People with shingles cannot spread the virus before the blisters appear or after the rash scabs over. Individuals should be excluded if the rash cannot be completely covered. Exclusion is not otherwise indicated unless the infected person does not feel well enough to participate. **Treatment:** Antiviral therapy, pain management, and wet compresses, oatmeal baths, or calamine lotion for itching	School health personnel (e.g., school nurses, consulting physician, and administrators), in consultation with the LHD should determine whether some or all parents /guardians should be notified
Sports Related Infectious Diseases (Including, herpes simplex virus, molluscum contagiosum, warts, ringworm, athlete's foot, staphylococcal or streptococcal skin infections)	• Varies by specific disease	Varies by specific disease – may occur with direct person-to-person contact (e.g., warts), or may require contact with body fluids	History, physical examination, and possibly laboratory testing	Diligent hand and personal hygiene; prevent sharing of personal items; encourage showering after practices and games; immunization compliance per code § 22.1-271.2 and § 32.1-46	Refer to the Virginia Reportable Disease List†	**School Exclusion Guidelines:** School exclusion is generally not indicated. In certain circumstances, if a wound cannot be covered, exclusion may be necessary. The contagious period is dependent on the specific infection. Students should be referred to a healthcare provider for diagnosis and follow up care. **Treatment:** Varies by specific condition, but may include antibiotics, antifungals, or antivirals and supportive care	School health personnel (e.g., school nurses, consulting physician, and administrators), in consultation with the LHD should determine whether some or all parents /guardians should be notified
Stye	• Small, red, painful bump on eyelid • Eyelid pain or swelling • Tearing • Drainage of	Not typically transmitted person- to-person, although possible if contact with drainage occurs	History, physical examination	Encourage diligent hand washing and personal hygiene; limit touching or rubbing eyes	Not reportable	**School Exclusion Guidelines:** Exclusion not necessary unless the eye is actively draining, or the person is unable to participate activities **Treatment:** Typically resolve most quickly with warm compresses applied for 10	None

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	pus					minutes, 3-4 times a day. Some may require antibiotics.	
Tetanus (Lockjaw)	• Jaw cramping (lockjaw) • Painful muscle stiffness • Trouble swallowing • Muscle spasms, often in stomach • Fever • Headache	Spores get into body through puncture wounds, crush injuries, burns, or wounds contaminated with soil, dust, or feces; also through procedures and IV drug use; no person-to-person spread	History, physical examination	Follow immunization compliance per code § 22.1-271.2 and § 32.1-46, remain up-to-date on tetanus vaccinations, thoroughly clean any wounds	Suspected or confirmed cases must be reported **within 3 days** of diagnosis†	**School Exclusion Guidelines:** Infected persons should be excluded from school until they feel well **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.	None
Tuberculosis (TB Disease)	• Prolonged cough productive of blood or sputum • Chest pain • Fever • Weakness • Loss of appetite • Weight loss • Night sweats	Inhalation of respiratory droplets	TB skin test and TB blood tests	Travelers should avoid close contact or prolonged time with known TB patients in crowded, enclosed environments (e.g., clinics, hospitals, prisons, homeless shelters)	Suspected or confirmed cases must be reported **immediately** to the LHD †	**School Exclusion Guidelines:** Persons with active TB disease may need to be isolated while contagious to prevent spreading the disease. Consult with your LHD on all TB cases regarding isolation/school exclusion. Contacts should be evaluated by their healthcare provider or the LHD to determine level of exposure and any indicated testing. **Treatment:** Several medications are used to treat TB infection in children, often for a period of 4–9 months	School health personnel (e.g., school nurses, consulting physician, and administrators), in consultation with the LHD should determine whether some or all parents /guardians should be notified of TB within the school population TB Screening & Testing: vdh.virginia.gov/tuberculosis/screening-testing/
Upper Respiratory Infection (Common cold)	• Stuffy or runny nose • Sore throat • Coughing • Sneezing	Direct person-to-person contact or inhalation of respiratory droplets	History, physical exam	Cover cough; hand hygiene; avoid crowding; avoid contact with respiratory secretions; environmental cleaning	Not reportable	**School Exclusion Guidelines:** School exclusion is not indicated if the person feels well enough to attend school‡ **Treatment:** Symptomatic treatment only; rest and drink plenty of fluids	None

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Supplemental Disease Reference Chart for School and Child Care Facility Personnel

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NOTE: THESE RECOMMENDATIONS APPLY ONLY TO CHILDREN IN K-12 SCHOOLS OR CHILD CARE - A more complete discussion of these conditions and other communicable diseases may be found in the Control of Communicable Diseases Manual (2022) published by the American Public Health Association and the 2021 Report of the Committee on Infectious Diseases (The Red Book) published by the American Academy of Pediatrics. Additional information and consultation are also available through your local health department.

Additional References:

1. www.cdc.gov
2. https://publications.aap.org/redbook
3. https://www.mayoclinic.org/diseases-conditions/roseola/symptoms-causes/syc-20377283
4. https://www.mayoclinic.org/diseases-conditions/sty/symptoms-causes/syc-20378017
5. https://publications.aap.org/pediatrics/article/140/4/e20172477/38139/Infectious-Diseases-Associated-With-Organized?autologincheck=redirected

Summary of Major Changes in the February 2024 Revision:

- Updated content using CDC websites, APHA Communicable Diseases Manual (2022), and the 2021 Report of the Committee on Infectious Diseases (The Red Book)
- Deleted diseases already in the VDH School Communicable Disease Reference Chart (deleted: Campylobacteriosis, STEC, Giardiasis, Salmonellosis, Shigellosis, Impetigo)
- Added links to most relevant CDC webpage, if available

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School Health Services

Referring To Child Protective Services

Collaborative decisions should be made in consultation with School Administrator, School Counselor, and School Resource Officer, if applicable. Follow local school board policy for mandated reporting requirements for your division.

Authorizations

- Code of Virginia, Section 63.1-1509. 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 63.1-1512. 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.
- Code of Virginia, Section 63.2-100, Definitions. "Abused or neglected child".

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.

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.

School Health Services

Definitions and Causes of Abuse

Operational Definitions of Abuse	Causes 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.	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.

School Health Services

Referring To Child Protective Services, Physical Abuse/Neglect

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 below.

TYPE OF INFORMATION AND RATIONALE USED TO DISTINGUISH UNINTENTIONAL INJURIES FROM THOSE 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.

School Health Services

Referring To Child Protective Services, Mental Abuse/Neglect

Overview

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 may be indicates of mental abuse or neglect.

BEHAVIORS AND INTERACTION STYLES THAT MAY BE INDICATORS OF MENTAL ABUSE OR NEGLECT

Behavior	Example
Habit Disorders	• Biting. • Sucking. • Rocking. • Enuresis. • Over- or under-eating without physical cause.
Conduct Disorders	• Withdrawal. • Antisocial behavior, such as destructiveness, cruelty, and stealing.
Neurotic Traits	• Sleep disorders. • Speech disorders. • Inhibition of play.
Others	• 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.

School Health Services

Referring To Child Protective Services, Sexual Abuse/Neglect

Overview

A child that has been a victim of sexual abuse, *whether it is a single incident or a long-term pattern of sexual abuse*, will be less forthcoming 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 signs that may indicate a child is in a sexually abusive situation. The signs may be physical, emotional, or reflected in developmentally inappropriate behavior by the child. The information below has been divided into two age groups: the young 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.

SIGNS THAT MAY INDICATE SEXUAL ABUSE

YOUNGER CHILD	OLDER CHILD
Behavioral ● Reports sexual abuse. ● Sleep disturbances, such as fear of falling asleep and nightmares. ● Sudden changes in behavior and/or aggressive 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.	**Behavioral** ● Reports sexual abuse. ● Poor relationships with peers. (withdrawal from established relationships; an inability to establish new relationships; aggressive, violent, or sexually promiscuous behavior). ● Poor self-esteem and/or general feelings of shame or guilt. ● Eating disorders (bulimia and anorexia). ● Excessive concern about homosexuality (especially boys). ● Deterioration of academic performance. ● Role reversal with parent and overly concerned about younger sibling(s). ● Running away. ● Alcohol and/or drug abuse. ● Moderate to severe anxiety or depression.
Physical ● 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, mouth or throat lesions (as the result of oral-genital contact).	**Physical** ● Attempts at sucide. ● 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, mouth or throat lesions (as a result of oral-genital contact). ● Difficulty sitting or walking. ● Other signs of physical abuse.

School Health Services

Referring To Child Protective Services, Sexual Abuse/Neglect

Gathering 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.

School Health Services

Reporting To Child Protective Services

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 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.

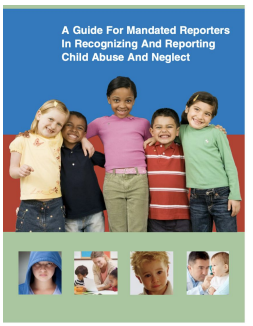
If A Report of Suspected Child Abuse or Neglect is Not Accepted by Child Protective Services

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



A Guide for Mandated Reporters in Recognizing and Reporting Child Abuse and Neglect

VIRGINIA DEPARTMENT OF SOCIAL SERVICES

Virginia Department of Social Services, Child and Protective Services

Administering Emergency 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.



First Aid Guide for Child Care and School Emergencies

This flipchart is a quick reference guide for administering emergency care to an injured or ill individual. It is designed for use by school nurses, clinic aides, teachers, and other staff members who are responsible for the health and safety of students, staff, and visitors in the school setting. The flipchart should be readily available in the school clinic.

Prior To An Emergency

Each school should have contingency plans for emergencies that include staff certified in: cardiopulmonary resuscitation (CPR)/use of an automated external defibrillator (AED), administration of emergency medication, and have readily available access to the **First Aid Guide for Child Care and School Emergencies** flipchart.

Per Code of Virginia, § 22.1-274 (E), a minimum number of staff members should be adequately trained to administer emergency first aid.

During An Emergency

Reference the First Aid Guide for Child Care and School Emergencies.

Notify parent/guardians so follow-up care can be provided.

Document accurate reporting of injuries using an injury reporting form approved by your school division.

Worker's Compensation
Staff members sustaining work-related injuries should follow the appropriate guidelines for Worker's Compensation per school division policy. Staff may also consult with Risk Management.

Ongoing Evaluation

Code of Virginia
§ 22.1-279.8. School safety audits and school crisis, emergency management, and medical emergency response plans required.

School Nurses are encouraged to:

be knowledgeable of the school safety audit process; and participate in the audit team, if possible.

audit injury reports, using data to support supplemental classroom health curriculum.

Managing Extreme Emergencies

During an extreme emergency, the principal and his/her designee may make arrangements for immediate hospitalization of a student; making every attempt to contact the parent/guardian in advance, if and when possible. The principal should assign an appropriate school staff member to accompany the ill/injured person until their parent/guardian arrives.

Recommendations for Emergency Go Bag

- ⬜ Ace bandage(s) (Various sizes)
- ⬜ Adherent cohesive bandage(s)
- ⬜ Alcohol wipes
- ⬜ Aluminized rescue blanket (Pack)
- ⬜ Automated External Defibrillator
- ⬜ Band-aids *various sizes (Latex Free)
- ⬜ Battery operated portable radio (with extra batteries)
- ⬜ Biohazard bags
- ⬜ Blood pressure cuffs (Pediatric and Adult size regular and large sizes)
- ⬜ Clipboard (with storage)
- ⬜ Compression bandage(s) for first-aid use
- ⬜ CPR one-way resuscitation mask (Adult and Pediatric sizes)
- ⬜ Disposable tweezers
- ⬜ Emesis bags
- ⬜ Emergency whistle
- ⬜ Electronic pulse oximetry
- ⬜ Eye irrigation solution (Sterile Eye Wash)
- ⬜ Eye pads
- ⬜ Eye protection (Goggles, Face Shield)
- ⬜ Face masks (Regular Face Masks)
- ⬜ Facial Tissues (travel size packets)
- ⬜ First-aid tape *Various sizes (Latex Free)
- ⬜ Flashlight (with extra batteries)
- ⬜ Gauze (various sizes 4x4, 2x2, etc.)
- ⬜ Glucose monitor with strips (*Maintain regular calibration guidelines, per monitor)
- ⬜ Glucose-quick acting source (i.e. Glucose Tablets, Cake-Make Gel)
- ⬜ Hand sanitizer
- ⬜ Hand soap- with adequate water supply
- ⬜ Instant cool/heat packs
- ⬜ Latex free gloves
- ⬜ Moist towelettes
- ⬜ Normal saline solution
- ⬜ Pen(s)/Pencil(s) (for documentation-fine point black permanent marker)
- ⬜ Penlight (with extra batteries)
- ⬜ Re-sealable plastic bags
- ⬜ Stethoscope
- ⬜ Shears (Medical Scissors)
- ⬜ Tourniquet(s)
- ⬜ Triage tags and forms for documentation (i.e. your school/district preferred form)
- ⬜ Tweezers- disposable
- ⬜ Water (2 to 3 bottles)

List retrieved from National Association for School Nurses: Emergency Resources, Equipment and Supplies List for Schools

Recommendations For Field Trip Go-Bag

- ⬜ Gloves
- ⬜ First aid kit (if available)
- ⬜ Band-aids
- ⬜ Gauze pads
- ⬜ Instant cold pack
- ⬜ Antiseptic wipes
- ⬜ Bottle of water (1)
- ⬜ Small snack packs/candy to manage low blood sugar (i.e. nutrigrain bar, peppermints, lifesavers, etc.)
- ⬜ Provide any student medication required during field trip (provide dosage instructions for administration and emergency action plans)
- ⬜ Emergency Contact Information

List retrieved from National Association for School Nurses: Emergency Resources, Equipment and Supplies List for Schools

IN CASE OF EMERGENCY

_____ SCHOOL NURSE

_____ CLINIC PHONE NUMBER

_____ SCHOOL NAME

_____ OFFICE PHONE NUMBER

EMERGENCY CONTACTS:

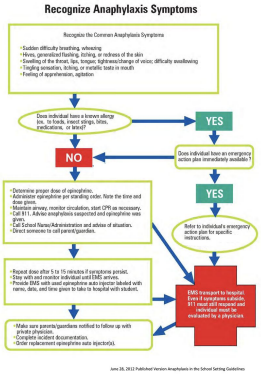
Poison Control 1-800-222-1222
Emergency Medical Services (EMS) 1-800-523-6019

In case of emergency, call 911.

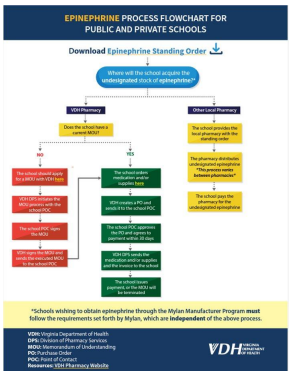


Flowcharts, Actions Plans, and Algorithms

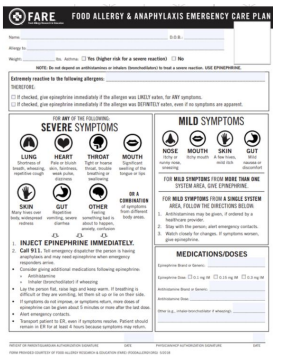
Epinephrine and Albuterol



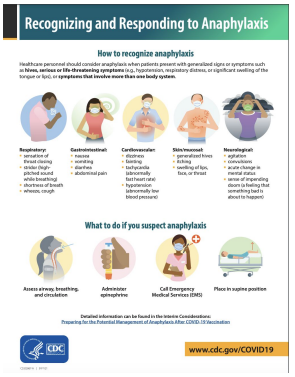
[Recognizing Anaphylaxis Symptoms](#) (page 458)



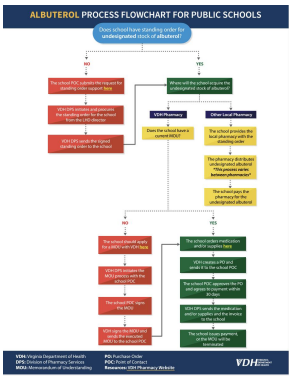
[Epinephrine Flowchart for Procurement of Medication](#)



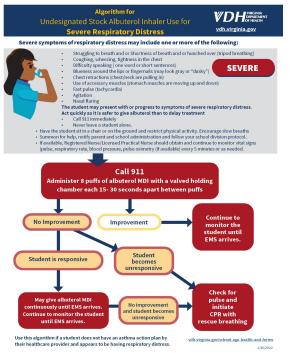
[Food Allergy & Anaphylaxis Emergency Care Plan](#)



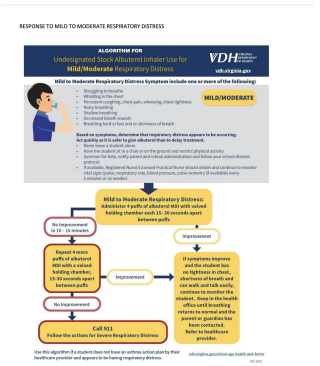
[Recognizing and Responding to Anaphylaxis](#)



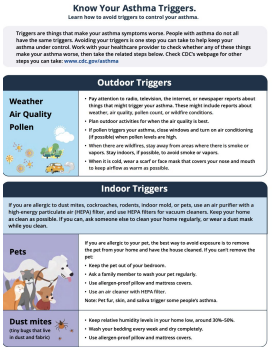
[Albuterol Process Flowchart for Public Schools](#)



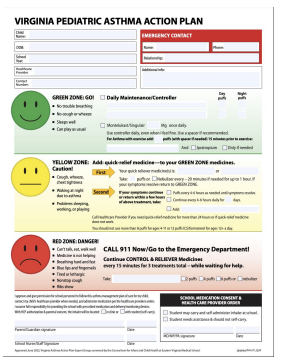
[Severe Respiratory Distress Flowchart](#)



[Mild Respiratory Distress Flowchart](#)



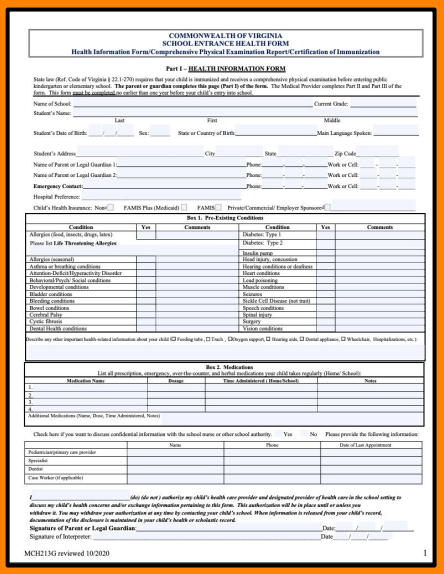
[Know Your Asthma Triggers](#)



[Virginia Pediatric Action Plan](#)

School Entrance Physicals

Role of The School Nurse



COMMONWEALTH OF VIRGINIA
SCHOOL ENTRANCE HEALTH FORM
Health Information Form/Comprehensive Physical Examination Report/Certification of Immunization

Part I – HEALTH INFORMATION FORM

State law (Ref. Code of Virginia § 22.1-270) requires that your child is immunized and receives a comprehensive physical examination before entering public kindergarten or elementary school. **The parent or guardian completes this page (Part I) of the form.** The Medical Provider completes Part II and Part III of the form. This form must be completed no earlier than one year before your child's entry into school.

Name of School: _____ Current Grade: _____
Student's Name: _____ (Last / First / Middle)
Student's Date of Birth: ___/___/___ Sex: ____ State or Country of Birth: _____ Main Language Spoken: _____
Student's Address _____ City _____ State _____ Zip Code _____
Name of Parent or Legal Guardian 1: _____ Phone: ___-___-____ Work or Cell: ___-___-____
Name of Parent or Legal Guardian 2: _____ Phone: ___-___-____ Work or Cell: ___-___-____
Emergency Contact: _____ Phone: ___-___-____ Work or Cell: ___-___-____
Hospital Preference: _____
Child's Health Insurance: None ☐ FAMIS Plus (Medicaid) ☐ FAMIS ☐ Private/Commercial/ Employer Sponsored ☐

Box 1. Pre-Existing Conditions

Condition	Yes	Comments	Condition	Yes	Comments
Allergies (food, insects, drugs, latex)			Diabetes: Type 1		
Please list **Life Threatening Allergies**			Diabetes: Type 2		
			Insulin pump		
Allergies (seasonal)			Head injury, concussion		
Asthma or breathing conditions			Hearing conditions or deafness		
Attention-Deficit/Hyperactivity Disorder			Heart conditions		
Behavioral/Psych/ Social conditions			Lead poisoning		
Developmental conditions			Muscle conditions		
Bladder conditions			Seizures		
Bleeding conditions			Sickle Cell Disease (not trait)		
Bowel conditions			Speech conditions		
Cerebral Palsy			Spinal injury		
Cystic Fibrosis			Surgery		
Dental Health conditions			Vision conditions		

Describe any other important health-related information about your child ☐ Feeding tube ; ☐ Trach ; ☐ Oxygen support, ☐ Hearing aids, ☐ Dental appliance, ☐ Wheelchair, Hospitalizations, etc.)

Box 2. Medications

List all prescription, emergency, over-the-counter, and herbal medications your child takes regularly (Home/ School):

Medication Name	Dosage	Time Administered (Home/School)	Notes
1.			
2.			
3.			
4.			

Additional Medications (Name, Dose, Time Administered, Notes)

Check here if you want to discuss confidential information with the school nurse or other school authority. Yes No Please provide the following information:

	Name	Phone	Date of Last Appointment
Pediatrician/primary care provider			
Specialist			
Dentist			
Case Worker (if applicable)			

I, _____ (do /do not) authorize my child's health care provider and designated provider of health care in the school setting to discuss my child's health concerns and/or exchange information pertaining to this form. This authorization will be in place until or unless you withdraw it. You may withdraw your authorization at any time by contacting your child's school. When information is released from your child's record, documentation of the disclosure is maintained in your child's health or scholastic record.

Signature of Parent or Legal Guardian: _____ Date: ___/___/___
Signature of Interpreter: _____ Date: ___/___/___

MCH213G reviewed 10/2020 1

MCH 213G (Digitized, fillable form)



Virginia Department of Health Resources

- School Age Health Forms and Action Plans
- Back to School Checklist
- School Entrance Form

HAPPY, HEALTHY CHILDREN.

01 **Review** and take record of completed School Entrance Health Forms for students. Electronic signatures are acceptable.

02 **Identify** health concerns that might require evaluation for special education services or medication at school.

03 **Collaborate** with parents/guardians and appropriate health care providers to ensure students have required vaccines and medication.

04 **Perform** mandatory health screenings and refer for follow up care (if applicable).

05 **Communicate** with parents/guardians regarding students with special healthcare needs.







School Entrance Physicals
Frequently Asked Questions

The Code of Virginia § 22.1-270. Preschool physical examinations requires a child enrolling in public kindergarten or elementary school for the first time must be properly immunized and receive a comprehensive physical examination.

Enrollment At Public Elementary Schools

When **enlisting for kindergarten**, ***all*** students must provide a comprehensive, up-to-date, physical that satisfies mandated admission requirements, per code §22.1-270. **First time enrollees and those who attended a preschool program *prior to enrolling* in public kindergarten,** must complete a school health entrance physical within 12 months prior to enrolling.
**Private schools should reach out to their accrediting agency for additional guidance.*

Does my child need a physical to attend a preschool program?
For admittance into preschool programs, students may need to complete a physical that meets the requirements for enrollment. Check specific program guidance.

My student was retained in kindergarten, do they need a new physical?
A kindergarten student who has been retained does not require another physical.

What are the required boosters?
Most pre-kindergarteners need a final boosters of certain vaccinations even if they have completed a school entrance physical for admittance into a preschool program.

Which form is best for School Entrance Physicals?
The State Health Commissioner approves and recommends use of the **Virginia School Entrance Form: MCH213G.** The physical assessment must be completed by: **a qualified licensed physician, a licensed advanced practice registered nurse, or a licensed physician assistant**, per § 22.1-270. *Note: Alternative school entrance physical forms are acceptable if all components found on MCH213G are present.*

Where can my child go to get a physical?
Local health departments can complete school entrance physicals if clients meet income requirements. In addition, flat rate medical clinics, nonprofit organizations, and community providers, can also perform physical examinations. **Find Your LHD Locator.**

Are school entrance physicals required for middle and high schoolers?
Public middle and high school students **are not required** to provide a school entrance physical; however, they are required to have immunizations appropriate for the grade level they are entering, and may need additional screenings such as TB. Check your local school division policy for specific guidance.

SCHOOL ENROLLMENT RECOMMENDATIONS FOR STUDENTS OF DISTINCT POPULATIONS

School Entrance Health Form: MCH 231G

Foster Care

Code of Virginia § 22.1-3.4
Code of Virginia § 63.2-900

ENROLLMENT: Immediately enroll.

IMMUNIZATIONS: Follow-up until required immunizations are completed.

PROCEDURES: Within 72 hours of foster care placement, the local social services agency should notify the division superintendent and the school principal of child's status. The School Nurse should coordinate: (1) physical examination; and, (2) school required immunizations.

RESOURCES:
Enrollment Of Students In Foster Care | VDOE

Military Families

Code of Virginia § 22.1-360

ENROLLMENT: Immediately enroll.

IMMUNIZATIONS: Obtain student health records within 30 days of enrollment, including immunizations and school entrance physical.

PROCEDURES: In collaboration with the School Liaison Officer (SLO), the School Nurse should coordinate: (1) physical examination; and, (2) required school immunizations.

RESOURCES:
Military Families | VDOE
School Liaison Officers (SLO) Directory (Word)

Refugees

ENROLLMENT: Conditionally enrolled.

IMMUNIZATIONS: Upon arriving to military bases, refugee students should complete a physical examination, health screenings, and required school immunizations. Follow-up until required immunizations are completed.

PROCEDURES: Refer student/family to the school division liaison for support.

RESOURCES:
Title III: Language Instruction for English Learners & Immigrant Students (VDOE)

Unhoused/Homeless

ENROLLMENT: Immediately enroll.

IMMUNIZATIONS: Follow-up until required immunizations are completed.

PROCEDURES: Refer student/family to the Mckinney-Vento Liaison for their school division to coordinate health services. A directory is available on the Project HOPE webpage.

RESOURCES:
Project HOPE-Virginia | College of William & Mary
Virginia Vaccines for Children (VVFC)
Student Success for Distinct Populations (VDOE)

FIND MY MCKINNEY-VENTO LIAISON

Eligibility of Services
For students/families of *distinct populations,* eligibility for services under the McKinney-Vento Act are **considered on a case-by-case basis.**



School Immunization Requirements

www.vdh.virginia.gov/backtoschool

Authorization

- Code of Virginia, Section 22.1-271.2, Immunization Requirements.
- Code of Virginia, Section 22.1-271.1, Definitions.
- 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

DID YOU KNOW?

- All students enrolling in public and private schools are required to be immunized. Most students enrolling in school for the first time will get vaccines from their healthcare provider prior to entry; rising 7th and 12th graders will need additional vaccines.
- The most current edition of the "Recommended Immunization Schedule for Children and Adolescents Aged 18 Years and Younger" is approved by the Advisory Committee of Immunization Practices (ACIP).
- School divisions can monitor their immunization status using this p latform: Annual School Self-Reports of Immunization Coverage.
- Creating systems and checklists to manage student's immunization records helps School Nurses stay organized! See the appendix for school entrance checklist resources.

Exemptions

The Code of Virginia, §22.1-271.2, provides for exemptions from immunization requirements for religious and medical reasons.

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.
🔗Spanish Version | 🔗English Version

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).



SEEKING A COPY OF YOUR CHILD'S IMMUNIZATION RECORDS?

There are two options:
(1) Complete the Immunization Request Form.
(2) Call 877-VAX-IN-VA.

Additional Guidance

- School and Day Care Minimum Immunization Requirements (VDH)
- Supplemental Guidance (VDH)
- Playbook to Support Meningococcal Vaccination Events for Rising 12th Graders
- Playbook to Support School-Age Vaccination Events

Guidance for School Immunization Requirements

Procedure and Personnel. To accomplish immunization compliance in assigned school(s), **the School Nurse should:**

- **Issue** special exemption certificates.
- **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, have a system for periodic follow up to ensure compliance, and special exemption certificates issued.
- **Report** to principal any students who fail to provide required documentation and must be excluded from school until this requirement is met. Consult with your local health department before exclusion.
- **Serve** as a liaison with state health department immunization representative.
- **Complete**** the Certification of Immunization, found on form MCH213G, if applicable.

***Only School Registered Nurses are able to sign the Certification of Immunization.*

Proof of Immunization. The school is responsible for ensuring the definition of *documentary proof (*per 12VAC5-110-80) has been met. One of the following is needed to certify the child has been adequately immunized.

01 A MCH 213G signed by a physician or his designee, registered nurse, or an official of a local health department. If the school/school division has a physician or their designee, a registered nurse, or a local health department official, they are able to sign the Certification of Immunization form.

02 A copy of the immunization record signed or stamped by a physician or his designee, registered nurse, or an official of a local health department indicating the dates of administration including month, day, and year of the required vaccines, shall be acceptable in lieu of recording these dates on Form MCH 213G, as long as the record is attached to Form MCH 213G and the remainder of Form MCH 213G has been appropriately completed.

How does a school maintain accurate records of student's immunizations?

Every school must record each student's immunizations on the school immunization record and be made part of the mandatory permanent student record.

Code of Virginia § 22.1-271.2, E.
Code of Virginia § 22.1-289

Based on § 22.1-289, cumulative health records may be recorded in any way, including, but not limited to, handwriting, print, computer media, video or audio tape, film, microfilm, and microfiche. However, part of a student's cumulative health record is the immunization record which is to be documented on a standardized form provided by the Virginia Department of Health per § 22.1-271.2. Providing the immunization record meets this requirement, there is nothing precluding the record from being stored electronically.

Who can sign the Certification of Immunization: "I certify that this child is adequately or age appropriately immunized" on the MCH213G form?

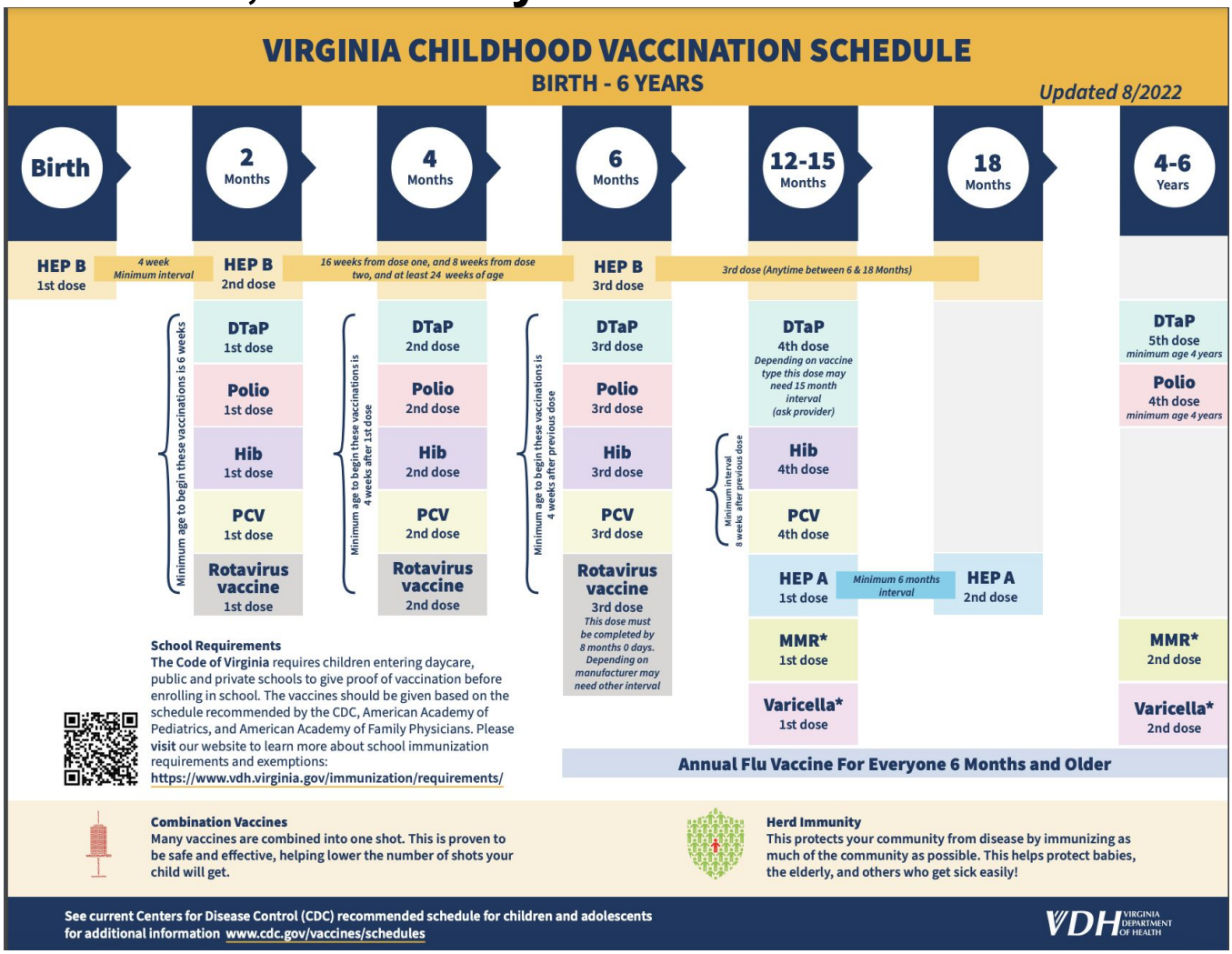
The following are authorized to sign:

1. A physician or their designee,
2. registered nurse, or
3. an official of a local health department.

For a new student transferring from out of state, can a school accept a printout of immunization records?

For a new student transferring from an out-of-state school, documentary proof specifies that a print out from an electronic health record without a signature/stamp can be accepted so long as the MCH213G is attached and Part II is appropriately signed.

Virginia Childhood Vaccination Schedule, Birth to 6 years old



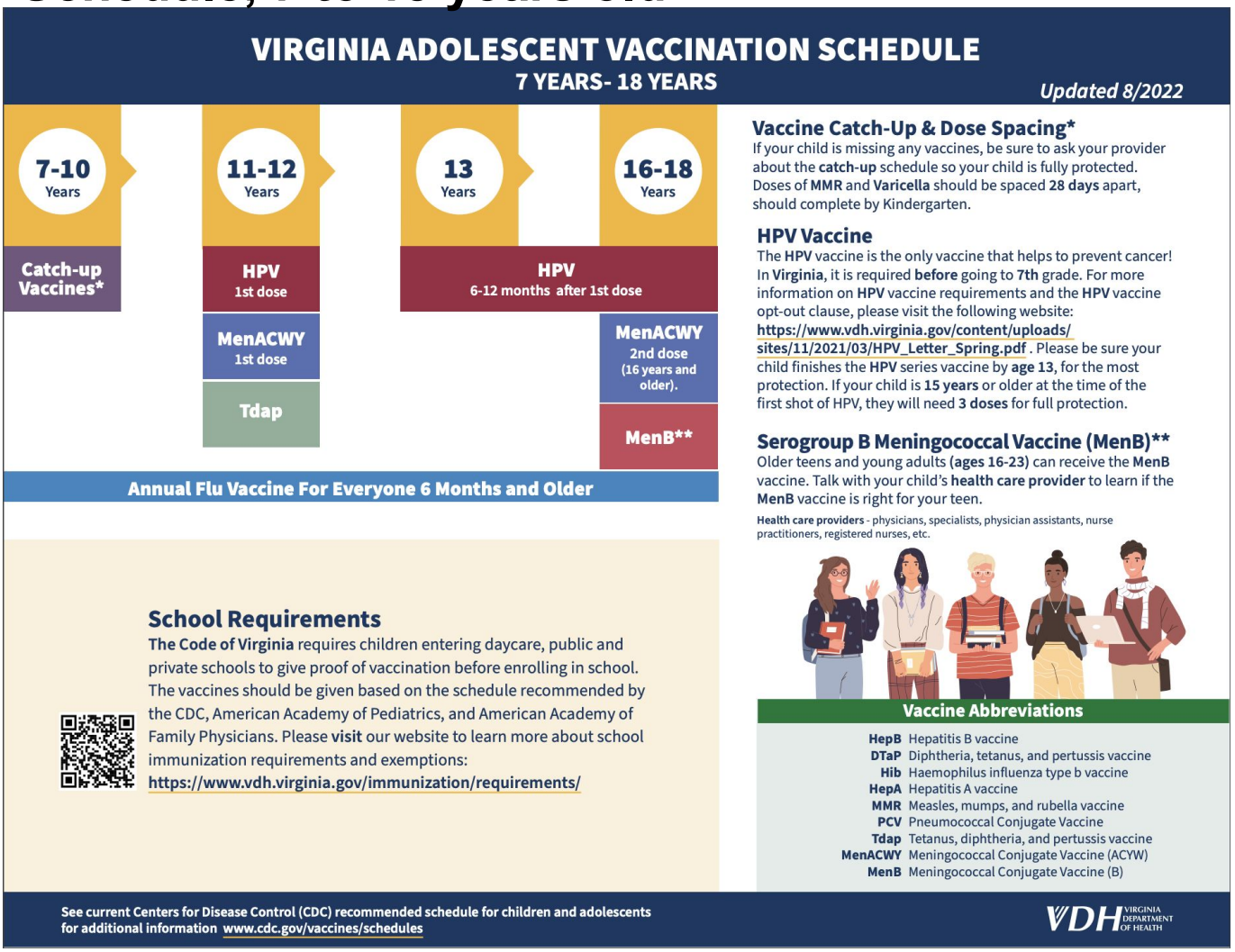
Virginia Childhood Vaccination Schedule (Birth-6 years old) / Spanish Version
Vaccine Schedule for Children, 6 or younger

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.

Consultation and Collaboration. Although these guidelines are designed to cover most situations, school personnel should refer to the Virginia Department of Health, Division of Immunization, School Requirements website and consult with the Virginia Department of Health, Division of Immunization for technical assistance to ensure that all students attending any public or private 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.

Virginia Childhood Vaccination Schedule, 7 to 18 years old



Virginia Adolescent Vaccination Schedule (7-18 years old) / Spanish Version Vaccine Schedule 7-18 years old

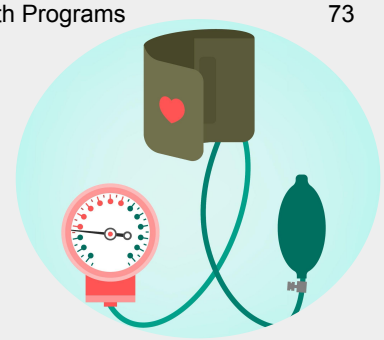
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Blood Pressure Screening

There is no specific legal mandate to provide blood pressure screening. Blood pressure management should be included in the physical examination as part of the continuing care of the child, not as an isolated screening procedure.



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 is at or above the blood pressure of 95% of children at the same age andsex on initial screening on at least three back-to-back occurrences. The detection of high blood pressure during childhood is of potential value in identifying those children who are increased risk of primary 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 likely to have primary hypertension. 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.

Authorization

The **school entrance physical examination** and the yearly **athletic physical for high school athletes** requires documentation of a student's blood pressure.

Recommendations

1. Trained health care personnel should follow standard practices for procedures for measuring blood pressure.

2. Ideally, an accurate BP measurement should be taken after the student rests for five minutes, in a seated position, using an appropriately sized cuff covering 40% of the circumference of the student's miss right upper arm.

3. All children with blood pressure readings inconsistent with norms for their age, weight, sex, and height should be referred to a health care provider for follow-up care. *Every attempt should be made by school health personnel to work with parents/guardians to seek follow-up care with a healthcare provider.*

4. School health personnel should make appropriate educational adjustments, getting feedback from healthcare provider to ensure the child reaches their optimum learning experience.

Screening Guidelines

The American Academy of Pediatrics ((AAP) screening guidelines recommend blood measure measurement annually in children between 3 and 21 years of age.

School Entrance Health Forms

Form:
Commonwealth of Virginia School Entrance Health Form MCH 213G

Instructions:
Commonwealth of Virginia School Entrance Health Form MCH 213G

Virginia High School League Athletic Participation Forms

www.vhsl.org/forms

Dental Screening

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

School-Based Oral Health Programs for Virginia Schools



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 office. However, dental screening can be an important component of an oral health program and an important element of a school health program.

Why Is Oral Health Important?
Oral health is a critical aspect of an individual's overall health, contributing to their general wellness and affecting their quality of life. 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 person's oral health throughout their life.

How Can Schools Help?
A child suffering with oral disease is often unable to concentrate on schoolwork or other tasks. They may experience pain, infections, unable to chew, resulting in decreased nutrition. In addition poor oral health can result in speech defect, poor appearance, and permanent loss of teeth, negatively impacting their ability to reach their full potential in academics, physical, and emotional health. Schools have a unique opportunity to affect the oral/dental health of the community by providing:

- Dental screening to all students and staff.
- Dental health education, 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.

Recommendations

1. Conduct routine dental health screenings.
2. Refer children with obvious tooth decay, mild gum disease, or complaint of oral pain related to possible infection or injury to a dentist for a more complete examination. *Every attempt should be made by school health personnel to work with parents/guardians to seek follow-up care with a dentist.*
3. Dental health education.

Oral Care

It is recommended that a child's first dental visit should occur no later than 1 year of age, with the frequency of subsequent visits determined by the dentist.

- American Academy of Dentistry
- Academy of General Dentistry
- American Dental Association
- American Academy of Pediatrics

Community Partnerships for Dental Screening and Oral Health Education Programs

An effective dental screening and oral health education program can be done with the collaboration of community partners at state agencies and nonprofit organizations.

- Local Health Department
- Virginia Health Catalyst
- Department of Medical Assistance Services
- Virginia Department of Health, Division of Dental Health
- Federally Qualified Healthcare Centers

Hearing Screening

The Code of Virginia, § 22.1-273, requires the principal of each public elementary, middle, and high school, shall conduct hearing screenings of students enrolled: in Kindergarten, Grade 2 or 3, Grade 7, and Grade 10. Principals must notify parents/guardians, in writing, of any defect of hearing for further examination.



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 hindering academic achievement and delaying speech and language development.

Conducting Hearing Screening

Assigning Personnel. Each school division may set a policy to assign the proper personnel responsible for completing hearing screenings. School nurses, speech-language pathologists, and audiologists are qualified to conduct hearing screening programs. Certification programs and training modules are available for other personnel. Confidentiality needs to be maintained. The testing environment should be in a private room with low noise levels.

Reporting. Every principal must keep record of hearing screening results for reporting and must notify the parent/guardian, in writing, of any defect or disease of the ears needing further examination.

Record Management. Per code § 22.1-289**,** cumulative health records may be recorded in any way, including, but not limited to, handwriting, print, computer media, video or audio tape, film, microfilm, and microfiche.

Mandated Timeline.

- ***When should hearing screenings be scheduled?*** Hearing screenings for mandated grade levels shall be **scheduled within 60 administrative working days of the school year.**

- ***When should hearing screenings be conducted?*** Once the screening is scheduled, **it may completed at anytime** within the current school year. For assistance reach out to community partners such as Lions Club, Conexus, or the Medical Reserve Corps.

Regulations

Code of Virginia:

§ 22.1-273
§ 22.1-214
§ 22.1-270

Virginia Administrative Code:
8VAC20-81-30
8VAC20-81-50

Hearing and Vision Criteria

For policy, procedures, and guidelines review the:

Hearing and Vision Criteria Screenings for Public Schools

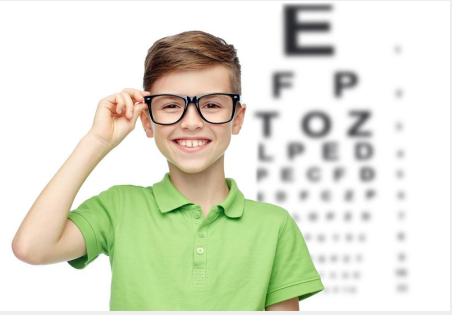
Virginia Guidelines Hearing Screening Endorsements

- American Academy of Audiology Childhood Hearing - CDC
- American Academy of Pediatrics
- American Speech Language Hearing Association

Commonwealth of Virginia School Entrance Health Form MCH 213G

Vision Screening

The Code of Virginia, § 22.1-273, requires the principal of each public elementary, middle, and high school, shall conduct vision screenings of students enrolled: in Kindergarten, Grade 2 or 3, Grade 7, and Grade 10. Principals must notify parents/guardians, in writing, of any defect of vision or disease of the eyes for further examination.



Overview
Visual acuity develops from newborn age and matures "to adult levels of 20/20 vision when the child is five to six years of age." Testing for visual acuity should take place as soon as the child is old enough to cooperate in an eye exam, typically around age three. Vision screening and eye examination are essential for detecting visual impairment. Undetected impairments of visual acuity 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 obtaining maximum benefits from educational experiences.

Mandated Timeline.
When should vision screenings be scheduled?
Vision screenings for mandated grade levels shall be **scheduled within 60 administrative working days of the school year.**

When should vision screenings be conducted?
Once the screening is scheduled, it may completed at anytime within the current school year. The *Code* defines the quality-controlled requirements of a "comprehensive vision program". For assistance reach out to community partners such as Lions Club, Conexus, or the Medical Reserve Corps.

Who is responsible for conducting vision screenings?

Assigning Personnel. Each school division may set a policy to assign the personnel responsible for completing vision screenings. Personnel should receive adequate training, understanding the screenings are only designed to identify students who may need further examination. Screenings may also be conducted by a "qualified nonprofit vision health organizations", defined in the *Code,* that use a digital photoscreening or other methods that comply with DOE requirements.

Screening Protocol. Confidentiality needs to be maintained; therefore, students should be screened in a private setting.

Regulations

Code of Virginia:

§ 22.1-273, § 22.1-214, § 22.1-270

Virginia Administrative Code:
8VAC20-81-30, 8VAC20-81-50

Hearing and Vision Criteria

For policy, procedures, and guidelines review the:

Hearing and Vision Screenings for Public Schools

Virginia Guidelines Visual Screening Endorsements

- American Academy of Pediatrics
- American Association for Pediatric Ophthalmology and Strabismus
- American Academy of Ophthalmology

Record Management

Per code § 22.1-289

Cumulative health records may be recorded in any way, including, but not limited to, handwriting, print, computer media, video or audio tape, film, microfilm, and microfiche.

Commonwealth of Virginia School Entrance Health Form MCH 213G

Height and Weight Screening

There is no specific legal mandate for annual height and weight screening 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 at the highschool level.

Overview

Annual height and weight measurements provide a simple, effective method of identifying significant childhood health problems. In addition yearly height and weight measurements can be used as an educational tool for parents, students, and school personnel. School nurses, school nutritionists, and physical education teachers create awareness of the relationship between nutrition and healthy growth.

Recommendations

Childhood obesity is a public health concern. Obesity is defined as a BMI at or above 95th percentile for age and gender growth charts. CDC and AAP recommend all children and adolescents between ages 6 and 19 be screened for obesity using body mass index (BMI). The range of normal height and weight varies for each child, but general growth remains relatively constant at 2 to 2 ½ inches each year, taking into consideration rapid growth as a result of puberty. Growth patterns should follow the normal growth curves of children the same age and gender falling between the 5th and 95th percentile curves on a standardized growth chart.

Who conducts height and weight screening?

Each school division should set a policy, assigning the personnel responsible for completion of annual height and weight screening. The school nurse is the ideal personnel to ensure the early identification of students at risk for growth problems by providing appropriate assessments and referrals. Other school personnel conducting screening should receive instruction in proper techniques to be used.

Reporting

School Nurses should refer children for follow-up care to address dramatic and rapid changes in a child's growth pattern. Documentation of referral should be noted. Height and weight can be charted on student's comprehensive health record.

Height and Weight Percentiles. Annual screenings for height and weight can evaluate eating disorders, body image, and dieting patterns. The **Children's BMI Tools for Schools** (CDC) can help with charting height and weight percentiles.



1 in 5 **"children suffer from obesity related health concerns"**

Preventing Childhood Obesity: 6 Things Families Can Do, CDC (2023)

Scoliosis Screening

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.

Overview

Scoliosis is a lateral curvature of the spine that impacts two to three percent of the population. “Most are diagnosed with scoliosis between the ages of 10 and 15”. If left untreated, scoliosis may progress causing spine deformity, chronic back pain, impair heart and lung function, and affect self-esteem. 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:

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

Recommendations

Each school board shall provide parent educational information or implement a program of regular screening for scoliosis for pupils in grades five through ten within 60 business days after the start of the school each year.

Procedure

Local school boards shall develop procedures for parents to indicate preference for their children to participate in the scoliosis screening. 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). The screening program has two components: (1) an initial educational session; (2) the actual screening assessment. For the screener to have optimal view of the spine, girls are asked to wear halter tops and boys are asked to remove their shirt. **Girls and boys are screened separately.**

Personnel

School Nurses may have the responsibility for organizing and implementing the scoliosis screening program collaboratively with physical education teachers.

Regulations

Code of Virginia:
§ 22.1-270 | § 22.1-273.1

Virginia Administrative Code:
8VAC20-690-10. Definitions.
8VAC20-690-20. Scoliosis program.
8VAC20-690-30. Parent education.
8VAC20-690-40. Scoliosis screening.
8VAC20-690-50. Required training.

Parent Education

Educational Materials
Each school board shall provide parent educational information or implement a program of regular screening for scoliosis for pupils in grades five through ten within 60 business days after the start of the school year.
8VAC20-690-30

Parental Consent
Parents/guardians can indicate if their child can participate in the scoliosis screening.

Record Management

Per the code of § 22.1-289 results of screening are locally determined.

Speech and Language Screening

Code of Virginia, Section 22.1-214, details: "Board to prepare special education program for children with disabilities" 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.

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. Because all children are required to have a physical examination when they first enter school, it was determined this requirement would provide adequate screening for kindergarten students.

Virginia Department of Education

For comprehensive guidelines and procedures on speech and language screenings in schools, please visit the Virginia Department of Education Special Education webpage.

Code of Virginia Reference and Guidance Documents

- 8VAC20-81-50
- Code of Virginia 22.1-214
- DOE SUPTS Memo Library



Additional Resources:

VDOE
Office of Special Programs: Regulations, Laws, Policies, and Guidance

VDOE
Evaluation & Eligibility for Special Education & Related Services

VDOE
Introduction to Individual With Disability Education Act (IDEA)

VDOE
E-Learning Modules for Special Education and Student Services

VDH
School Health Activity Chart

VDOE
Speech and Language Impairment Resources

Fine and Gross Motor Skills

Code of Virginia, Section 22.1-214, details: "Board to prepare special education program for children with disabilities" 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.

Overview

The purpose of the screening in the area of fine and gross motor skills is to identify students who may have a motor skill deficit. As a result of the screening, students may be referred for a special education eligibility assessment or may consult with the teacher or parents/guardians regarding the student's fine motor skills. Because all children are required to have a physical examination when they first enter school, it was determined this requirement would provide adequate screening for kindergarten students.

Virginia Department of Education

For comprehensive guidelines and procedures on speech and language screenings in schools, please visit the Virginia Department of Education Special Education webpage.

Code of Virginia Reference and Guidance Documents

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Additional Resources:

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VDOE
Evaluation & Eligibility for Special Education & Related Services

VDOE
Introduction to Individual With Disability Education Act (IDEA)

VDOE
E-Learning Modules for Special Education and Student Services

VDH
School Health Activity Chart

VDH
School Nurse Checklist

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



Medicaid (FAMIS PLUS)

A jointly funded, federal-state health insurance program for individuals with limited income and resources.



Children's Health Insurance Programs (FAMIS)

The Federal Children's Health Insurance Program is a publicly-funded insurance program providing uninsured children (19 and under) in families with household income below 200% the federal poverty level but do not qualify for Medicaid.



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. EPSDT provides periodic and inter-periodic screenings for vision, dental, and hearing services. Medicaid enrolled children receive EPSDT benefits. Services are limited for those who receive FAMIS.

Federal Guidelines

The federal government sets minimum guidelines for Medicaid eligibility, but individual states can choose to expand coverage beyond the minimum threshold. Schools are by definition "in the business of serving children", and serve as the catalyst for encouraging families to apply for programs to obtain preventative and primary services, as well as, other necessary treatments.

Am I Eligible?

Specific eligibility requirements for programs can be found through the: **Cover Virginia: Am I Eligible?** screening tool provided by the Department of Medical Assistance Services.

Role of The School Nurse

School personnel, in particular, school nurses are encouraged to learn about state and local resources that are available to assist families in need. Understanding and identifying children in need of Medicaid-eligible services is a critical component of school health programs.

FAMILIES CAN APPLY FOR SERVICES BY

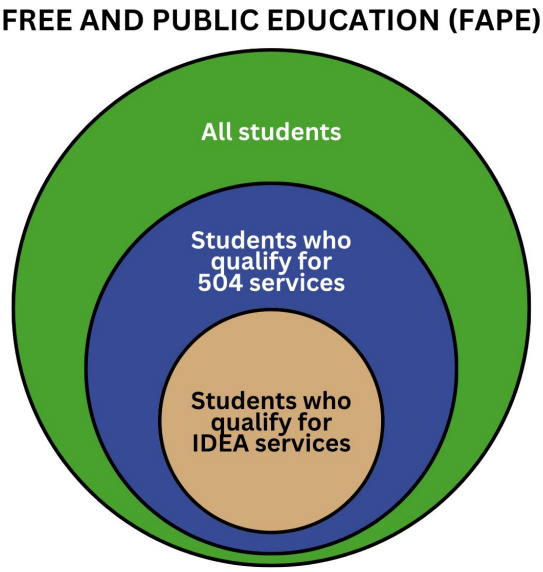
DIALING: 1-855-242-8282 | VISITING: CoverVA

Implementing Special Education Services for Students with Special Needs

Code of Virginia, Section 22.1-214, details: "Board to prepare special education program for children with disabilities" 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.

Historical Perspective: Key Federal Legislation

Federal laws have been in place to protect and assist individuals with disabilities. In 1975, the "Individuals with Disabilities Education Act (IDEA) is a law that makes free and affordable public education to eligible children with disabilities". Later Section 504 was added to accommodate students with individual needs who participate in program and activities that receive federal funding. Some students with disabilities may not qualify for special education and services under IDEA, but may qualify for services under Section 504. Early determination of a child's need and eligibility for services leads to better educational outcomes. School nurses and other school health personnel are involved in identifying and serving students with special needs. The Virginia Department of Education offers additional guidelines and procedures for special education screenings and services.



Virginia Department of Education, Office of Special Education

For comprehensive guidelines, procedures, federal laws, and parent resources, visit the Virginia Department of Education Virginia Department of Education Special Education webpage.

Additional Resources:

VDOE
Office of Special Programs: Regulations, Laws, Policies, and Guidance

VDOE
Evaluation & Eligibility for Special Education & Related Services

VDH
School Health Activity Chart

VDOE
E-Learning Modules for Special Education and Student Services

Special Education Health Assessment for Students with Special Needs

Code of Virginia, Section 22.1-214.

Overview

An important component of the special education assessment is a complete medical history and physical examination, including **health screenings**. The school nurse may play an integral part by taking the medical history of the student. A complete physical examination should be performed by a licensed physician or licensed nurse practitioner (directly supervised by a physician)

Determining Student Health History

What is the school nurse's role?

It is imperative school nurses understand federal and state laws protecting students with disabilities. 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/guardian is unlikely to be able to provide answers to some of the questions posed by the school nurse. The school nurse should use professional judgement 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/guardian. If the nurse completes the health history, it should be reviewed by the examiner prior to medical assessment.

How to determine the setting for the assessment?

The assessment 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. The school nurse should inform the parent of the relevance of the information the student provides and explain who has access to the information shared.

How to complete a referral for the follow-up process?

School nurses and healthcare 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.

> ***"Promoting the presence of a qualified school nurse in every school and a school physician in every district fosters the close interdependent relationship between health and education." (Holmes & Sheetz, 2016)***



Additional Resources:

National Association of School Nurses: The Role Of The School Nurse In Section 504

Medicaid for Education: Lock In Your Team, The Role of The School Nurse in Special Education

Health History Categories

Past Medical History	General state of health: including appetite, weight fluctuations, fatigue, and stressors; birth history or complications; previous illnesses, operations, hospitalizations, or injuries, including date and reason; chronic illness; current medications, including prescription and non-prescription drugs; allergies; immunization status; developmental delays.
Growth and Development	Physical development, including height and weight; developmental history, including developmental milestones of when child rolled over, crawled, spoke first words, etc.; social history, including temperament, attention span, adjustment to school, tobacco, alcohol, drug use; relationships with family members; toileting habits (where appropriate)
Review of Systems	General health status, skin, head and neck, ears, eyes, face and nose, thorax and lungs, cardiovascular, abdominal, genitourinary/reproductive, musculoskeletal, neurologic

Physical Examination

A complete physical examination should be performed by a qualified licensed physician or licensed nurse practitioner (directly supervised by a physician). The healthcare 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.

Documentation

The entire special education assessment is confidential. Any information collected should be documented in the student's record. The record is the collaborative responsibility of the Director of Special Education or Pupil Personnel Services; Special Education Teacher; and, the School Nurse. A copy of the medical/health history must be available for the school nurse.

Importance Of The School Nurse in Special Education Services

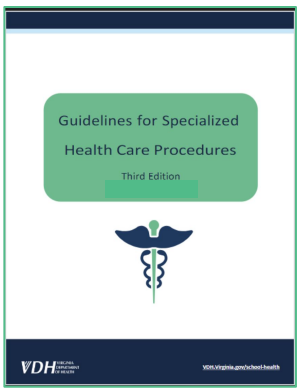
School nurses have a unique perspective to be able to understand both the medical and education components of a student's overall success. They serve as a valuable resource for parents and advocate for special health needs. School Nurses play a critical role as an essential member of the multidisciplinary education team, identifying children who may be eligible for special education services through IDEA and Section 504. School Nurses can:

assess	*the student's physical and functional health status.*
recommend	*health-related accommodations/services.*
participate	*in the planning, implementation and evaluation of IEPs and 504 plans.*
identify	*community referrals/resources available to assist students who qualify for IDEA and/or Section 504.*

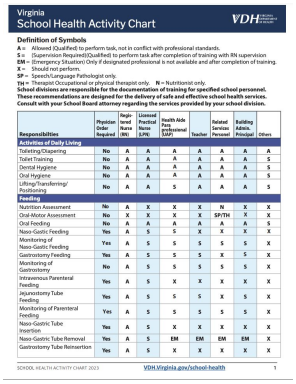
Students Requiring Specialized Health Care Procedures

Resources, Recommendations, and Action Plans

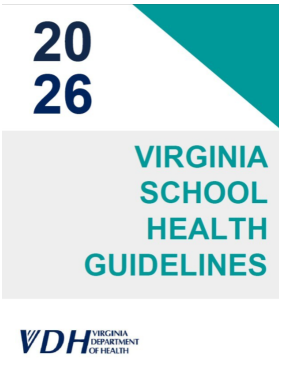
The Virginia Department of Health provides resources to assist school and public health personnel with providing care for students with specialized needs. The resources are intended to enhance the educational process by providing guidance to school administrators, school nurses, teachers, and other staff members on the care of students with special health care needs. Websites, manuals, and charts 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.



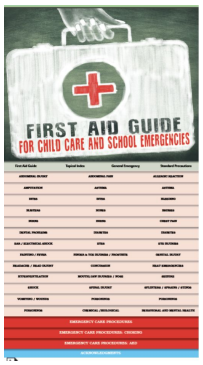
Guidelines for Healthcare Procedures In Schools (VDH)



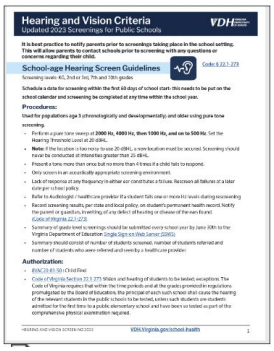
School Health Activity Chart (VDH)



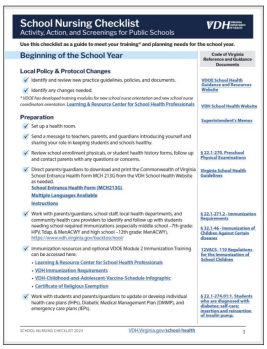
Virginia School Health Guidelines (VDH)



First Aid Flipchart



Hearing and Vision Screening Criteria



School Nurse Checklist

Action Plans and Toolkits

Anaphylaxis

- ACAAI Allergy/Anaphylaxis Information
- Anaphylaxis Emergency Action Plan
- Food Allergy.org - FARE
- FARE Food and Allergy Emergency Action Plan

Asthma

- ACAAI Asthma Resource
- AAAAI Asthma Emergency Action Plan and Resources
- Virginia Pediatric Asthma Action Plan

VDOE School Health Services Website

Concussion

- CDC Concussion Signs and Symptoms Toolkit

Diabetes

- Diabetes Medical Management Plan
- Virginia Diabetes Council Resources
- Virginia Diabetes Council Tool Kit – DMMP and Forms

Epilepsy

- Epilepsy Foundation Information
- Epilepsy Seizure Action Plan

Animals In Schools

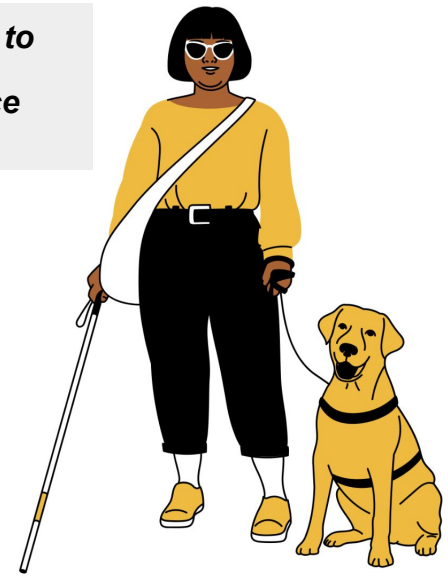
Authorization

Code of Virginia §51.5-44. **Rights of persons with disabilities in public places and places of public accommodation.**

Service Animals. Service animals allow students with disabilities to equitably access their education and develop greater independence. The National Association of School Nurses believes school nurses can ***"provide care coordination for students with service animals to ensure the smooth transition of a service animal to school, as well as monitoring the effectiveness of the animal for the task it is to perform"*** (Services Animals In Schools, 2019).

The Virginia Department of Education provides **Guidelines for School Division Policy and Procedures Regarding Service Animals in Virginia's Public Schools** to assist local school divisions as they consider protocols related to service animals access. Service animals are not pets, thus a no pet policy cannot be applied to a service animal. *"Work or tasks performed by a service animal must be directly related to the handler's disability. Examples include, but are not limited to, assisting individuals who are blind or have low vision with navigation and other tasks, alerting individuals who are deaf or hard of hearing to the presence of people or sounds, providing non-violent protection or rescue work, pulling a wheelchair, assisting an individual during a seizure, alerting individuals to the presence of allergens, retrieving items such as medicine or the telephone, providing physical support and assistance with balance and stability to individuals with mobility disabilities, and helping persons with psychiatric and neurological disabilities by preventing or interrupting impulsive or destructive behaviors." (*Service Animals in Virginia's Public Schools, 2011)

School Nurses and School Administrators should refer to local policy and procedures to ensure they effectively communicate speciality healthcare protocols for Service Animals to teachers, parents/guardians, and students.



Wildlife In The Classroom. *Some schools allow animals to be used for instructional purposes. Here a recommendations to consider.*

- Maintain wildlife animal(s) in a sanitary condition and in a manner to prevent health hazards or nuisance conditions, per local school division policy.
- Animal(s) kept at school must be adequately immunized fed, sheltered, and kept clean.
- Animal(s) are prohibited from food storage, preparation, service, and dining areas.
- Washing hands after handling or cleaning service animals is recommended
- Pest control/management should be a part of the **Integrated Pest Management** program.
- Any wildlife known to carry rabies (turtles, parrots, raccoons, bats, etc.) are not permitted.
- Ensure children in class are not allergic to animals.

Additional Resources

Service Animals In Schools | NASN

Animals In Schools & Daycares | CDC

Home Visits

School Nurses In The Community



WHO

Home visits made by the School Nurse or other members of the school health team offer an excellent opportunity to foster communication and collaboration between school and home.

PURPOSE

Home visits are offer convenience for families who are unable to commute. They also offer parents/guardians a safe space to discuss a student's health needs. School health personnel also get the opportunity to make observations of the home environment and identify both barriers and support for reaching family health promotion goals. The opportunity to gain a more accurate assessment of the student's family structure and behavior in the natural environment.

BEST PRACTICES & RECOMMENDATIONS

During Visit	Follow-Up Care/Services
Explain *purpose of the visit.*	**Discuss** *alternative solutions and available community resources.*
Observe *the home and surrounding environment, significant sociocultural influences, and interaction of family members.*	**Develop** *referrals as necessary to appropriate health care providers.*
Identify *health care needs/problems, based on subjective and objective data, and involve the family members in the process.*	**Assist** *the family in contacting local resources and services in the community.*
List *problems in order of importance in accordance with family perceptions.*	**Share** *the plan with appropriate persons involved in the health care of the student.*
	Document *subjective and objective data, recommendations, identified problems, and plans of action (including timeline for achieving planned interventions) for additional future home visits.*

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 Administrative Code. Chapter 131.** Regulations Establishing Standards for Accrediting Public Schools in Virginia
- **Virginia Department of Education.** Regulations Governing Special Education Programs for Children with Disabilities in Virginia.

Nursing Liaison Services for Homebound Students



Who receives homebound instruction?

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. The goal of homebound instruction is to provide alternative instructional methods while the student makes progress to return to school. Depending on the student's needs, The School Health Team* and support staff, such as the School Nurse, School Counselor, IEP Case Manager, or School Psychologist may be assigned to the student for transition purposes.

What is the role of the School Nurse?

School nurses are great advocates. They 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.

Best Practice Recommendations

The school nurse interprets medical information for school personnel and assists the student in making the transition from hospital and/or home to school.	**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.**
When homebound instruction is deemed necessary, the school nurse will be notified by the appropriate school personnel.	**An individualized healthcare plan (IHP) should be written prior to student returning to school. The IHP should be developed by the Registered School Nurse (RN), in collaboration with the school health team*.**

***The School Health Team** consists the Registered School Nurse, parents/guardian, student, healthcare provider, school administrator, guidance counselors, classroom teacher(s), homebound teacher, and other applicable personnel.

For more information on Homebound Services, visit the Virginia Department of Education webpage.



ENROLLMENT IN CAREER & TECHNICAL PROGRAM REQUIREMENTS

Career and Technical Education 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. Consulting with the health department or a healthcare provider is recommended.

Program	Health Requirements
Cosmetology	• Annual Tuberculin skin test
Licensed Practical Nursing **Emergency Medical Technician** **Dental Assistant**	• Annual Tuberculin skin test • Hepatitis B vaccine series • MMR Vaccine • Tetanus Vaccine
Horticulture	• Tetanus Vaccine

Recommendations

1. **Providing Support.** Each school division should counsel students about the health requirements and provide available community resources for students to meet requirements.

2. **Referral and Follow-Up Process.** The completed forms should be reviewed by the school nurse or a licensed health professional to clarify questionable health information. The school nurse should track such referrals and collaborate with parents/guardians on follow-up care.

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

Additional Resources. The Virginia Department of Education provides a comprehensive list of resources for schools on their webpage.
Career & Technical Education (CTE) | CTE Student Profiles

SCHOOL ENROLLMENT RECOMMENDATIONS FOR STUDENTS OF DISTINCT POPULATIONS

School Entrance Health Form: MCH 231G

Foster Care

Code of Virginia § 22.1-3.4
Code of Virginia § 63.2-900

ENROLLMENT: Immediately enroll.

IMMUNIZATIONS: Follow-up until required immunizations are completed.

PROCEDURES: Within 72 hours of foster care placement, the local social services agency should notify the division superintendent and the school principal of child's status. The School Nurse should coordinate: (1) physical examination; and, (2) school required immunizations.

RESOURCES:
Enrollment Of Students In Foster Care | VDOE

Military Families

Code of Virginia § 22.1-360

ENROLLMENT: Immediately enroll.

IMMUNIZATIONS: Obtain student health records within 30 days of enrollment, including immunizations and school entrance physical.

PROCEDURES: In collaboration with the School Liaison Officer (SLO), the School Nurse should coordinate: (1) physical examination; and, (2) required school immunizations.

RESOURCES:
Military Families | VDOE
School Liaison Officers (SLO) Directory (Word)

Refugees

ENROLLMENT: Conditionally enrolled.

IMMUNIZATIONS: Upon arriving to military bases, refugee students should complete a physical examination, health screenings, and required school immunizations. Follow-up until required immunizations are completed.

PROCEDURES: Refer student/family to the school division liaison for support.

RESOURCES:
Title III: Language Instruction for English Learners & Immigrant Students (VDOE)

Unhoused/Homeless

ENROLLMENT: Immediately enroll.

IMMUNIZATIONS: Follow-up until required immunizations are completed.

PROCEDURES: Refer student/family to the Mckinney-Vento Liaison for their school division to coordinate health services. A directory is available on the Project HOPE webpage.

RESOURCES:
Project HOPE-Virginia | College of William & Mary
Virginia Vaccines for Children (VVFC)
Student Success for Distinct Populations (VDOE)

FIND MY MCKINNEY-VENTO LIAISON

Eligibility of Services

For students/families of *distinct populations,* eligibility for services under the McKinney-Vento Act are **considered on a case-by-case basis.**



CRISIS MANAGEMENT

An unexpected crisis can occur at any time. The following samples of incidents, recommendations, and checklists for the management of crisis situations are below.

Examples of Crisis Events:

- **Basic Response Procedures**

  Evacuation, Lockdown, Shelter-In-Place

- **Non-Emergency Events Affecting Schools**

  Death, 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, Pandemic

- **Weather Emergencies/Disasters**

  Earthquake, Hurricane, Lightening, Tornado

- **Critical Incidents at/or Affecting Schools**

  Fire, Hazardous Materials, Hostaged Armed/Dangerous Situations, Intruder/Trespasser, Kidnapping, Shootings/Woundings/Attacks, Weapons, Explosion/Threat of Explosion, Disaster Preventing Dismissal, Disaster, Chemical Spill, Bus/Auto Accidents, Bomb Threat, Bomb, Bio-Hazard Threats

Making Decisions

The principal bears responsibility for all decision-making and is a crucial leader for effective crisis management. When making decisions pertaining to **new or existing** crises, shared decision-making with the local health department, department of education, and community stakeholders is strongly encouraged.

[Department of Criminal Justice, School Safety Audits Division & School Safety (VDOE)]

Role of The School Nurse

- Become knowledgeable of school's crisis management plan and designated staff.
- Understand the unique needs of the school community.
- Pack emergency bags with gloves, bandages, and undesignated stock medication.
- Anticipate potential healthcare needs of special populations.
- Knowledge of drill to allow preparation.
- Personal assistance provided by an assigned individual.
- Specialized location or route.
- Social stories for students to practice drill expectations.
- Signs or cue cards to assist with communication.
- Knowledge of specialized equipment.
- Train and prepare teachers to handle crisis by preparing emergency crisis go-bags for the classroom.
- Coordinate emergency care and triage with school staff and EMS providers.



Crisis Management Teams

Crisis response teams are typically responsible for:

1. **Establishing** relationships with community partners.
2. **Coordinating** vulnerability assessments.
3. **Developing** training activities and conducting exercises to support and improve the emergency management plan.
4. **Establishing** and enforcing a school and school division's emergency management plans.
5. **Guiding** and supporting the development of individual schools' crisis response teams.
6. **Communicating** with school, parents, and community at large, during and after the crisis event.
7. **Maintaining** the safety of students and staff.

School-Based Crisis Teams are typically comprised of the: principal, assistant principal(s), school counselor(s), school nurse, school psychologist, resource officer, and/or school social worker.

Role Of The School Nurse

Review division-wide policies related to crisis and emergency management, including any interagency agreements.

Request to become a member of the school crisis team and understand role, responsibilities, and the chain of command.

Develop a school crisis plan within the framework of division policy and tailored to the school's unique needs.

Meet on a routine basis to review school's crisis management plan. Familiarize yourself with the school building and grounds, including the mechanical infrastructure.

Ensure staff members understand specific responsibilities in the event of an emergency and have Emergency Go-Bags for crisis situations.

Prepare students by conducting practice drills.

Communicate the school's crisis management plan to parents and the community at large, if applicable.

Athletic Participation In Sports



The Virginia High School League (VHSL) requires all high school students complete a p pre-participation physical examination to be eligible to represent their school in any VHSL interscholastic athletic content.

Pre-Participation Physical Examination

Physical examinations are valid from May 1 of the current year through June 30 of the succeeding year. VHSL Physical Form**.**

- **Middle School Athletes.** School divisions requiring middle school athletes to provide physical examinations may use the VHSL form or provider another form developed by a health care provider of their choice.

- **Referrals and Follow-Up.** The purpose of the physical examination is to screen for life threatening health conditions and/or underlying health conditions that may lead to injury/illness. The completed forms should be reviewed by the school nurse or other health professional to clarify questionable health information.

Sports Related Infectious Diseases

When sharing common areas, equipment, or uniforms, sports-related infectious diseases can occur. There may be risk of exposure for the individual athlete, the team, and spectators.

- **Role of The School Nurse.** The school nurse should track referrals from coaches, the Athletic Director, and/or the Athletic Trainer, and collaborate with parents/guardians for follow-up care.
- **Communicable Diseases.** Refer to the VDH Communicable Disease Chart and the for guidance and reporting requirements.
- **Prevention and Recommendations.** Prevention of Infectious Diseases in Athletes

Prevent athletes from sharing water bottles and pails during sports-related activities.	Students diagnosed with skin infections, or open lesions, should be **cautioned about their participation in sports** involving close physical contact.	All athletic equipment in contact with student's skin or secretions should be **routinely cleaned and sanitized** after use.
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.	**Timely reporting** of even a suspected case of an infectious disease may help to prevent further spread among athletes, spectators, and the community.	All students must be **vaccinated against communicable diseases** as described on the VDH School and Daycare Minimum Immunization Requirements webpage.

For additional resources, visit: **vhsl.org**

Concussion Management

Code of Virginia, § 22.1-271.5.
Code of Virginia, § 22.1-271.6.

What is a concussion?

A concussion is a type of traumatic brain injury (TBI) 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. For additional resources refer to: **VDOE, Guidelines for Policies on Concussions in Students** (Word).

Common Symptoms

Symptoms may vary per student and severity of injury.



Headache, or feeling nauseous



Confusion, difficulty concentrating



Sensitivity to light or sound



Trouble walking, standing, or balancing



Blurred or double vision



Loss of consciousness, fainting

Role Of The School Nurse

01 **Conduct concussion assessment**. Periodic monitoring of the student's symptoms should continue as long as symptoms are present.

- Returning to School After a Concussion, CDC
- Concussion Signs and Symptoms Checklist, CDC
- What Is A Concussion?

02 **Immediately follow-up with parent/guardian** with results from assessment and serve as the liaison between parents and concussion experts. Encourage parent/guardian to seek further evaluation from a healthcare provider.

- Concussion Fact Sheet for Parents, CDC | Return To School Fact Sheet, CDC

03 **Ensure guidelines** recommended by the healthcare provider are followed by school staff.



Return-to-Learn describes the gradual allowance of the student to participate in school-sponsored interscholastic activities and learn without worsening symptoms and potentially delaying healing.



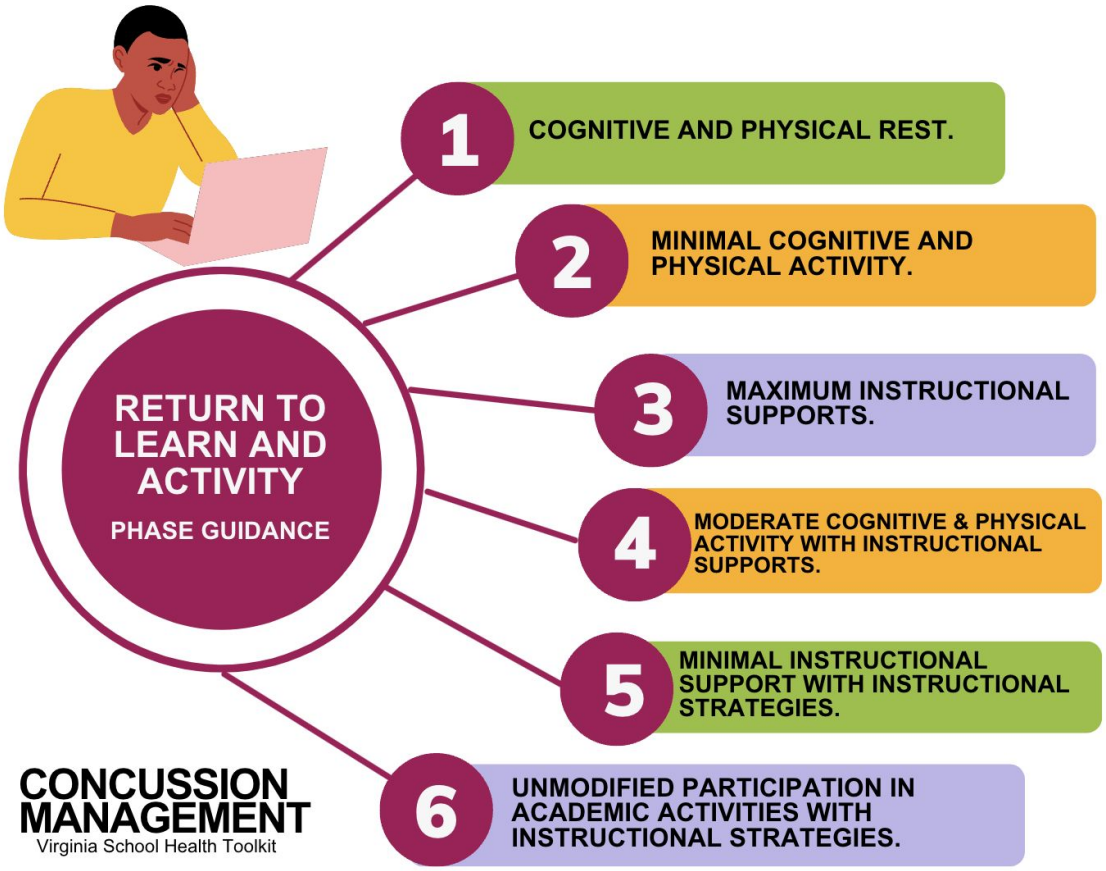
Return-to-Activity describes the gradual reintroduction of physical activities*, without return of symptoms for students in the school environment: walking, recess, classes requiring physical activity (e.g., show choir, dance, physical education).
**Does not include participation in school-sponsored athletics.*



Return-to-Play describes a incremental increase into participation in sports-related tasks, limiting the return of symptoms for students participating in a sports program.

Virginia Department of Education. *Guidelines for Policies on Concussions in Students*. (2019).

PHASE GUIDANCE FOR INSTRUCTIONAL MODIFICATIONS



Phase 1	Limit reading, screen time, no driving and minimal physical activity.
Phase 2	Up to 30 minutes sustained cognitive engagement, no driving, limited physical activity.
Phase 3	Modified classes and environment for light and noise, exclude from testing.
Phase 4	Establish priorities, alternate grading strategies, built-in breaks, reduction of instructional supports
Phase 5	Limit formative and summative testing, continued reduction of instructional supports, exclusion of standardized testing
Phase 6	No instructional supports, return to educational plan before concussion injury.

A student recovering from a brain injury shall gradually increase cognitive and physical activities, progressing through some or all of the phases outlined until asymptomatic or exhibits no symptoms consistent with a concussion.
Virginia Board of Education Guidelines for Policies on Concussions in Students

PHASE GUIDANCE FOR ATHLETIC PARTICIPATION

When in doubt, sit them out!



Phase 1	**Limit daily activities that provoke or agitate symptoms.**
Phase 2	**Walking or stationary bike, no resistance training.**
Phase 3	**Sport specific exercise, running drills that do not risk head impact.**
Phase 4	**More challenging drills, passing, team plays, progressive resistance training.**
Phase 5	**With medical clearance participate in full, normal training activities, coaches assess functional skills.**
Phase 6	**Unmodified game play; goal is full participation.**

A student recovering from a brain injury shall gradually increase cognitive and physical activities, progressing through some or all of the phases outlined until asymptomatic or exhibits no symptoms consistent with a concussion.

Virginia Board of Education Guidelines for Policies on Concussions in Students

Concussion Management Resources

TRAINING & CHECKLISTS:

- HEADS UP to Youth Sports: Online Training for Coaches
- How do I know if it's a concussion?
- A Fact Sheet for School Nurses

CONCUSSION EVALUATION TOOLS:

- VDOE, Guidelines for Policies on Concussions in Students (Word)
- Concussion Signs And Symptoms Checklist
- CONCUSSION Signs & Symptoms - Card
- Tools for Providers | HEADS UP | CDC Injury Center
- What Is A Concussion? - CDC Heads Up

EMPOWERING PARENTS/GUARDIANS:

Heads Up To High School Sports

SUPPORTING EDUCATORS AND COACHES:

- Returning to Sports and Activities | HEADS UP | CDC Injury Center
- Returning to Learning Following a Concussion | Pediatrics

vci.gmu.edu
Virginia Concussion Initiative



Sudden Cardiac Arrest (SCA)
Recognizing The Symptoms

§ 22.1-271.8. Sudden cardiac arrest prevention in student-athletes

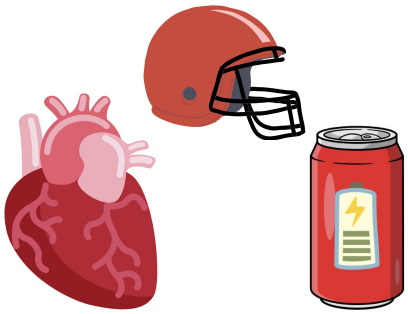
Sudden Cardiac Arrest (SCA) is a life-threatening emergency that happens from an "abrupt and unexpected loss of heart function leading to loss of consciousness and collapse." SCA can be fatal if not treated within minutes. Survival outside a hospital depends on people nearby calling 911, along with prompt bystander emergency response such as using CPR and automatic defibrillators. (May & Menon, 2023) **Each local school division shall develop and biennially update policies and procedures regarding the identification and handling of symptoms that may lead to sudden cardiac arrest in student-athletes.**

Guidelines for Policies on Sudden Cardiac Arrest Prevention in Student-Athletes

Factors that May Increase the Risk of SCA

- structural/functional/electrical causes;
- use of recreational drugs, excessive energy drinks, diet pills, performance enhancing supplements, and some prescription medications;
- other causes including blunt force trauma to the chest, family history of known heart abnormalities, sudden death before 50, some autoimmune disorders, sickle cell trait or sickle cell disease.

(Sudden Cardiac Arrest Prevention, 2020)



Symptoms



- unexplained fainting during or right after exercise
- fainting with excitement or when startled
- chest pain or discomfort with exercise excessive shortness of breath during exercise
- racing or fluttering heart palpitations or irregular heartbeat dizziness or lightheadedness
- extreme unexpected fatigue during or after exercise
- does not respond to shouting or shaking
- no pulse
- asymptomatic onset of sudden episode

cdc.gov | Cardiac Arrest

Save a Life

A student-athlete reporting any warning signs of SCA should be removed immediately from activity and referred for further evaluation. Survival depends on **immediately activating EMS/calling 911, starting cardiopulmonary resuscitation (CPR), and using an Automated External Defibrillator (AED)** if available. Consider developing a Cardiac Emergency Response Plan and Protocol.



Sudden Arrhythmia Death Syndrome

§ 22.1-271.8. Sudden cardiac arrest prevention in student-athletes

Recommendations for School Health Professionals

Sudden Arrhythmia Death Syndromes (SADS) are genetic heart conditions that can cause sudden death in young, apparently healthy, people. These conditions can be treated and deaths can be prevented. SADS Foundation

Conditions that can Result in SADS

- Acquired long QT syndrome (LQTS)
- Arrhythmogenic Right Ventricular Dysplasia/Cardiomyopathy (ARVD/C)
- Brugada Syndrome
- Catecholaminergic Polymorphic Ventricular Tachycardia (CPVT)
- Long QT Syndrome (LQTS)
- Short QT Syndrome (SQTS)
- Timothy Syndromes
- Wolff Parkinson White (WPW)

Resources
SADS | Conditions

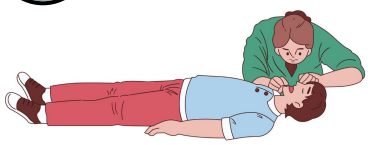
Warning Signs

01



Family history of unexpected, unexplained sudden death under age 40.

02



Fainting or seizure during exercise, excitement or startle.

03



Consistent or unusual chest pain and/or shortness of breath during exercise.

- With any warning signs immediately remove from play to be evaluated by a Licensed Healthcare Professional; student may return only with the Licensed Healthcare Professional's written consent.
- "Unfortunately, the first indication of SADS conditions for many families is an unexpected death. Due to the genetic aspect of these conditions, we recognize this is an important opportunity to save the lives of other at-risk family members." (Sudden Death Response Plan, 2020)

Supporting Schools Through Adverse Events

If the event happened in a young person, or on the campus of a school, information about SADS conditions, support and treatment programs, and other educational materials is sent to the school administration and nurse.

Sudden Death Response Plan - SADS Foundation | SADS | Warning Signs

Resources

Sudden Arrhythmia Death Syndrome

Policy

Code of Virginia § 22.1-271.8. Sudden cardiac arrest prevention in student-athletes

School Division Responsibility. Each local school division shall develop and biennially update policies and procedures regarding the identification and handling of symptoms that may lead to sudden cardiac arrest in student-athletes.

Training

The Virginia Department of Education recommends that all school health staff be certified in Cardiopulmonary Resuscitation (CPR), First Aid, and use of an Automated External Defibrillator (AED).

Emergency First Aid, CPR & AED Certification or Training

CPR/AED/first aid hands-on training is a graduation requirement for high school students; a licensure requirement for public school teachers and administrators; and a Virginia High School League (VHSL) coaches' education requirement for athletic coaches.

Frequency of training is determined by the credentialing or training provider. For all school health staff and designated school personnel per school policy and 8VAC20-131-260.

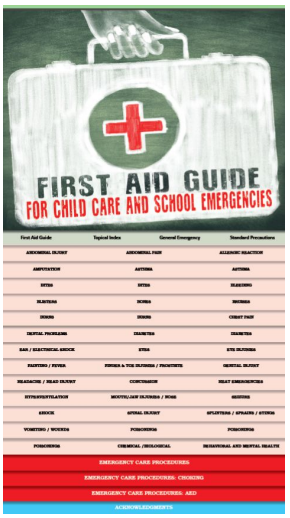
"Get trained. Act with confidence."

-American Red Cross



Resources

- American Heart Association CPR & First Aid
- Red Cross Training | Take a Class
- First Aid Flipchart, VDH
- Virginia Board of Education Guidelines for Policies on Sudden Cardiac. Arrest Prevention in Student-Athletes
- SADS School Nurses; SADS School Care Plans
- Sudden Cardiac Arrest Course
- Cardiac Emergency Response Plan CERP | American Heart Association CPR & First Aid
- Cardiac Emergency Response Plan and Protocol Community
- Cardiac Emergency Response https://www.sca-aware.org/Plan and Protocol Schools
- Sudden Cardiac Arrest Foundation



Creating Healthy and Safe School Environments

Code of Virginia, Section 22.1-138

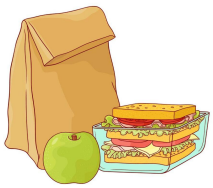
The Health Is Academic: A Guide to Coordinated School Health Programs defines the term "**healthy school environment"** as a supportive physical, emotional, and social school climate that fosters learning. A safe and healthful physical environment includes the school building(s), as well as surrounding areas, school equipment, and appropriate physical learning conditions. 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. In Virginia, the responsibility for establishing and enforcing minimal building and environmental standards for schools is shared by two state agencies: **Virginia Department of Housing and Community Development** and **Virginia Department of Education.**

For additional information on Creating Healthy and Safe Environments, visit the VDOE websites:

01 **School Building Regulations & Guidelines**: The site provides a comprehensive list of resources detailing: building codes & regulations, guidelines for school facilities, water management program, school safety exit (fire) drills.

02 **Safety & Crisis Management: Division of 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.

03 **School Nutrition:** The Office of School Nutrition (VDOE-SNP) is committed to ensuring that every Virginia student has access to freshly prepared, nutritious, locally sourced, and culturally-inclusive meals.



04 **Student & School Support: Facility Construction and Maintenance**: Provides leadership and technical services to Virginia public school facilities (building guidelines, energy efficiency, trainings, school safety, playground safety, and more).

Additional Resources

Virginia Department of Environmental Quality
Environmental Health Services (VDH)
EPA Indoor Air and Coronavirus (COVID-19
EPA Indoor Air Quality Tools for Schools Action Kit
CDC Ventilation in Schools and Childcare Programs
CDC Ventilation in Buildings
CDC Cleaning, Disinfection, and Prevention
CDC When and How to Disinfect a Facility

Occupational Safety and Health Administration

OSHA Fact Sheet: Steps to an Effective Hazard Communication Program for Employers That Use Hazardous Chemicals

Building and Environmental Standards

In Virginia, the responsibility for establishing and enforcing minimal building and environmental standard for school buildings is shared by two state agencies: **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 facility as being in conformance with applicable state codes and regulations.

Virginia Department of Education

The Virginia Department of Education is responsible for ensuring that the building meets the Guideline for School Facilities in Virginia's Public Schools.

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.

Building Requirements

The school plant and accessory buildings should be maintained in good repair and in 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 1) should be used as a guidelines for the construction or alteration of school buildings. (Note: For information on maintenance standards, refer to the 205 Virginia Maintenance Code (USBC, Part III).

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 approaching school buildings with their municipality.

Additional Resources

- School Safety Audit
- Department of Criminal Justice Services
- Virginia Center for School and Campus Safety



Indoor Air Quality (IAQ)

Code of Virginia, Section 22.1-138

"When school health policies and practices are put in place, healthy students can grow to be healthy and successful adults."
-CDC, About Healthy Schools

Overview

Unlike other buildings, managing IAQ in schools involves the combined responsibility for public funds and child safety issues. These can instigate strong reactions from concerned parents and the general community.

Poor Indoor Air Quality (IAQ) deficiencies can:

- ***speed up*** deterioration and reduce efficiency of the school's infrastructure.
- ***affect*** students and staff learning environment, productivity, and performance.
- ***negatively impact*** health and well-being, presenting symptoms such as: headache, fatigue, shortness of breath, asthma attacks, sinus congestion, coughing, sneezing, dizziness, nausea, and spread of communicable diseases.

Indicators Of An IAQ Problem

- **(1)** Widespread presence of symptoms in a class.
- **(2)** Symptoms dissipate when staff or students leave the building.
- **(3)** A staff or student has been diagnosed with having an indoor air-related illness.

A lack of symptoms does not mean the air quality is acceptable.

IAQ. Indoor air contaminants can begin within the building or be drawn in from outdoors. If pollutant sources are not controlled, IAQ problems may occur, even if the HVAC system is working properly.

Air Quality. Dry, hot air removes moisture from skin and mucous membranes. Stagnant, humid air in closed rooms causes various types of mold to flourish. **Specific temperatures for school buildings are not mandated by regulation in Virginia**, however it is recommend that heating and cooling systems be properly maintained.

Air Pressure. AIr pressure differences 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.

Air Contaminants. Air pollutants consist of numerous particles, fibers, mists, molds, bacteria, gases, pollen, and animal dander. Indoor air levels vary within the school building or even a single classroom.

Resources

Environmental Protection Agency (EPA)
School Building Regulations & Guidelines (VDOE)
EPA Indoor Air and Coronavirus (COVID-19)
EPA Indoor Air Quality Tools for Schools Action Kit
CDC Ventilation in Schools and Childcare Programs
CDC Ventilation in Buildings



School Maintenance and Sanitation

Authorization

Follow regulations for maintenance and sanitation per local school division policy.



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 division 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 and is used to sanitize food contact services, equipment, and utensils. Approved EPA registration numbers should be present on containers.
- Housekeeping, maintenance equipment, and cleaning supplies should be appropriate for the task it is intended to do. Equipment, such as vacuum cleaners, must be kept clean, in good working conditions, and stored safely.
- Toxic cleaning supplies must be kept in properly labeled containers and stored away from food. Some chemicals should be stored in a separate place from others. A 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 efforts and proper cleanup of chemical spills should be provided and/or posted by the school.



Resources

Guidelines for School Facilities In Virginia's Public Schools
CDC Cleaning, Disinfection, and Prevention
CDC When and How to Disinfect a Facility
School Building Regulations & Guidelines (VDOE)

Waste Disposal and Recycling

No specific regulations for recycling.

Waste Management

The storage collection, transportation and disposal of waste should be controlled to reduce odors, insects, rodents, spread of communicable diseases, accidents, or other nuisance conditions.

Recommendations:

- Containers should be durable and non absorbent.
- Universal precautions should be taken when cleaning up blood, bodily fluids, biohazardous materials, sharp-edged instruments (for example: blades, needles, or X-acto craft knives).

146

million tons of wate sent to landfill

91

million tons of waste was composted or recycled

4.9

pounds per person/per day

epa.gov

Recycling Programs At School

Schools can take leadership role in recycling. **Developing school recycling programs can promote environmental stewardship, become aware of their impact, and develop positive practices, attitudes, and behaviors. The Environmental Protection Agency (EPA)** encourages waste prevention, recycling, and composting.

"Recycling promotes environmental stewardship."

Resources

Virginia Department of Environmental Quality: deq.virginia.gov

Virginia Department of Conservation and Recreation: dcr.virginia.gov

Central Virginia Waste Management Authority: cvwma.com

The Recycling Partnership: recyclingpartnership.org





Safety & Security

Virginia Department of Education, Division & School Safety

Authorization

Code of Virginia, Section 22.1-279.8, **School Safety Audits and School Crisis, Emergency Management, and Medical Emergency Response Plans Required:**

An excerpt:

Each local school board shall require all schools under its supervisory control to annually conduct school safety audits, as defined in this section, consistent with such list and in collaboration with the chief law-enforcement officer of the locality or his designee. As part of each such audit, the school board shall create a detailed and accurate floor plan for each public school building in the local school division or shall certify that the existing floor plan for each such school is sufficiently detailed and accurate.

"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 Data

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 and their schools' environment and safety.

1. **Virginia School Safety Survey**
2. **School Division Level Survey**
3. **Virginia Crisis Management Plan Review and Certification**
4. **Virginia Secondary School Climate Survey**
5. **School Safety Inspection Checklist**

Crime Prevention

School divisions are working 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. Studies show that combining security hardware, psychology, and site design of a physical environment could be developed that would by its very nature, discourage crime. **Crime Prevention Through Environmental Design,** or CPTED, (pronounced "sep-ted"), creates a defensive environment both form a physical and psychological aspect. It is recommended every school conduct an annual audit to review and inspect safety, including these key areas: exterior, interior, and traffic/parking lot safety.

Additional Requirements To Ensure A Safe Environment in Virginia Public Schools:

School Safety Audit Committee, 22.1-279.8	**Emergency Manager**	**Lock-down Drills**	**Threat Assessment Teams**



Foodservice Workers and Health Inspections

Authorization

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. 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 infectious levels of bacteria or toxic production of foodborne illness. Food serve operations in the schools of the Commonwealth must be carried out in a manner that will prevent the occurrence of foodborne illness, a major public health issue.

Guidelines

Food Service Personnel. Food service personnel must be in good physical health and be free of symptoms of communicable disease. (Virginia Reportable Disease List), open or infected cuts, burns, sores, or skin conditions that may contaminate food.

Training. Training of food services 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, free of jewelry at all times, utilizing proper handwashing techniques, using hot running water and soap after using the restroom, coughing, sneezing, or other behaviors that may contaminate food.

Food Handling. Foodservice workers should keep fingers out of mouth, hair, and face. They should also not use tobacco products in food areas. Plastic gloves are primarily suited for food handling. away from

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. Sufficient numbers of thermometers must be used to monitor temperatures consistently.

Food Transportation and Storage. If food is transported from one facility to another, adequate holding temperate must be maintained at all times. Potentially hazardous foods must be either below forty two degrees fahrenheit or above 134 degrees at all times. Schools must have the facilities to maintain appropriate temperatures during storage, transportation, and service.

VDOE, Office of School Nutrition Programs
VDH, Food and General Environmental Services

Asbestos In Schools

How harmful is asbestos?

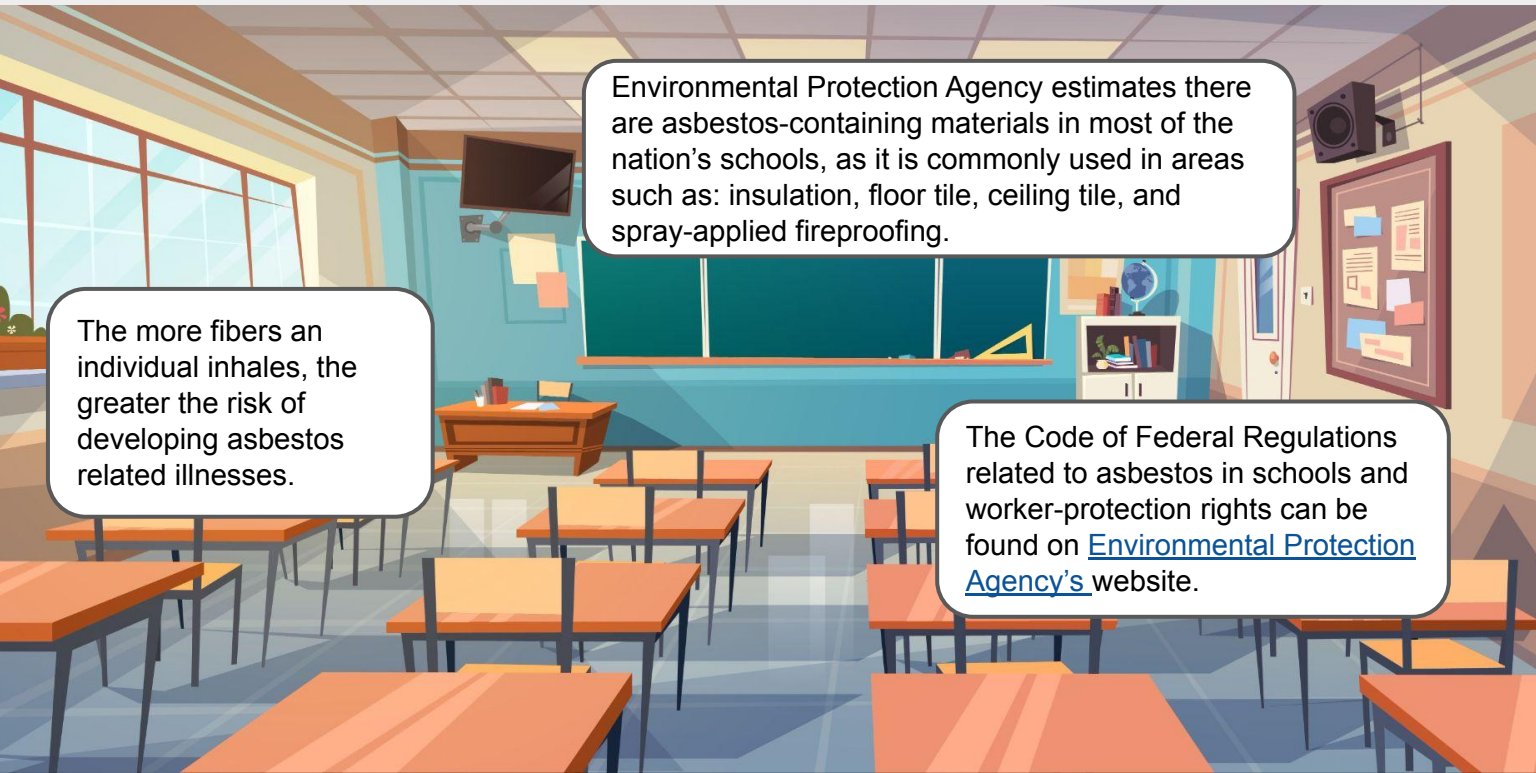
Asbestos is a mineral found in certain types of rock formations. It takes the form of small fibers that are usually invisible to the naked eye. Because the fibers are so small and light, they can remain in the air for many hours if they are released from asbestos-containing material, increasing the danger of being inhaled. Intact and undisturbed asbestos materials do not pose great health risk. However, asbestos that has shown deterioration over time (i.e. cracking, tearing, or crumbling) releases harmful fibers and causes serious health risks. If left untreated, asbestos can lead to diseases like lung cancer, mesothelioma, and asbestosis.

What is the role of the 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. The Virginia Department of Labor and Industry (DOLI) enforces the OSHA standards that govern work with asbestos. Inspectors and other designated asbestos professionals must be licensed by the Board for Asbestos, Lead, and Home Inspectors within the DPOR. For additional information, contact your school division's Asbestos Coordinator or the Director of Facilities at: Virginia Department of Education Facilities Construction & Maintenance.

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 in a timely fashion, and to inform parents/guardians of the presence of asbestos in the school.



Radon In Schools

Code of Virginia, Section 22.1-138B, Minimum Standards for Public School Buildings

Excerpt:

By July 1, 1994, every school building in operation in the Commonwealth shall be tested for radon pursuant to procedures established by the U.S. Environmental Protection Agency (EPA) for radon measurements in schools.

School buildings and additions opened for operation after July 1, 1994, shall be tested for radon pursuant to such EPA procedures and regulations prescribed by the Board of Education pursuant to subsection A. Each school shall maintain files of its radon test results and make such files available for review. The division superintendent shall report radon test results to the Department of Health.

Radon
Radon is naturally occurring radioactive gas that seeps into buildings from the surrounding soil. Radon can also accumulate in groundwater that supplies wells. A person cannot see, taste, or smell radon, thus the only way to detect risk is through routine testing.

Harmful Exposure
The primary source of harmful exposure to radon is from breathing air that contains elevated levels of radon gas. Breathing radon released into the air due to household water, such as showering, is second only to smoking as the leading cause of lung cancer.

Associated Risks
Radon gas decays into radioactive particles that can be trapped in a person's lungs. As these particles break down, they can damage lung tissue and lead to lung cancer over the course of a person's lifetime depending on the: level of radon and duration of exposure.



Code 22.1-1388B

Testing for Radon In Schools

A nationwide survey show at least one in five schools has at least one classroom with a small level of radon. If schools detect radon levels, the problem can be corrected to limited exposure and lower risks of lung cancer from radon exposure. The EPA has published guidance available for free to schools, 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.

Testing Recommendations:

(1) Test all frequency used rooms on and below the ground level.
(2) Conduct tests during the cooler months of the year.
(3) Follow testing and mitigation strategies for schools.

Additional Resources:

EPA/Radon Hotlines and Information Resource
Radon: Publications and Resources
Radon In Schools

Lead In Schools

§ 22.1-135.1. Potable water; lead testing.

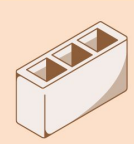
Each local school board shall develop and implement a plan to test and, if necessary, remediate potable water from sources identified by the U.S. Environmental Protection Agency as high priority for testing, including bubbler-style and cooler-style drinking fountains, cafeteria or kitchen taps, classroom combination sinks and drinking fountains, and sinks known to be or visibly used for consumption. Such plan shall be consistent with guidance published by the U.S. Environmental Protection Agency or the Department of Health. The local school board shall give priority in the testing plan to schools whose school building was constructed, in whole or in part, before 1986. Each local school board shall submit such testing plan and report the results of any such test to the Department of Health. Each local school board shall take all steps necessary to notify parents if testing results indicate lead contamination that exceeds 10 parts per billion.



In 1978, lead-based paint was banned for use in residences and child-care facilities.



Lead is rarely found in source water, but enters tap water through corrosion of plumbing materials.



Some schools may contain lead-based paint in steel structural components.



Once in the body, lead is very slow to leave the system damaging the brain and central nervous system of children.



Sources of lead can be found in materials used for art activity, glass, pottery, cosmetics, some children's toys, or artificial turf.



Young children are high risk as their brain cells are still developing. Low levels of lead can interfere with normal brain development.



All children enrolled in Medicaid are required to be tested at 1 or 2 years of age.



School officials should be monitor the existence of lead in: **paint, playground equipment, water, and soil.**

3Ts

The United States Environmental Protection Agency Office of Ground Water and Drinking Water manual, **3Ts: Training, Testing, and Taking Action 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.

Additional Resources

The Safe Drinking Water Act (SDWA)
Virginia Guidelines: Testing Virginia Children For Lead Exposure
Center for Disease Control and Protection: Lead
Childhood Lead Poisoning Prevention Program
Virginia Department of Health - Childhood Office Lead Poisoning Prevention

Integrated Pest Management

Code §22.1-132.2

Authorization

Per **Code §22.1-132.2,** "integrated pest management" shall mean a managed pest control and suppression program that uses various integrated methods to keep pests from causing economic, health-related, or aesthetic injury and minimizes the use of pesticides and the risk to human health and the environment associated with pesticide applications. The Department of Education shall make information available to school boards on integrated pest management programs that appropriately address the application of chemical pesticides and other pest control measures on school property.

U.S. Environmental Protection Agency (EPA)

All pesticides legally sold in the United States must bear a EPA registration number on the front of the product label. There are very few expectations to this rule.

Virginia Department of Agriculture and Consumer Services

Only a pesticide applicator 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, thus pest management may be required. 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. Pest management is schools should be conducted as part of an integrated pest management program (IPM). This includes the coordinated use of pest and environmental information, with available pest management methods, to prevent unacceptable levels of pest damage with the most economical means and the least possible hazard to people, property, and the environment.

Integrated Pest Management Program (IPM). A successful IPM program requires not only hazard to people, property, and the environment, 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 Use. All pesticides: (1) must be stored in a locked storage area that is accessible only to authorized personnel; (2) must be used in accordance with registered label directions; (3) must have 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
Virginia School Integrated Pest Management Program (IPM)
Environmental Protection Agency (EPA), Office of Pesticide Programs



Playground Safety

Authorization

See local regulations for guidance.

Overview

The United States Consumer Product Safety Commission (CPSC) 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; however, falls from one piece of equipment to the another are also reported. The majority of the deaths are due to strangulation or falls.

Resources

The U.S. Consumer Product Safety Commission (CPSC) explains specific recommendations to address hazards that result in playground-related injuries and death.	Virginia Department of Health provides a digital flipchart reference guide for administering emergency care to an injured or ill individual. The flip chart contains practical, step-by-step instructions that describe what to do when caring for an injured or ill person. Hard copies of the First Aid Guide for Child Care and School Emergencies Flip Chart, **free of charge,** download and complete the **order form**.	Information on current product recalls, safety education, regulations and laws, and educational programs. **www.cpsc.gov/recalls** **Product Safety Hotline: 800-638-2772** or **301-595-7054** (TTY)
Public Playground Safety Handbook	**First Aid Guide for Child Care and School Emergencies**	**U.S. Consumer Product Safety Commission (CPSC)**

Menstrual Supplies, Toilets, Lavatories, Drinking Fountains, and Bathing Facilities

Authorization

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 meet their educational program needs. It is the responsibility of the local school board to determine school facilities needs in the form of an architectural program.

Menstrual Supplies: **Code of Virginia § 22.1-6.1. Menstrual supplies; availability; public elementary, middle, and high schools.** Each local school board shall make menstrual supplies available, at all times and at no cost to students, **in the bathrooms** of each middle school and high school; and, if deemed appropriate for elementary school.

Recommendations

The **Guidelines for School Facilities In Virginia's Public Schools** are intended to provide more detailed guidance for the planning and design of local public school facilities. The recommendations are 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

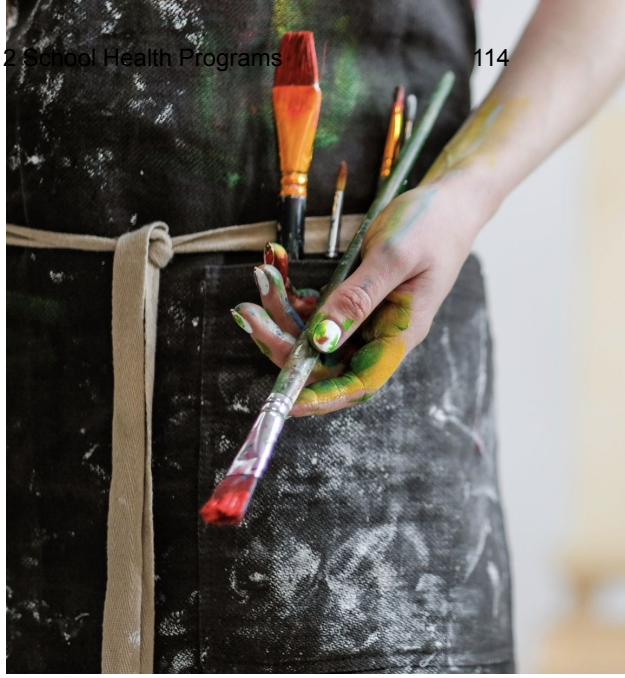
VDH, OFFICE OF ENVIRONMENTAL HEALTH SERVICES:
vdh.virginia.gov/environmentalhealth

VDOE:
Guidelines for School Facilities In Virginia's Public Schools

VIRGINIA UNIFORM STATEWIDE BUILDING CODE:
dhcd.virginia.gov/codes



TOXIC ART SUPPLIES



Criteria to Identify Toxic Art Materials. 22.1.-274.1
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 art materials shall be prohibited in kindergarten through grade five.

In October 1988, the U.S. Congress passed the Labeling of Hazardous Materials Act (Use with Children Under Age 12 Prohibited) Public Law 100-695, 15 U.S.C. that requires mandatory warning labels on art and craft materials with chronic long-term health hazards.

Arts and crafts materials (**8VAC20-530-10**) like: solvents, spray paints, silk-screen inks, adhesives, and other substances, should be labeled with a warning statement. The label should identify the hazard, as well as, guidelines for safe use.

Art educators are responsible for the art materials (**8VAC20-530-10**) they order and the safe use thereof. Although there is no legislation prohibiting students older than age 12 rom using toxic agents, there is the Hazard Communication Standard which addresses potentially hazardous materials in the workplace.

Children can be exposed to toxic art supplies by **inhalation, ingestion, and skin contact**. Younger children are especially vulnerable to *ingesting* toxic art supplies, as the they regularly put their hands in their mouth.

Art and craft materials can contain toxic ingredients, that when used or stored in a play area, create a risk to the health and well-being of children. Some art supplies can trigger asthma, allergies, headaches, nausea, especially if used in a poorly ventilated area.

Products To Avoid:

- Solvent based products.
- Products containing lead.
- Products that can be inhaled.
- Commercial dyes.
- Products not in original packaging.
- Instant paper-mache'.
- Permanent or felt-tip markers.

Code of Virginia, 22.1-274.1

Resources:

- **Children's Environmental Health Network**
- **Teacher's Classroom Checklist**

Additional Information:

For more information, visit the VDOE, Fine Arts webpage.

Storage and Handling of Toxic or Hazardous Materials

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

1. 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. 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.

2. Containers of chemicals, poisons, corrosive substances, and flammable liquids should be cleared labeled with the name of 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.

3. 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.

4. A written plan for response efforts and proper cleanup of chemical spills should be provided and/or posted by the school. A written plan should also be available 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.

5. Chemical storage should be based on ensuring 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.

6. Pesticides, chemicals, toxic, or hazardous materials should be stored separately in a ventilated and locked cabinet, or in an area accessible only to authorized personnel. Flammable or combustible materials should be stored separately in a ventilated and locked cabinet or in an area accessible only to authorized personnel.

7. Chemical storage should be based on ensuring 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.

8. A material safety data sheet should be provided for all poisonous, toxic, or hazardous substances and should be available for review upon request.

Additional Resources
Virginia Department of Environmental Quality: www.deq.virginia.gov
Virginia Department of Agriculture and Consumer Services: www.vdacs.virginia.gov
Poison Control: 800-222-1222

Laboratory, Industrial, and Vocational Hazards

Code of Virginia, Section 22.1-275, 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.

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.

- Instructional, athletic, recreational, and other equipment used in or out of the classroom should be maintained in safe, locked area and should be cleaned after use. Toys and equipment should meet applicable state and local regulations.

- All areas should be adequately ventilated so that exposures to hazardous or toxic materials are maintained at a safe level. 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. Airflow of fume hoods should be tested at least once per school year.

- Discharges from any exhaust hood should meet applicable Virginia Air Pollution Standards**.** Specific questions should be directed to the local building/facilities coordinator for suggestions and guidelines per individual school division policy.

Virginia Department of Environmental Quality: **www.deq.virginia.gov | 804-698-4000**





Swimming and Therapy Pools

12VAC5-462-20

AUTHORIZATION

Excerpt:

Per 12VAC5-462-20, 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

Water Quality Standards For Pools

Free Residual Disinfectant	Minimum	Maximum
Chlorine	1.0 ppm	3.0 ppm
Bromine	2.0 ppm	4.0 ppm
pH	7.2	7.8
Temperature	none	104° Fahrenheit (40° Celsius) (Heated Pools Only)

Water Quality Standards For Spas

Free Residual Disinfectant	Minimum	Maximum
Chlorine	2.0 ppm	10.0 ppm
Bromine	2.0 ppm	10.0 ppm
pH	7.2	7.8
Temperature	none	104° Fahrenheit (40° Celsius)

RESOURCES

- School Building Regulations & Guidelines (VDOE)
- Student & School Support: Facility Construction and Maintenance (VDOE)
- VDH, Division of Onsite Sewage and Water Services (VDOE)



Lighting

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 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. To avoid harmful effects from glares, there should be controlled bright and dark areas. This is best accomplished by artificial or natural light coming from many different directions rather than a single source, known as diffusion. In addition, the reflective surfaces of desks, walls, woodwork, etc., should be considered.

Light Recommendations. The electrical lighting system should be capable of the following minimum illumination levels given in footcandles (FC). Light level intensities should be measured at the tasks level or 30 inches from the floor.

60-70 FC for science labs and kitchens
55-60 FC for classrooms, media centers
30-50 FC for offices, gynamiums
30 FC for computer labs
10-30 FC for auditoriums

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: warm, cool, neutral, or depressing.

Determination of Appropriate Lighting. Illuminations 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?

Additional Resources

- School Building Regulations & Guidelines (VDOE)
- Student & School Support: Facility Construction and Maintenance (VDOE)

Screen Time



Authorization.
House Bill 817 requires the Department of Education, in collaboration with the Department of Health and medical professional societies, to develop and distribute health and safety best practice guidelines and recommendations for the use of digital devices in Virginia's public schools.

Recommendations for Digital Device Usage



Take a break from digital devices every 20-30 minutes. Rest eyes for 15 minutes.



Use digital devices to enhance learning and promote critical thinking, collaboration, research, and creativity.



Maintain good posture when working at keyboard. Utilize chair for back support.



Foster online safety when using digital devices for games and social media.



Participate in intermittent brain breaks to promote blood flow, improve alertness, and increase engagement.



Work in well-lit spaces using screen filters to reduce glare.



Frequently take into consideration the benefits and risks of digital device usage.

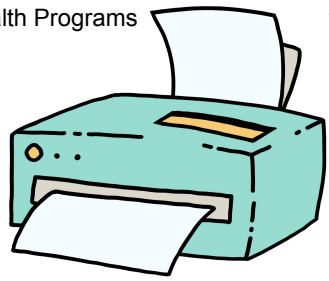


Provide ongoing professional development for educators.

RESOURCES

- Digital Devices In Classroom: Health & Safety Guidelines (PDF)
- Digital Devices in the Classroom: Health and Safety Guidelines document (Word)
- Virtual Learning
- VDOE YouTube Channel

Technology Related Concerns



Hazards from Video Display Terminals (VDTs)	Photocopier Machine and Other Machines	Radiation Producing Devices
Overview. 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.	**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.	Use of 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. 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.

Resources

American Optometric Association: www.aoa.org

Virginia Department Health, Office of Radiological Health: vdh.virginia.gov/radiological-health

For recommendations on screen time for digital devices, refer to **Screen Time Usage For Digital Device Usage.**

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-1800s 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.

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." 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. 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. New health promotion philosophies and movement began to replace outdated 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 heath, most of these programs focused on disadvantaged and special populations. 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.

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. In addition, summaries of key school health-related legislative studies are provided in the following subsections.

Legislative Studies

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

Searchable Database
A searchable database of the Code of Virginia is available 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 a phrase (example: comprehensive physical examination) into the screen's search window and press submit. The Code of Virginia contains the laws passed by the General Assembly and signed by the Governor for the Commonwealth of Virginia. *Updated July 1 to reflect the legislation passed during the previous session.*

Copies of Legislative Reports

- 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
- **Senate Joint Resolution 358, Document No. 2003** , Virginia Commision on Youth
- 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
- Establishment of an Office of Children's Services Ombudsman (Senate Bill No. 208, 2008)

- **A Plan for Community-Based Children's Behavioral Health Services in Virginia, Item 304.M. - Interim Report (2010)**
- **School Enrollment Practices for Virginia's Kinship Caregivers**
- **(VA General Assembly Report Doc. 135, 2012)**
- **Study of Seclusion and Restraint in Schools: Recommendations**
- **(House Document 21, 2014)**

- **Medical Cannabis Products (CBD and THC-A Oil) Administration Required School Form (2019)**

- **School Health Personnel in Virginia Public Schools: Recommendations for Qualifications and Training (House Document No. 21, 2021)**

- **Comprehensive Plan for Virginia's Youth: Universal Cannabis and Other Substance Use Education, Prevention, and Professional Development (Chapter 552, 2021 SSI)**

- **School Health Committees, (SB 62, Title 30, 2021)**

- **Maximizing School-Based Mental Health Services (Behavior Health Commission Report Document #764, 2023)**
- **Virginia's K-12 Funding Formula (JLARC, SJ 294, 2023)**

- **Standards Of Quality (SOQ), Standards #2**
- **(SB 1257)**

- **Standards Of Quality (SOQ), Standards #2 (SB 1257) (continued)**

Legislative Information Systems
To obtain a complete copy of any of the 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. 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.

3. 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.

4. Minimum standards for school health services in Virginia should be developed jointly by the Departments of Education and Health.

5. 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.

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. 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.

Continued on next page.

9. 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.

10. 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.

11. Formal, written emergency medical procedures should be developed in every school division within the state.

12. 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.

13. 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.

14. 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.

15. 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.

16. 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.

17. 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.

Continued on next page.

18. 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.

19. 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.

20. 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.

21. The Department of Education should assist all school divisions with guidance on the physical education curriculum to develop and emphasize individual fitness 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.

Continued on next page.

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 cosponsored 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.

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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.

Continued on next page.

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.

Virginia Commission on Youth, Senate Joint Resolution 358, DocumentNo. 2003

Background

The purpose of the Commission shall be to study and provide recommendations addressing the needs of and services to the Commonwealth's youth and their families.

§ 30-174. Virginia Commission on Youth; purpose; membership; terms; compensation and expenses; quorum; voting on recommendations.

A. The Virginia Commission on Youth (the Commission) is established in the legislative branch of state government. The purpose of the Commission shall be to study and provide recommendations addressing the needs of and services to the Commonwealth's youth and their families. In so doing, it shall 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. In addition to its own proposals, the Commission shall coordinate the proposals and recommendations of all commissions and agencies as to legislation affecting youth.

B. The Commission shall consist of 12 members to be appointed as follows: six members of the House of Delegates to be appointed by the Speaker of the House of Delegates; three members of the Senate to be appointed by the Senate Committee on Rules; and three nonlegislative citizen members to be appointed by the Governor. Nonlegislative citizen members shall be citizens of the Commonwealth.

C. Legislative members shall serve terms coincident with their terms of office. Nonlegislative citizen members shall serve four-year terms. Members may be reappointed for successive terms. Vacancies shall be filled for the unexpired terms. Vacancies shall be filled in the same manner as the original appointments.

D. The Commission shall elect its chairman and vice-chairman annually. A majority of the members shall constitute a quorum. The meetings of the Commission shall be held at the call of the chairman or whenever the majority of the members so request.

E. Members of the Commission shall receive compensation as provided in § 30-19.12 and shall be reimbursed for all reasonable and necessary expenses incurred in the performance of their duties as provided in §§ 2.2-2813 and 2.2-2825. However, all such compensation and expense payments shall come from existing appropriations to the Commission.

F. No recommendation of the Commission shall be adopted if a majority of the Senate members or a majority of the House members appointed to the Commission (i) vote against the recommendation and (ii) vote for the recommendation to fail notwithstanding the majority vote of the Commission.
1989, c. 189, §§ 9-292, 9-293; 1992, c. 778; 2001, c. 844; 2004, c. 1000.

The chapters of the acts of assembly referenced in the historical citation at the end of this section may not constitute a comprehensive list of such chapters and may exclude chapters whose provisions have expired.

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."

Recommendations

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.

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:
    i. • Require K-10 instruction in health and physical education to be delivered by a qualified, endorsed health and physical education teacher;
    ii. • 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
    iii. • 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.

Additional Recommendations for Senate Joint Resolution 358:
§ 30-174. Virginia Commission on Youth; purpose; membership; terms; compensation and expenses; quorum; voting on recommendations.

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

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

Establishment of an Office of Children's Services Ombudsman (Senate Bill No. 208, 2008)

Background

This study relates to a 2006 General Assembly legislative proposal, Senate Bill 208, introduced by Senator John Edwards, which proposed the creation of an Office of Children's Services Ombudsman within the legislative branch of state government. The Senate Committee on General Laws and Technology reviewed this bill and unanimously agreed to request the commission on Youth to further study the impact of the bill. *Establishment of an Office of Children's Services Ombudsman, Report Document 81 (2007)* was published as the commission on Youth's Interim Report.

Recommendations

1. Introduce legislation during the 2008 General Assembly Session to create an Office of the Children's Ombudsman (Office) as a separate and independent state agency.

2. Introduce an enactment clause of the legislation creating the Office of the Children's Ombudsman to 1) direct the Office of the Governor to conduct a needs assessment of resources and to work with General Services to provide for the Ombudsman's office space needs and 2) clarify that the Office of the Children's Ombudsman is an independent agency and technical support of the establishment of the Office shall not give such an entity any authority over the operation or function of the Children's Ombudsman.

3. The Office of the Children's Ombudsman should provide ombudsman services for children served by state departments in a phase-in operation for the first three years of implementation.

4. The Office of the Children's Ombudsman shall be authorized to investigate complaints regarding actions of child-serving agencies for the purposes of resolving and mediating complaints from children, parents and citizens concerning harmful actions or inactions of any child-serving agency.

5. The Office of the Children's Ombudsman shall promote continuous quality improvement in the administration of children's services.

6. The Office of the Children's Ombudsman shall promote higher standards of competency, efficiency and justice in the administration of children's services with considerations given to best-practices for serving children within the state system.

7. The Office of the Children's Ombudsman shall serve as a resource for information, referral, and guidance for children, parents, caregivers, providers and citizens of the Commonwealth.

8. The Children's Ombudsman shall be authorized to operate and manage the Office of the Children's Ombudsman and to employ the personnel required to carry out duties and responsibilities of the Office. In addition, the Children's Ombudsman shall be authorized to make and enter into contracts and agreements that may be necessary and incidental to carry out the duties and responsibilities of the Office, and to apply for and accept grants from the United States government, agencies and instrumentalities thereof, and any other source, in furtherance of the provisions of this article.

9. The Children's Ombudsman shall be appointed by the Governor, initially for a term that expires one full year following the end of the Governor's term of office, and, thereafter, the term shall be for four years and the Ombudsman may be reappointed for subsequent terms.

Continued on next page.

Recommendations (Continued)

11. The Office of the Children's Ombudsman shall have the duty to keep the Governor, General Assembly, the Virginia Commission on Youth and the public fully and currently informed concerning significant problems, abuses, and deficiencies relating to the administration of the specified programs and child services; to recommend corrective actions concerning the problems, abuses, and deficiencies of such programs and services; and to report on the progress made in implementing the corrective actions.

12. The Children's Ombudsman shall provide periodic reports on the work of the Office of the Children's Ombudsman, including but not limited to an annual written report to the Governor, General Assembly and the Virginia Commission on Youth by November 30 of each year.

13. The Office of the Children's Ombudsman shall notify in a timely manner the attorney for the Commonwealth for the locality in which a state facility, shelter care facility or detention home, as defined in §16.1-228, or residential public charter school is located and law enforcement, as appropriate, whenever the Children's Ombudsman has reasonable grounds to believe there has been a violation of state criminal law. However, where the Children's Ombudsman has reason to believe that a criminal offense has been committed in a state facility, notification of that suspicion shall be given to the agency head of that department.

14. The Children's Ombudsman shall report immediately to the Governor and the Commissioners of the Department of Social Services, and Mental Health, Mental Retardation and Substance Abuse Services, the Director of Juvenile Justice, Health, and the Comprehensive Services for At Risk Youth and Families, or the Superintendent of the Department of Education, and Department of Correctional Education, as may be appropriate, whenever the Office becomes aware of serious problems, abuses or deficiencies relating to the administration of the programs and services of state facilities and of providers.

15. The reports, information, or documents required by or under this section shall be transmitted directly to the Governor, the General Assembly and the Virginia Commission on Youth without preliminary clearances or approvals. The Children's Ombudsman shall, insofar as feasible, provide copies of the annual report to the Governor in advance of the date for their submission to allow a reasonable opportunity for comments of the Governor to be appended to the reports.

16. Records that are confidential under federal or state law shall be maintained by the Office of the Children's Ombudsman as confidential by the Ombudsman and shall not be further disclosed, except as permitted by law.

17. The Office of the Children's Ombudsman may request and shall receive from every department, division, board, bureau, commission, authority, or other agency created by the Commonwealth, or to which the Commonwealth is a party, or from any political subdivision of the Commonwealth, cooperation and assistance in the performance of its duties.

18. The Office may enter into cooperative agreements with any state agency providing advocacy, client assistance or ombudsman services for the agency's clients, in order to ensure the protection of and advocacy for children, provided that such agreements do not restrict such authority as the Office may otherwise have to pursue any legal or administrative remedy on behalf of children.

19. Introduce a budget amendment providing the monies necessary for the Office of the Children's Ombudsman to carry out its duties and responsibilities. In addition, the budget amendment shall include funding for marketing the services of the agency. This budget amendment will set forth the operating budget for the Office of the Children's Ombudsman, as well as the number of full time equivalents (FTEs).

Additional Resources

Virginia Department of Education:

Parent Ombudsman for Special Education Services

A Plan for Community-Based Children's Behavioral Health Services in Virginia, Item 304.M. - Interim Report (2010)

Background

Planning process to develop a comprehensive plan for Virginia's child and adolescent behavioral health services that ensures there are child-centered services, both inpatient and community based, delivered at the community level in every Health Planning Region in the Commonwealth.

Recommendations

- Define and promote through DBHDS the full comprehensive service array as the goal and standard for children's behavioral health services in every community.

- Expand the array and capacity of services to assure a consistent base level of services for children and families statewide.
  a. Crisis Response Services
  b. Case Management and Intensive Care Coordination
  c. Psychiatric Services
  d. In-Home Services

- Establish a children's behavioral health workforce development initiative to be organized by DBHDS.

- Continue the current role of CCCA for the foreseeable future, and until more adequate community-based services are in place.

- Establish quality management mechanisms and metrics to improve access and quality in behavioral health services for children and families.

School Enrollment Practices for Virginia's Kinship Caregivers (VA General Assembly Report Doc. 135, 2012)

Background

On April 5, 2011, the Commission directed staff to convene an advisory group of representatives from impacted agencies and stakeholder organizations to study ways to clarify the school enrollment process for informal kinship caregivers. At the December 19, 2011 meeting, the Commission on Youth approved a recommendation to request the State Executive Council to review the work of the Commission and Youth and develop a plan to ensure school stability for children in out~of~home care, including children in kinship care arrangements, both formal and informal.

Definition of Kinship Caregiver

Kinship care is defined in the Code as the "full-time care, nurturing, and protection of children by relatives. Kinship care arrangements can be either informal or formal. In Virginia, informal arrangements are the more common of the two types.

Recommendations

The State Executive Council to review the work of the Commission on Youth and develop a plan to ensure school stability for children in out of-home care, including children in kinship care arrangements, both formal and informal.

§ 22.1-4. of the Code states that children in foster care cannot be denied free public schooling or be charged tuition. The LDSS are responsible for coordinating the immediate enrollment of foster care children.

In addition to requirements outlined in the Code, the Virginia Department of Education (VDOE) requires that a parent or guardian must produce the following to enroll a child into a Virginia public school:

1. Official Birth Certificate
2. Documentation of Street Address
3. School Entrance Health Form, MCH 213G
4. Immunizations Records
5. Social Security Number
6. Expulsion Statement
7. Enrollment of Homeless Students

    Project HOPE ensures the enrollment, attendance, and the success of homeless children and youth in school and through public awareness efforts across the commonwealth and subgrants to local school divisions

Study of Seclusion and Restraint in Schools: Recommendations (House Document 21, 2014)

Background

During the 2014 General Assembly Session, Delegate Patrick Hope introduced House Bill 1106, directing the Commission on Youth, in consultation with the Department of Education and the Department of Behavioral Health and Developmental Services, to review: statewide policies and regulations related to seclusion and restraint in public and private elementary and secondary schools; and methods used in other states to reduce and eliminate the use of seclusion and restraint in public and private elementary and secondary schools.

Recommendations

1 Request that the Governor finalize Virginia's Proposed Regulations Governing the Operation of Private Day Schools for Students with Disabilities.

2 Introduce legislation requiring the Board of Education to promulgate regulations on the use of seclusion and restraint in Virginia's public schools. These regulations will incorporate the 2009 Department of Education Guidelines and the U.S. DOE 15 Principles on Seclusion & Restraint and address definitions, criteria for use, restrictions for use, training, notification requirements, reporting, and follow-up. The regulations will also address the diverse population of students in the public school setting including students in the general education and special education populations and distinctions between primary and secondary schools including the students' emotional and physical developmental differences.

3 Support the Department of Criminal Justice Services efforts in training appropriate parties, including School Resource Officers and School Security Officers, in student development, de-escalation, and conflict mediation in the school setting. Recommendation

4 Request the Department of Education support local school divisions by providing resources and training on research-based appropriate behavioral management, prevention, de-escalation techniques to reduce the use of seclusion and restraint.

Final Report on Mental Health Screening in Public Elementary Schools
(House Joint Resolution No. 586, 2016)

Background

HJR 586 required the Department of Behavioral Health and Developmental Services to "study the benefits of offering voluntary mental health screenings to students in public elementary schools". The workgroup strongly supports the idea that early intervention can reduce more serious emotional disturbances for many children in the future. Schools have the opportunity to identify children early and provide mental health services and supports in a familiar setting with parent involvement.

Recommendations

1. After careful consideration of the benefits and challenges of implementing mental health screening in schools, the workgroup recommends that the General Assembly provide funding to the (DOE) for three pilots to be implemented in Virginia schools. The pilot schools would be selected by DOE. DOE would implement the screening and follow-up services as described in the mental health screening process flow chart as a three year pilot. Next steps and future implementation in elementary schools would be based on the experience of the pilots.
    a. Decrease the current ratios of school counselors to students and include school psychological, school social work, school nursing services at each pilot school to more closely align to national recommended ratios.

2. Provide funding for general mental health education for all school employees. Before a screening process is implemented, it is important for school personnel to have a good understanding of the mental health needs of students. It is recommended that early childhood mental health training is offered to all school employees. Teacher participation in early childhood mental health training is affected by the lack of funds available to support substitute teaching hours.

Immunization Requirements for Schools (HB 1090, 2020)

Authorization

Code of Virginia § **32.1-46**. Immunization of patients against certain diseases.

The parent, guardian or person standing in loco parentis of each child within this Commonwealth shall cause such child to be immunized in accordance with the Immunization Schedule developed and published by the Centers for Disease Control and Prevention (CDC), Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP). The required immunizations for attendance at a public or private elementary, middle or secondary school, child care center, nursery school, family day care home, or developmental center shall be those set forth in the State Board of Health Regulations for the Immunization of School Children.

Recommendations

1. **Refer to the Child and Adolescent Immunization Schedule by Age (ACIP for the most up-to-date guidance.**

2. **For school required immunizations, refer to:**
   a. **School and Day Care Minimum Immunization Requirements (website).**
   b. **Minimum Immunization Requirements (PDF).**

School Health Personnel in Virginia Public Schools: Recommendations for Qualifications and Training (House Doc. 21, 2021)

Background

Qualifications and training of school health personnel vary widely across the Commonwealth. Virginia does not currently have a consistent definition or training requirement for what constitutes a "school nurse." Some school divisions hire only registered nurses (RNs) as school nurses; others hire a combination of RNs and licensed practical nurses (LPNs), while others also hire unlicensed assistive personnel (UAPs) and/or utilize volunteers in their school health offices. The variability can be confusing to parents, students, and staff who may not understand the different levels of credentials and often assume that the individuals providing school health services have the same level of qualifications and training. Professional associations (National Association of School Nurses) have provided a definition of school nursing as well as guidance on qualification requirements.

Recommendations

1. Direct the Board of Education to establish a definition of "school nurse" and "unlicensed assistive personnel" that includes education, licensure, and/or certification requirements.

A consistent definition of "school nurse" that includes specific qualification and training requirements will ensure equitable access to health services across the Commonwealth. By establishing a definition of "school nurse" through the Board of Education, Virginia ensures that various voices and perspectives are considered, including that of existing school health personnel and local educational agencies. In line with national professional associations,5 the Workgroup recommended that the term "school nurse" refer to a registered nurse (RN) with a Bachelor of Science in Nursing (BSN). However, it is important to note that Virginia currently has several associate degree school nursing programs, and only approximately half of the RNs employed by schools in Virginia hold a BSN degree.

Additionally, the Workgroup proposed that UAP providing direct services in schools should also have clearly defined education and minimal training requirements. Possible considerations proposed by the Workgroup include having a minimum of a high school diploma, CPR/AED and first aid certification, as well as being subject to all state and local training requirements established for school health personnel.

2. Ensure that every Virginia elementary and secondary school is served by a full-time registered nurse (RN) as their school nurse.

The Qualification and Training of School Health Staff Workgroup overwhelmingly recommends that each school employ, at a minimum, a full-time RN. This recommendation is also endorsed by the American Academy of Pediatrics, the National Association of School Nurses, and Healthy People 2030. The rationale contributing to this recommendation included: the ability of RNs to provide comprehensive nursing services without supervision; increased education and training requirements of RNs; the complexity of student health needs; and analysis of the RN versus LPN scope of work, which included several critical nursing services such as performing nursing assessments and creating individualized healthcare plans for students in schools. Many of the benefits that school nurses provide are often only realized if the nurse is always in the school building, developing relationships with students, parents, and staff, noting trends in health, and detecting early warning signs of health issues. School nurses who travel between schools must lose available "nursing time" while commuting between schools.

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2. (Continued)

Additionally, there are several localities that currently employ LPNs to provide critical school health services. Recommendations 3 and 4, below, address how LPNs can continue to support school health services under this model. Additionally, the Workgroup proposed that UAP providing direct services in schools should also have clearly defined education and minimal training requirements. Possible considerations proposed by the Workgroup include having a minimum of a high school diploma, CPR/AED and first aid certification, as well as being subject to all state and local training requirements established for school health personnel.

- RNs in schools correlate with fewer absences, fewer early dismissals, and more instructional time for students.
- UAPs in schools make more medication errors than nurses.
- RNs correlate with increased immunization rates and fewer parents requesting immunization exemptions.
- Every $1.00 invested in school health services saves $2.20 in the community.
- When there is not a full-time school nurse in a building, cost analysis found that the school instructional staff spent $134,000 per year in time caring for the health care needs of the students; school nurses allow teachers and administration to focus on instruction.

Great effort is ongoing nationally to better understand and address health disparities to promote health equity. Access to a registered nurse across all Virginia schools will advance efforts to ensure equitable care for all students. Research suggests that the current quality or accessibility of school health services may be more dependent on zip code versus a school's acuity or health conditions. The disparity in funding to schools often places school health services at risk. Despite the positive outcomes that school health services provide in the school setting (disease management, chronic illnesses, absenteeism, and emergencies), funding remains an issue that impacts the equitable care of all students.

3. Allow currently employed LPNs serving as school nurses to maintain employment as a school nurse with a five-year "grace period" to pursue/complete licensure requirements to become an RN.

Recognizing the value of experience of the LPNs currently employed as schools' full-time nurses, the workgroup recommends that these LPNs be allowed to maintain their status as a "school nurse" and that a five-year "grace period" be established to allow currently employed LPNs to become RNs. School divisions may continue to use LPNs to provide supplemental school health services as outlined in Recommendation 4.

Data obtained from 68 percent of Virginia school divisions show that 185 LPNs are currently employed. LPNs must obtain a certificate or diploma in nursing, which takes less than one year. The path to become an RN requires at least an associate's degree. The most marketable RNs hold a bachelor's degree, which is typically a four-year commitment. In order to make the transition from LPN to RN, LPNs generally complete an accredited registered nurse program and take the national exam for RN licensure. LPNs may typically take between two to four years to make the transition, depending on the length of their program. There are many programs to choose from, including online LPN to RN programs.

Due to the national shortage of school nurses, the workgroup highly recommends that school divisions and the state make every effort to provide incentives, such as tuition reimbursement, flexible leave, and scholarships to assist LPNs in becoming RNs.

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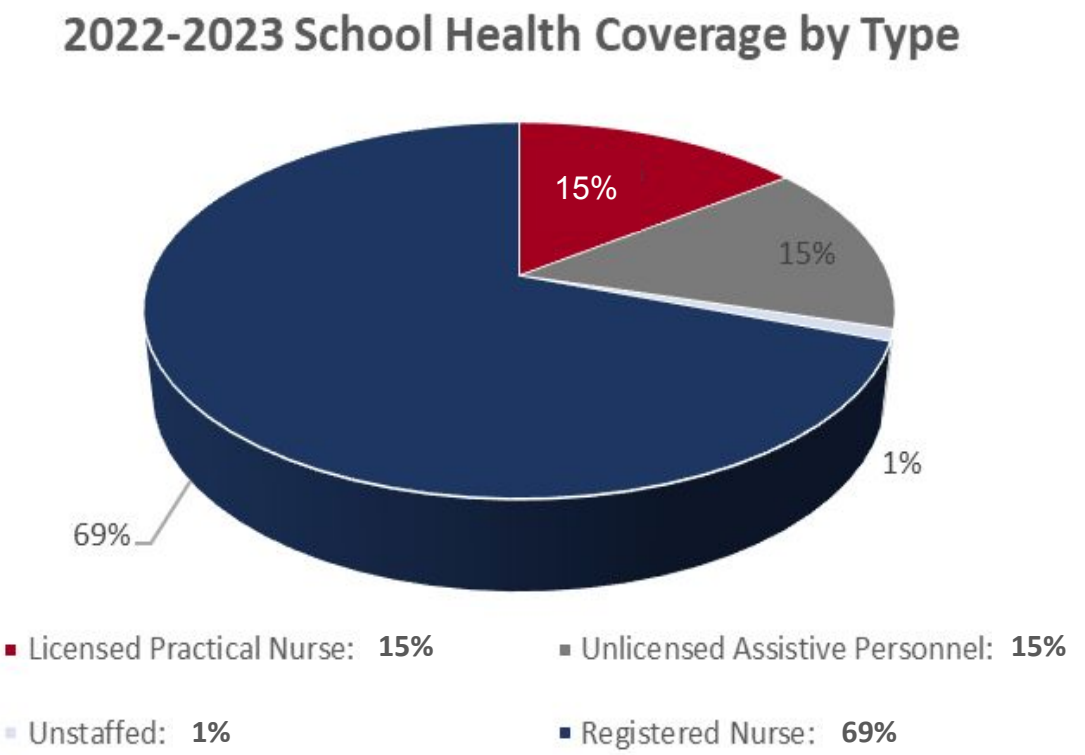
4. School divisions should allocate LPNs and/or UAPs to provide supplemental health services to large schools (over 750-1,000 students) and schools with high populations of students with special health care needs.

The National Association of School Nurses and the American Academy of Pediatrics previously recommended a ratio of one RN for every 750 students, but now recommend one RN per school with additional school health personnel as appropriate. Larger schools and schools with high percentages of students with special needs may require additional school health personnel to meet the health needs of the school community.

The Workgroup emphasized that the first priority is to ensure that every school has a full-time RN, yet acknowledged the critical importance of LPNs and UAPs in contributing a supporting role in the school health workforce. School divisions should be encouraged to employ LPNs and UAPs in schools where supplemental health services are needed, such as in schools with student populations of over 1,000 students or schools with large numbers of students requiring ongoing health services.

5. Strengthen the comprehensive availability of school health services information by requiring the annual collection of school health data from all Virginia school divisions.

Currently, the Virginia Department of Education (VDOE) collects annual "school health survey" data from Virginia school divisions, but reporting is voluntary. Thus, only approximately two-thirds of Virginia school divisions consistently participate in this survey, which makes it challenging to assess needs and make informed policy decisions. The Workgroup recommended that annually collected school health data include: staffing levels of school health personnel, prevalence of students with chronic health conditions, percentage of students with health services written in their records, visits to the school health office and dispositions, and health services provided.



Medical Cannabis Products (CBD and THC-A Oil) Administration Required School Form (2019)

Authorization

- Code of Virginia § § 22.1-277. Suspensions and expulsions of students generally.
- Code of Virginia § 54.1-3408.3. (Effective January 1, 2024) Certification for use of cannabis for treatment.
- Code of Virginia § 18.2-251.1:1. (Effective January 1, 2024) Possession or distribution of cannabis oil; public schools.

Background

The 2019 Virginia General Assembly passed HB1720 (Hurst) / SB1632 (Stutervant) which allows for the administration of Medical Cannabis, this includes Cannabidiol (CBD) oil or Tetrahydrocannabinol Acid (THC-A) oil in schools.

The Code of Virginia § 18.2-251.1:1 protects school and health department employees from prosecution in the storing, dispensing, or administering of Medical Cannabis (CBD or THC-A oil), i**n accordance with a policy adopted by the local school board,** to a student who has been issued a valid written certification for the use of Medical Cannabis (CBD or THC-A oil).

- **Superintendent Memo #059-20 (Word)**
- **Student Form for Administration of CBD/THC-A Oil (Word)**

HB1720/SB1632 also amended § 22.1-277 of the Code to add that “no school board shall be required to suspend or expel any student who holds a valid written certification for the use of CBD or THC-A oil issued by a practitioner in accordance with subsection B of § 54.1-3408.3 for the possession or use of such oil in accordance with the student's individualized health plan and in compliance with a policy adopted by the school board.”

School Health Personnel in Virginia Public Schools: Recommendations for Qualifications and Training (House Document No. 21, 2021)

Background

The 2021 Virginia General Assembly, in Budget Item 137 (Paragraph T) of the 2021 Appropriation Act (i.e., Chapter 552) directed the Superintendent of Public Instruction to convene a workgroup with the purpose of making recommendations on the desired qualifications and training for school personnel providing health services in Virginia schools.

Qualifications and training of school health personnel vary widely across the Commonwealth. Virginia does not currently have a consistent definition or training requirement for what constitutes a “school nurse.” Some school divisions hire only registered nurses (RNs) as school nurses; others hire a combination of RNs and licensed practical nurses (LPNs), while others also hire unlicensed assistive personnel (UAPs) and/or utilize volunteers in their school health offices. The variability can be confusing to parents, students, and staff who may not understand the different levels of credentials and often assume that the individuals providing school health services have the same level of qualifications and training.

Recommendations

1. Direct the Board of Education to establish a definition of “school nurse” and “unlicensed assistive personnel” that includes education, licensure, and/or certification requirements.
2.
2. Ensure that every Virginia elementary and secondary school is served by a full-time registered nurse (RN) as their school nurse.
3.
3. Allow currently employed LPNs serving as school nurses to maintain employment as a school nurse with a five-year “grace period” to pursue/complete licensure requirements to become an RN.
4.
4. School divisions should allocate LPNs and/or UAPs to provide supplemental health services to large schools (over 750-1,000 students) and schools with high populations of students with special health care needs.
5.
5. Strengthen the comprehensive availability of school health services information by requiring the annual collection of school health data from all Virginia school divisions.

[School Health Personnel in Virginia Public Schools: Recommendations for Qualifications and Training]

Comprehensive Plan for Virginia's Youth: Universal Cannabis and Other Substance Use Education, Prevention, and Professional Development (Chapter 552, 2021 SSI)

Background

During the 2021 legislative session, HB2312 (Herring) and SB1406 (Ebbin; Lucas) were passed by the General Assembly, and signed into law. HB2312 and SB1406 include prevention and education measures, and commit resources to needed health and education services.

By implementing a comprehensive evidence-based cannabis education curriculum in public schools using a health and wellness approach, Virginia will proactively support healthy lifestyles for youth, emotional health and wellbeing and social skills integrated with a wide range of risk and protective factors.

Recommendations

1. Instruction concerning drugs and drug abuse shall be provided by the public schools as prescribed by the Board of Education.
2. Instruction concerning the public safety hazards and dangers of alcohol abuse, underage drinking, underage marijuana use, and drunk driving shall be provided in the public schools. The Virginia Alcoholic Beverage Control Authority and the Virginia Cannabis Control Authority shall provide educational materials to the Department of Education. The Department of Education shall review and shall distribute such materials as are approved to the public schools.
3. The Virginia Foundation for Healthy Youth shall develop and the Department of Education shall distribute to each local school division educational materials concerning the health and safety risks of using tobacco products, nicotine vapor products, and alternative nicotine products, as such terms are defined in §18.2-371.2. Instruction concerning the health and safety risks of using tobacco products, nicotine vapor products, and alternative nicotine products, as such terms are defined in § 18.2-371.2, shall be provided in each public elementary and secondary school in the Commonwealth, consistent with such educational materials.

School Health Committees, (SB 62, Title 30, 2021)

Background

The purpose of the Committee is to review and provide advice to the General Assembly and other policy makers regarding proposals that require local school boards to offer certain health services in a school setting.

- § 30-409. **School Health Services Committee; purpose.**
  - *The School Health Services Committee (the Committee) is established in the legislative branch of state government.*

- § 30-410. **Membership; terms; quorum; meetings.**
  - *The Committee shall have a total membership of 15 members that shall consist of 8 legislative members, five non legislative citizen members, and two ex officio members. The Superintendent of Public Instruction and the State Health Commissioner, or their designees, shall serve ex officio with non voting privileges.*

- § 30-411. **Compensation; expenses; annual report.**
  - *The Committee shall submit to the General Assembly and the Governor an annual report for publication (by October 1 of each year) as a report document as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents and reports.*

- § 30-413. **Sunset.**
  - *This chapter shall expire on July 1, 2025.*

Additional Resources To Support School Health Programs

- School Health Personnel in Virginia Public Schools: Recommendations for Qualifications and Training | (House Doc. 21, 2021)
- Joint Legislative Audit and Review Committee (JLARC)
- Establishing A School Health Team: Position Descriptions, Roles, and Scope of Responsibilities
- School Health Services Committee (generalassembly.gov)

Maximizing School-Based Mental Health Services (Behavior Health Commission Report Document #764, 2023)

Background

2022-2024 Appropriation Act § 1-9: The Behavioral Health Commission shall conduct a study of how to maximize school-based mental health services across the Commonwealth. The Commission shall form a task force of local school administrators, school-based mental health professionals, community-based mental health professionals in public and private settings, teachers, students, and parents as well as relevant stakeholders from the Departments of Medical Assistance Services, Behavioral Health and Developmental Services, and Education to evaluate the current reach of school-based mental health services and to identify strategies to connect mental health clinical interventions (Tier 2 and Tier 3) to school settings.

Recommendations

The General Assembly may wish to consider including funding in the Appropriation Act for DMAS to commission a review of Multi-Tiered School Based Behavioral Health Services including (1) whether and how to redesign Therapeutic Day Treatment, and (2) the rate structure and amount that should be used to enroll a sufficient number of providers qualified to deliver services identified. BHC staff typically offer recommendations or options to address findings identified in its reports. Staff will usually propose options, rather than recommendations, when the action proposed is a policy judgment best made by the General Assembly or other elected officials.

Youth Mental Health Strategy

To better equip parents and support our young people, Governor Youngkin is taking immediate action in year two of Right Help, Right Now. In 2023, according to Mental Health America, Virginia ranked 48th in the nation for youth mental health, which demands a collective and comprehensive approach to prioritize the health of the Commonwealth's youngest and most vulnerable citizens.

Inside our schools:

- We will expand eligibility for school-based mental health services to students across Virginia using a waiver and provide technical assistance and support to localities that provide matching funds and wish to utilize these services.
- We will require schools to notify parents when students overdose from drugs or schedule/receive counseling services. School boards would also be required to offer an option for parents to attend counseling sessions with their students.
- We will expand the behavioral health workforce in schools and other community settings.
- We will increase access to care by providing funds for tele-behavioral health for children in grades 6-12, with their parents' permission, as well as in our public colleges.

Supporting Documents

- SB 1268 School psychologists; staffing flexibility.
- Governor Glenn Youngkin Unveils Youth Mental Health Strategy on the One Year Anniversary of Right Help, Right Now Initiative, (December 14, 2023)
- About Right Help Right Now
- 22.1-274 (A). **School health services.** (A) A school board shall provide pupil personnel and support services in compliance with § 22.1-253.13:2.

Virginia's K-12 Funding Formula (JLARC, SJ 294, 2023)

Background

The General Assembly (SJ 294) directed the Joint Legislative Audit and Review Commission (JLARC) to study the cost of education in Virginia and make an accurate assessment of the costs of the Standards of Quality.

The Standards of Quality (SOQ) funding formula is how the General Assembly fulfills its constitutional obligation to seek to establish and maintain a high quality public school system. The formula estimates how many staff positions are needed for each school division, then applies cost assumptions to estimate the cost of K–12 staff needed in each division. That cost is then apportioned between the state and each local government using the Local Composite Index.

Findings

Virginia school divisions receive less K–12 funding per student than the 50-state average, the regional average, and three of Virginia's five bordering states (figure). School divisions in other states receive 14 percent more per student than school divisions in Virginia, on average, after normalizing for differences in cost of labor among states. This equates to about $1,900 more per student than Virginia.

1. The vast majority of the additional funding for school divisions comes from local governments.
2. An effective SOQ formula should account for the higher costs divisions incur because of factors outside their control. Divisions have little or no control over how many higher needs students (at-risk due to poverty, special education, or English learners) live in their division. On average, divisions need more funds to educate these students.

Supporting Documents

- JLARC Reports By Topic: Education
- Recommendations and Policy Options: Virginia's K– 12 Funding Formula
- Report of The House Appropriations Subcommittee On Elementary & Secondary Education, House Bill 29 & House Bill 30 (2024)

Standards Of Quality (SOQ), Standards #2 (SB 1257)

SOQ; school board to provide at least three specialized student support positions.

Background

The bill modifies a school personnel requirement in Standard 2 of the Standards of Quality. It requires each school board to provide at least three specialized student support positions, including school social workers, school psychologists, school nurses, licensed behavior analysts, licensed assistant behavior analysts, and other licensed health and behavioral positions, per 1,000 students. The provisions of the bill are contingent on funding in a general appropriation act.

Findings

A. A school board shall provide pupil personnel and support services in compliance with §22.1-253.13:2. A school board may employ school nurses, physicians, physical therapists, occupational therapists, and speech therapists. No such personnel shall be employed unless they meet such standards as may be determined by the Board of Education. Subject to the approval of the appropriate local governing body, a local health department may provide personnel for health services for the school division.

B. In implementing subsection P of § 22.1-253.13:2, relating to providing support services that are necessary for the efficient and cost-effective operation and maintenance of its public schools, 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.

C. The Board of Education shall monitor the progress in achieving the ratios set forth in subsection B and any subsequent increase in prevailing statewide costs, and the mechanism for funding health services, pursuant to subsection P of §22.1-253.13:2 and the appropriation act. The Board shall also determine how school health funds are used and school health services are delivered in each locality and shall provide, by December 1, 1994, a detailed analysis of school health expenditures to the House Committee on Education, the House Committee on Appropriations, the Senate Committee on Education and Health, and the Senate Committee on Finance.

Continued on next page.

Supporting Legislation

In 1994, the Code of Virginia §22.1- 274 was amended to outline an aspirational goal for the staffing of school health personnel as follows:

"…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."

Staffing requirements for school personnel are set in the Standards of Quality (SOQ), found in the Code of Virginia at § 22.1-253.13:1 through 22.1-253.13:9.

Prior to 2020, there was no staffing requirement for school nurses in the SOQ.

School nurses were classified as "student support positions," and thus staffing was left to the discretion of local educational agencies based on what each division felt was necessary for the efficient and cost-effective operation and maintenance of its public schools.

Mandated Parental Notification Requirements

School Nurses are required to notify parents of the following:

1. **Hearing and Vision Screening** (§ 22.1-273, 8VAC20-81-50(C), 8VAC20-250-10).
    - For all students in KG, 2nd or 3rd, 7th, and 10th grades and out of state transfers unless exception noted.

2. **Scoliosis screening** (8VAC20-690-20. (§ 22.1-273.1)
    - Screening for scoliosis may assist in early detection and referrals for follow up care.
    - Hands-on Scoliosis Screening or information on Scoliosis shared with parents within the first 60 days of school.
    - Division should provide educational information to parents/guardians of students whether the optional screening ***is*** or ***is not*** conducted.

3. **Eating disorders** (§ 22.1-273.2.)

    Optional Screening Program
    If schools conduct optional screening for eating disorders they may use the sample forms provided below:
    Sample Eating Disorders Parent Information Sheet, Grades K-12 (Word)
    Report of Eating Disorder Screening Form (Word)
    Sample Eating Disorder Screening Opt-Out Form (Word)

    - Screening for eating disorders may assist in early detection and referrals for follow up care.
    - Screening tools should be evidence-based and age appropriate. Local policy should clearly indicate which grade levels are screened and which licensed school personnel will receive training.
    - Division must provide educational information to parents/guardians of students whether the optional screening ***is*** or ***is not*** conducted.

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VIRGINIA SCHOOL HEALTH GUIDELINES

To access the **Virginia School Health Guidelines**, visit the VDH School Health website.

VDH VIRGINIA DEPARTMENT OF HEALTH

VDH VIRGINIA DEPARTMENT OF HEALTH

Virginia School Health Toolkit: Adolescent Health Education Resources

To access the **Adolescent Health Education Resources Toolkit**, visit the VDH School Health website.



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Helpful Hints for Coordinating School-Based Vaccination Clinics

CATCH US IN ACTION!

School-Based Vaccination Clinics with Community Partners



Pittsylvania County Public Schools



Harrisonburg City Public Schools

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Appendix 22

Introduction

Disclaimer

This playbook has been adapted from the CDC's Influenza School-Located Vaccination (SLV): Information for Planners and the Vaccination of the School-Age Population in a School Setting and in the Community Playbook to Support Vaccination Events. This is to be used for informational purposes only and is not required to be used.

Target Audience

This playbook is directed at sites and site planners, including school nurses, school administrators, school staff (teachers, administrative, office, custodial, etc.), and community partners preparing to vaccinate adolescents. Partners may include local health departments, Federally Qualified Healthcare Centers, and nearby pharmacies that can provide support for vaccination clinics in the school setting. Schools should consider collaborating with their local health departments and community partners to plan and carry out vaccinations in schools.

Definition

School-located vaccination (SLV) is a vaccination clinic that is:

- Administered on school grounds
- Held during school hours; preferably during the spring season (March-June)
- Targeting enrolled students in the school division
- Involving collaboration between Local Health District (LHD), other community vaccine providers (FQHCs, pharmacies, private providers), and public and private schools/school districts

Background

The 2020 General Assembly passed HB 1090 which amends the minimum vaccination requirements for attendance at a public or private elementary, middle or secondary school, child care center, nursery school, family day care home, or developmental center. This legislation became effective July 1, 2021, and amends the ***Code of Virginia § 32.1-46.A.4***

Code of Virginia:

§ 22.1-271.2 - Immunization Requirements
§ 32.1-46 - Immunization of Children Against Certain Diseases
§ 23.1-800 Immunization Requirements for College Students
12VAC5- 110 Regulations for the Immunization of School Children

Planning for the Vaccination Clinic

In addition to the information provided below about planning for SLV clinics, please also see the more general guidelines for setting up vaccination clinics posted on the CDC's website.

Population(s) Identified for Vaccination

Planners will need to identify which students qualify for receiving vaccines and when the opportunity to be vaccinated will be offered. The information contained in this document focuses on vaccination of currently enrolled students only. Documentary proof shall be provided of adequate age appropriate immunization for attendance at a public or private elementary, middle or secondary school. Vaccines must be administered in accordance with the harmonized schedule of the Centers for Disease Control and Prevention, American Academy of Pediatrics, and American Academy of Family Physicians and must be administered within spacing and age requirements (available at https://www.vdh.virginia.gov/immunization/immunization-manual/acip/). 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."

Factors to Consider

- **Factors to Consider When Partnering with School/Educational Community by:**
  Tailor SLV clinics to meet the needs of the school community by:
    - Hosting clinics during school hours without parents/guardians or after school clinics with parents/guardians.
    - Scheduling immunization clinics during school registration, welcome back events, sporting events, etc.

- **Factors to Consider if partnering with Local Health Department:**
    - Utilize public health nurses as the team leader and schedule staffing with contract and Medical Reserve Corps (MRC) nurses and vaccinators.
    - Utilize the VDH Memorandum of Understanding
        - Allows contact with superintendents and/or designee
        - Outlines responsibilities for all parties
    - Develop registration
        - LHD or school divisions may develop an online survey tool for student registration
        - Obtain consent with each dose of vaccine (this is required)
        - Conduct review of encounters before the clinic
        - Contact parent/guardian if there is missing information such as responses to health questions, consent, insurance, etc.
    - Ensure Safety
        - Take steps to correctly identify students
        - Take steps to ensure correct vaccine is administered to correct student

Registration

Schools or districts will need to identify and define their preferred method of registration and form submission. The two options are:

- Manual Process: Entails printing consent forms to be taken home by students, manually processing intent forms during the clinic
- Automatic Process (*Recommended): Entails parents registering their child and signing consent form via an online tool. An online tool may be developed by your school division or provided by your local health department to assist with registration.

School Based Vaccination Clinic Timeline:

To enhance coordination efforts for the school based vaccination clinic, planners should consider modifying this timeline to fit the unique needs of the school community. It is recommended to print the timeline and check off the tasks as they are completed.

6 WEEKS PRIOR

☐ **Step 1:**

Obtain approval from school administration to host vaccination clinics during school hours; coordinate with school testing to determine date.

Date Completed: ____/____/____

☐ **Step 2:**

Collect applicable data such as: number of students to receive vaccine(s); names of students; date of birth; and, students who may be exempt from receiving vaccine.

Date Completed: ____/____/____

☐ **Step 3:**

Partner with the local health department or community partner to confirm: clinic date and time; staffing assistance needs; and, anticipated number of vaccine doses to be administered.

Date Completed: ____/____/____

5 WEEKS PRIOR

❏ **COMMUNICATION MATERIALS:** Develop communication materials for families (letter of intent, consent form and CDC VIS statement, social media shareables, and digital flyers).

❏ **CLINIC LOCATION:** Determine where the clinic will take place; coordinate with custodial staff on the equipment needed. (chairs, tables, trash can for disposables, etc.)

4 WEEKS PRIOR

❏ **COMMUNICATION MATERIALS:** Disseminate communication materials to families in both digital and printed copies. If feasible, consider mailing a letter of intent.

❏ ***Optional*** **DEVELOP AN ONLINE SURVEY:** Develop an online survey to collect consent forms, insurance information, and other health information from parents/ families.

3 WEEKS PRIOR

- ❑ ***Optional*** **MONITOR ONLINE SURVEY:** Review survey results to ensure consent forms, insurance information, and other health information from parents/families has been inputted.
- ❑ **STAFF AND/OR VOLUNTEER COORDINATION:** Solicit interest from school staff, PTA members, and/or Medical Reserve Corps volunteers to support vaccination clinic efforts.

2 WEEKS PRIOR

- ❑ **COMMUNICATION:** Consider daily social media posts, robo calls, and text messages reminding families to return a consent form.
- ❑ **CLINIC LOGISTICS & VACCINE VERIFICATION:**
  - ❑ Develop and share "Day Of Clinic Plan of Action" with all school staff.
  - ❑ For students who have returned forms, verify in VIIS that the student has not already received vaccine (s).

Target:

~20% of consent forms returned.

7 DAYS PRIOR

- ❑ **MULTI-LAYERED COMMUNICATION:**
  - ❑ Email, phone, and text parents/guardians with a reminder to return consent forms. Personal phone calls to parents/caregivers has been very effective in increasing the number of consents return.
- ❑ **VACCINE VERIFICATION:**
  - ❑ For students who have returned forms, verify in VIIS that the student has not previously received the vaccine.

Target:

~25% of consent forms returned.

- ❑ **COORDINATION:** Update the LHD with the anticipated number of students to receive vaccines and which vaccines are needed.

3-5 DAYS PRIOR	❑ **MULTI-LAYERED COMMUNICATION:** Consider reaching out to students directly via Morning Announcements and/or visit students in-class to deliver a brief reminder. ❑ **DEVELOP A PLAN OF ACTION FOR DAY OF LOGISTICS:** ❑ **Create a list of students participating in the clinic.** Share the list with their assigned teacher(s). ❑ **Create hall passes for the assigned vaccination time.** ❑ **Coordinate snacks/drinks** for students during their 15 minute required waiting period. ❑ **Communicate roles and responsibilities** with volunteers assisting with the clinic.	**Target:** **~30%** of consent forms returned.
EVENING PRIOR	**MULTI-LAYERED COMMUNICATION:** Coordinate a robocall, text message, and email to remind parents, guardians, and students of the upcoming vaccination clinic. *Remind parents, guardians, caregivers, and students consent forms can be submitted the day of the clinic.*	
DAY OF	**DAY OF LOGISTICS:** ❑ Remind teachers to allow students to visit the clinic during their assigned block/class period. Reiterate students are still able to attend the vaccination clinic if they provide a signed consent form the *day of.* ❑ Update the LHD with the exact number of students receiving vaccines. ❑ Send a post-letter to inform parents/guardians/caregivers of adverse reactions to vaccines.	
NEXT DAY	**FOLLOW-UP COMMUNICATION:** ❑ Verify with the local health district (LHD) the exact number of students who received vaccines. *The LHD will enter data for those students who received immunization. Validation of data can be found in the VIIS database: https://www.vdh.virginia.gov/immunization/viis/.*	

Strategies to Minimize Errors in Vaccine Administration

All Public health nursing personnel and vaccinators must complete the most current

training available to administer vaccines and follow the seven rights of vaccine administration: right client, right vaccine, right dosage, right route, right time, right site, and right documentation. Vaccine administration staff should perform verification of the seven rights of vaccine administration prior to administering the vaccine.

When to Hold SLV Clinics

Planners will also need to decide whether to hold SLV clinics before, during, and/or after school hours. **It is preferred to host clinics during school hours around the Spring time-frame (between March to May)**. The parent/guardian will consent to school staff to serve "in loco parentis" (means "in place of parents") for the vaccine clinic. Below are some benefits and challenges to consider when making decisions on holding in-school SLV clinics. In addition, regardless of whether a SLV clinic is held before, during, or after school hours, school officials may need to consult with their school board attorney and local union representatives if holding such a clinic has an impact on staff members' rights under a collective bargaining agreement.

Benefits Of Holding Clinic During School Hours:

Parents/guardians do not need to take time off work because their children can be vaccinated without them being present, increasing equity

- Transportation is not a barrier
- Children are present in large numbers

- Vaccinations can be conveniently provided to school staff, if desired and appropriate
- Parental consent is obtained prior to the clinic, so there is some lead time during which planning for adequate staffing, vaccine, and medical supplies can take place.

Challenges of Holding Clinic During School Hours:

Barrier to Implementation:	Possible Solution:
Coordinating and collecting consent forms	● Consider using "multi-layered" communication such as: emails, phone calls, text messages, mailing a hard copy letter of intention, and social media posts
Coordinating and collecting students' insurance information (health information)	● Encourage parents/guardians to take a photo of their insurance card and upload image to a secure online survey (managed by School Nurse)
Conflicting student/guardian priorities for a clinic held after school; such as work obligations, sports participation, clubs, etc.	● Consider hosting SLV clinics in school and serving 'in loco parentis' to provide equitable access to all students
Disruption of class time may be unacceptable to parents, students, and/or school administrators	● Consider using hall passes ● Share a list of students with their assigned teacher ● Provide snacks and/or drinks for students during their 15-minute waiting period
Determining a vaccination date that does not interfere with state required testing	● Collaborate with school administration and testing coordinator to schedule a clinic date and time
Staffing needs	● Consult with school administration to solicit school staff who can provide additional support ● Consult with LHD to obtain Medical Reserve Corps volunteers

Planning for Adequate Staff

School staff, including school nurses, teachers and teachers' assistants, security and maintenance personnel, and other staff, can contribute greatly to the success of a SLV clinic (list of staff) custodial staff, school admin staff, office staff, instructional staff, LHD staff, (PTA and MRC) volunteers. Medical Reserve Corps (MRC) have also been a source of experienced, credentialed volunteers. Please note that all volunteers working with the Local Health Department must be enrolled in the MRC.

Volunteers

Volunteers can serve as an excellent source of SLV clinic staff and may even be considered an essential component of an SLV program, depending on the number of SLV clinics planned within a jurisdiction. Volunteers can fill many roles in SLV clinics, both non-medical and medical. For example, volunteers can help by:

- Directing foot traffic
- Handing out take-home documents
- Sanitizing seats or stations between classes
- Monitoring the 15-30 minute observation period
- Other administrative needs
- Reminder calls to parents/caregivers to return consent forms

Medical Volunteers: For medical staffing needs, planners may consider contacting area colleges that grant degrees in healthcare-related fields, such as medicine, nursing, and pharmacy, to recruit staff, students, or alumni willing to provide assistance with SLV clinics. Planners may also consider soliciting assistance from retired health care professionals. Medical Reserve Corps (MRC) have also been a source of experienced, credentialed volunteers. Please note that all volunteers working with the Local Health Department must be enrolled in the MRC.

SLV Clinic Communications

Promotion and Education

Educating students and parents, as well as school staff, may contribute to the success of SLV programs. Consider hosting a Tele Town Hall to educate the school community.

Students

For schools willing to educate their students about vaccination, planners may consider providing teachers and school nurses with ideas for lesson plans. This represents an ideal opportunity to emphasize the importance of vaccination as well as hygienic measures that can reduce transmission of disease.

Parents/Guardians

Educational resources about the SLV clinic(s) should be disseminated to parents/guardians as early in the process as possible. Consent forms and other SLV informational materials can be distributed to parents/guardians through a variety of methods, including: public service announcements, radio campaigns, bulletins, and announcements on school websites, all of which have been used to successfully promote vaccination programs to parents/guardians. Messaging may also emphasize the importance of vaccination and debunk myths.

Teachers and Other Staff

Teacher support and participation has been perceived to be linked to the success of SLV programs, and students have reported that teacher influence was an important factor in returning consent forms. It is important that school staff are educated about the vaccination program. Educated school staff are able to answer questions from parents and others about the program, and are more likely to emphasize the importance of vaccination and provide vaccination-related lessons to students.

Frequently Asked Questions

Frequently Asked Questions (FAQ) are available on the VDH Division of Immunization website and are a useful tool to educate parents, teachers, school staff, and other community members about school required immunizations. FAQ sheets can be developed and included with other disseminated communications regarding the SLV clinic. A list of possible FAQs about the specific vaccine requirements are listed below, but are not meant to be inclusive.

https://www.vdh.virginia.gov/immunization/requirements/
Minimum Immunization Requirements FAQ
Spanish version

Informing and Enlisting the Support of Health Care Providers

In the U.S., children are vaccinated primarily in their pediatrician's or family doctor's office. Because the idea of vaccinating children at school may be unfamiliar to some parents/guardians, there may be reluctance to consent to vaccination at school. Parents/guardians may seek the advice of others, including their child's health care provider. Hopefully, most providers will be supportive of the SLV clinics, but some may be concerned about vaccinations occurring outside of their offices, especially with regard to keeping their patient records up-to-date and having adequate information in case a patient seeks care for a possible vaccine-related adverse event. The need to conduct SLV programs to ensure children are vaccinated in a timely manner can be explained given the likelihood that providers will be busy also will help them estimate how much vaccine they will need to order for their own patients. Keeping providers informed about planned SLV clinics also will help them estimate how much vaccine they will need to order for their own patients.

Preparing Forms and Letters to Provide to Parents/Guardians

The following are suggestions on the development of materials that should be delivered – via the child, mail, and/or email – to parents/guardians to inform them of the planned SLV clinic and solicit their permission to vaccinate their child. Each of the following materials should be translated and made available in various languages, as locally appropriate. All of the VDH Official School Consent Forms can be found on the VDH

School Health webpage, VDH Intranet and are available from the local health department. Consents are available in both English and Spanish. A letter to Parents/Guardians should be among the materials provided to parents/guardians announcing that the SLV clinics will be offered at their child's school. Typically, this letter is sent out as a cover letter to accompany other materials, including the consent form, VIS statement, information about the vaccine, and when the SLV clinics are scheduled to occur. Such a letter also could be sent well in advance of the planned SLV date. The letter to parents/guardians should include:

1. An explanation about why school required vaccines are recommended for their children
2. Information on how to register child for vaccine
3. A request for parental consent
4. The vaccine's VIS statement
5. Contact information in case parents/guardians have questions or concerns.
6. Information on how to prepare their child for the day of vaccination.

Materials to Send Home with Students Post-Vaccination

Planners are encouraged to send a letter to parents/guardians that includes the following information: date the child received the immunization(s), location of the clinic, typical side effects of the vaccine(s), and explanation of the child's record being updated in Virginia Immunization Information system (VIIS).

SLV Clinic Day-Of Logistics

Published guidelines for setting up large-scale vaccination clinics can be found on CDC Mass Clinic Activities website. Additional considerations apply to SLV clinics held during school hours. These challenges, along with tips and examples of how to manage them, are outlined below.

SLV Clinics Held During School Hours

- Rules determining who may be present in the school building during school hours may vary. Communicate well in advance about these issues and plan accordingly. Additional security staff to monitor safety and help with traffic flow may be necessary.

- Since parents/guardians may not be present when students are vaccinated, processes need to be in place to ensure that only children for whom parental consent was obtained are vaccinated. This process of confirming the identity of children is easiest if school staff (e.g., teachers and school nurses) are overseeing the process.
    - Placing labels and/or name tags on students can help reduce the risk of immunizing the wrong students, although monitoring is suggested as these identifiers can be exchanged by children.
    - Asking multiple questions in addition to the child's name (e.g., parent/guardian names, street address) may be helpful.
- Processes need to be in place for orderly vaccination of children. Staff will be needed to escort students to and from the clinic site.
    - Often, students are escorted classroom by classroom. It may be helpful to focus on one particular class that is attended at some point by most or all students (e.g., Language Arts/English).
- Despite some parents/guardians providing consent for their child to be vaccinated, it may not be possible to vaccinate the child at the clinic for reasons such as illness, child refusal, or discovering a contraindication. In this case, it is essential that parents/guardians are informed that the child was not actually vaccinated. This could be accomplished by returning a form to parents/guardians via the child or via U.S. mail, sending the parent an email message, and/or calling the parent on the telephone. It may be helpful to designate one SLV clinic staff member to be in charge of this important task.

Administering Vaccine and Preventing, Managing, and Reporting Possible Vaccine-related Adverse Events

Public Health Nurses (PHN) and health care providers are encouraged to report clinically significant adverse events after any vaccine to the Vaccine Adverse Event Reporting System (VAERS). If a child experiences an adverse event after receiving a vaccine, parents are encouraged to report the adverse reaction to the school nurse or principal.

Vaccine Storage and Handling

If partnering with the local health department, one fully trained VDH Public Health Nurse or Medical Reserve Corp trained volunteer is required to supervise vaccine storage and handling, and distribution under the current VDH training guidelines.

Recording, Reporting, and Tracking Vaccination Information

The Commonwealth of Virginia uses the Virginia Immunization Information system (VIIS) to collect information on vaccine administration. As of January 2022, reporting to

VIIS is required under state law. Providers can access VIIS to determine if their patient received a vaccine. SLV clinic planners should consider mechanisms for dissemination of vaccination information to the primary health care provider of participating students. This can be done by requesting the student's pediatrician's information on consent forms or other documents. The physician listed can then be sent information regarding their patient's vaccination once the SLV clinic has occurred.

"Legal Considerations"

Parental Consent Forms

The requirement to seek parental consent prior to vaccination, and the exact format and elements that must be included on a standard consent form, generally are not governed by federal law or regulation. However, all VDH staff must use the approved consent forms. Any electronic reproduction on the forms must include all elements. As a reminder, these forms are updated frequently as new guidelines are issued, so check the site frequently to make sure you are using the most current version. For entities other than VDH, requirements for informed consent are legislated or regulated by each entity, including the circumstances under which minors can consent to their own medical treatment. If planning on obtaining advanced consent, planners should discuss this approach with their respective legal advisors before deciding to implement it. Planners must plan for requiring separate consents for administration of each dose of a two dose vaccine series. While consent to be vaccinated is generally not regulated by federal law, federal law (as well as state law) may regulate the vaccinator's use or disclosure of individually identifiable health information regarding the child. Below are notes about recommended sections to include in the template consent form (for non-VDH entities):

- Information about child receiving vaccine: This section includes suggestions for collecting personal and demographic information.
- Screening for vaccine eligibility: This section includes COVID-19 vaccination eligibility screening questions.
- Consent: This section includes a statement and signature line for parents/guardians to consent to or decline vaccination on behalf of their child.
- Vaccination record: This section includes suggestions for collecting information regarding the vaccine and its administration.

SLV program planners may also want to include a section for consent or authorization for disclosures of certain vaccination, medical, personal, and/or demographic information. Student information contained in the vaccine consent form may be protected by privacy laws or regulations. Please consult with your entity's legal advisors regarding protected information. Requesting such authorization may be recommended or necessary, depending on local needs and/or laws such as the Family Educational

Rights and Privacy Act (FERPA) or the Health Insurance Portability and Accountability Act (HIPAA). The entity conducting the vaccination program is responsible for only using and disclosing a child's health information consistent with applicable laws. For example, the entity should know whether it is subject to the HIPAA Privacy Rule, which only applies to certain health care providers, to health plans and to health care clearinghouses, to FERPA, which only applies to educational agency or institutions receiving Department of Education funding, and/or to other Federal or state laws.

Consent Form Dissemination, Collection, and Follow-Up

Consent forms and other SLV informational materials can be provided to parents/guardians using a variety of methods. Sending information packets home with students is common. Schools also should consider making consent forms available online, either through the school website (if available) or via email (schools and/or parent organizations may have pre-established list serves for students' families). Additionally, high schools might want to make consent forms available on-site for eligible students who do not require parental consent (e.g., students ages 18 years or older). If resources are available, school staff should attempt to follow up with students who do not initially return the forms. For this reason, consent forms should include an option for the parent/guardian declining vaccination so that school staff can easily identify students who have not returned consent forms and distinguish them from students whose parents/guardians declined vaccination.

General Legal

States should consult their legal counsel for advice concerning the applicability of legal immunity, licensure, and privacy laws that may exist with respect to persons involved in vaccination programs. The paragraphs below provide general summaries of some relevant legal authorities, but the list is not intended to be exhaustive. Current as of December 2021.

Countermeasures Injury Compensation Program (CICP)

The Public Readiness and Emergency Preparedness Act (PREP Act) authorizes the Countermeasures Injury Compensation Program (CICP) to provide benefits to certain individuals or estates of individuals who sustain a covered serious physical injury as the direct result of the administration or use of covered countermeasures identified in and administered or used under a PREP Act declaration. The CICP also may provide benefits to certain survivors of individuals who die as a direct result of the administration or use of such covered countermeasures. Additionally, if all requirements set forth in the PREP Act are met, qualified persons who administer COVID-19 vaccines are immune from liability except for "willful misconduct" with respect to all claims for loss caused by, arising out of, relating to, or resulting from the manufacture, testing, development,

distribution, administration, and use of a COVID-19 vaccine. More information about the CICP can be found at https://www.hrsa.gov/cicp.

State and Local Government Immunity
Officials of state and local governments may also have "official" or "governmental" immunity under state legislation, municipal ordinances, or as otherwise provided for by common law. These laws may differ depending upon the level of government, the nature of the official function, the presence or absence of malice, and the degree of alleged negligence. In some instances, however, this immunity may only be provided to public officers while exposing their government employers to at least limited liability. Officials may wish to contact State and local legal advisors on these matters.

Family Educational Rights and Privacy Act (FERPA)
FERPA is the federal law, administered by the U.S. Department of Education, which protects the privacy of student education records, including health records, maintained by educational agencies and institutions. The law applies to all educational agencies and institutions that receive funds under a program administered by the U.S. Department of Education. FERPA generally prohibits the disclosure, without prior written consent, of education records or personally identifiable information (PII) from education records to outside entities, although there are a number of exceptions to the requirement of prior written consent (see: http://www.ed.gov/policy/gen/guid/fpco/ferpa/index.html). The applicability of FERPA will vary based on who is conducting the school-located vaccination clinic as follows:

- If a LHD, or an entity acting on its behalf (e.g., a commercial community vaccinator with whom the LHD developed a contract), conducts the clinic and maintains the student's records, FERPA does not apply to the vaccination records because they are maintained by the LHD.
- If a school, school district, or an entity acting on its behalf (e.g., a commercial community vaccinator with whom the school or district developed a contract) conducts the clinic and maintains the student's records, FERPA applies to the vaccination records because they are maintained by the school or school district.
- If an entity, other than the LHD or the school/school district, conducts the clinic (e.g., a commercial community vaccinator not under a contract with the school or the LHD) and maintains the student's records, then FERPA does not apply to the vaccination records because they are not maintained by an educational institution or agency or a party acting for an educational institution or agency.

Under the FERPA regulations at 34 Code of Federal Regulations (C.F.R.) Part 99, many disclosures of PII from education records of students require signed and dated parental consent. However, when a student turns 18 years of age or attends an institution of

postsecondary education, the signed and dated consent must be obtained from the student. 34 C.F.R .99.3 (definition of “Eligible student”) and 99.5. The FERPA regulations provide that the prior written consent must specify the records to be disclosed, the purpose of the disclosure, and the party or class of parties to whom the disclosure may be made. 34 C.F.R. 99.30. For example, in the absence of a health or safety emergency, signed and dated consent is generally needed for a school to release PII from education records to public health authorities (e.g., for entry into an immunization registry) or to the child’s health care provider (e.g., for inclusion in the child’s 15 Current as of December 2021 health care record). Certain disclosures may be made without prior written consent. 34 C.F.R. 99.31. For example, a disclosure may be made without prior written consent to other school officials within the educational agency or institution whom the agency or institution has determined to have legitimate educational interests (e.g., school officials may be informed that a student has the COVID-19 virus and has been advised to stay at home; the disclosure is needed so that school officials can monitor whether that student nevertheless attends school or a school-related activity). 34 C.F.R. 99.31(a)(1). Additional information regarding disclosures in a health or safety emergency may be found at 34 CFR 99.31(a)(10) and 99.36.

Health Insurance Portability and Accountability Act (HIPAA)

The HIPAA Privacy Rule provides federal protections for personal health information held by covered entities and gives patients an array of rights with respect to that information. At the same time, the Privacy Rule is balanced so that it permits the disclosure of personal health information needed for patient care and other important purposes. The HIPAA Privacy Rule requires covered entities to protect individuals’ health records and other identifiable health information by requiring appropriate safeguards to protect privacy, and setting limits and conditions on the uses and disclosures that may be made of such information without patient authorization. The rule also gives patients rights over their health information, including rights to examine and obtain a copy of their health records, and to request corrections. In most cases, the HIPAA Privacy Rule does not apply to elementary or secondary schools because the schools either: (1) are not HIPAA covered entities; or (2) are HIPAA covered entities, but maintain health information on students only in records that are by definition “education records” under FERPA and, therefore, are not subject to the HIPAA Privacy Rule. If a person or entity acting on behalf of a school subject to FERPA, such as a school nurse that provides services to students under contract with or otherwise under the direct control of the school, maintains student health records, these records are education records under FERPA, just as they would be if the school maintained the records directly. More information about HIPAA can be found at http://www.hhs.gov/ocr/privacy/

Joint Guidance on the Application of the Family Educational Rights and Privacy Act

(FERPA) And the Health Insurance Portability and Accountability Act of 1996 (HIPAA) To Student Health Records can be found here.

Appendix

Download most recent forms on website: School Nurse Resources

Adolescent Vaccine Consent Form - English VDH Use Only

Adolescent Vaccine Consent Form - Spanish VDH Use

CDC "You Call the Shots" Training Courses

Vaccine in Spanish (Español) and other languages. See http://www.immunize.org/visin Spanish (Español) and other languages. See http://www.immunize.org/vishttp://www.immunize.org/vis

Local Health District Directory link for site planners: www.vdh.virginia.gov/health-department-locator/

Center for Disease Control Pink Book: www.cdc.gov/vaccines/pubs/pinkbook/index.html

Vaccination Resources for Communities: www.healthiergeneration.org/campaigns/vaccines

School-Located Vaccination, School Nurse Planning Checklist (NASN):www.immunizationmanagers.org/content/uploads/2021/10/School-Vaccination-Nurse-Plan-Checklist.pdf

CDC Vaccine Schedules:

Vaccine Schedule for Children 6 Years or Younger

Vaccine Schedule for Children, 7 to 18 Years Old

School and Day Care Minimum Immunization Requirements: www.vdh.virginia.gov/immunization/requirements/

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Appendix

School Entrance Checklists

"This Is Quitting" Flyers

Department of Behavioral Health and Developmental Services (DBHDS) Resources

SCHOOL ENTRANCE CHECKLIST FOR PRESCHOOL PROGRAMS

202__ - 202__ School Year

Age-appropriate immunizations are required for admission into any preschool program.

Directions: Fill out a checklist on all pre-kindergarten students. Check appropriate spaces. If deficient, write "No" in red ink. When resolved, mark through the red "No" and write "corrected" in black ink, including the date resolved. A list of deficiencies is to be kept in a designated folder.

Student_____**Date of Birth**_____

DtaP, DTP, DT or Td ***If deficient, date resolved***_____

_____Is there a minimum of 4 doses with at least 6 months between doses 3 & 4? **OR**

_____Are there 3 doses with one after the 4th birthday, with at least 6 months between doses 2 & 3?

Polio (IPV) ***If deficient, date resolved***_____

_____Is there a minimum of 3 doses?

Hepatitis B ***If deficient, date resolved***_____

_____Is there a minimum of 3 doses?

_____Is there at least 1 month **(28days/4 weeks)** between the 1st and 2nd doses?

_____Are there at least 2 months **(56 days/8 weeks)** between the 2nd and 3rd doses?

_____Are there at least 4 months **(112 days/16weeks)** between the 1st and 3rd doses?

_____Is the 3rd dose given after age **168 days/24weeks**?

Haemophilus Influenzae Type B (HIB)

_____Are there 3 doses before age 12 months? **OR**

_____Is the child 11 months old with only 2 doses?

_____**IF SO**, is the 3rd dose given between 11-15 months with at least **56 days/ 8 weeks** between doses 2 & 3?

_____If there is only 1 dose, was it given after age **15 months**?

IF THE STUDENT IS "OFF SCHEDULE", CONTACT YOUR SCHOOL NURSE COORDINATOR.

Measles, Mumps, Rubella (MMR) ***If deficient, date resolved***_____

_____Is there a minimum of 1 Measles, 1 Mumps and 1 Rubella (MMR)?

_____Was the dose administered at age **12 months /365 days** or older?

_____If there are 2 doses, are there at least **28 days /4 weeks** between dose 1 and dose 2?

Note: If the MMR and Varicella are not given on the same day, the doses must be 4 weeks/28 days apart.

Varicella (Chickenpox) ***If deficient, date resolved***_____

_____Has the student had 1 dose of the vaccine?

_____Was the dose administered at age **12 months/365 days** or older?

_____If there are two doses, are there at least **4 weeks /28days** between dose 1 and dose 2? **OR**

_____Is there documentation by a physician that the student has had the disease (chickenpox)?

Pneumococcal Vaccine **If deficient, date resolved**_____

_____Has the student had 1 dose of this vaccine prior to age 60 months?

VACCINES ADMINISTERED EQUAL TO OR LESS THAN 4 DAYS BEFORE THE MINIMUM INTERVAL OR AGE ARE VALID.

PHYSICAL CHECKLIST

_____***Is Part I (Health Information Form, page 1) filled out? ***If not, date resolved***_____

_____***Is the Health Information Form signed by the person completing Part I (page 1)? ***If not, date resolved***_____

_____*Is either the **"do"** or **"do not"** blank checked in the box at the bottom of the Health Information Form (page 1)?
If not, date resolved_____

_____*Has the physician, nurse practitioner or physician's assistant filled out the "Summary of Findings" box (located above the signature box) and any recommendations (if applicable) on page 4? ***If not, date resolved***_____

_____Is there a physical examination **signed** by a licensed physician, nurse practitioner, or physician's assistant?
If not, date resolved_____

_____Is the physical examination **dated**? ***If not, date resolved***_____

_____Was the physical exam done within one year of the pupil entering the preschool program?
If not, date resolved_____

***applies to *Commonwealth of Virginia School Entrance Health Form* only**

IMMUNIZATION EXEMPTIONS

Medical Exemptions

_____Is there a statement signed by a licensed professional stating contraindication to one or more vaccines?

Religious Exemption

_____Has the parent signed and had notarized the Certificate of Religious Exemption form (CRE-1)?

NOTIFY THE SCHOOL NURSE OF ANY STUDENTS WITH THE ABOVE MENTIONED EXEMPTIONS.

Person reviewing record:_____**Date:**_____

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Revised 1/18/2024

KINDERGARTEN SCHOOL ENTRANCE CHECKLIST
202____- 202___ SCHOOL YEAR

MINIMUM IMMUNIZATION REQUIREMENTS FOR ENTRY INTO SCHOOL

Directions: Fill out a checklist on all kindergarten students. Check appropriate spaces. If deficient, write "No" in red ink. When resolved, mark through the red "No" and write "corrected" in black ink, including the date resolved. A list of deficiencies is to be kept in a designated folder.

Student_____ **Date of Birth**_____

DtaP, DTP, DT or Td ***If deficient, date resolved***_____

_____Is there a minimum of 4 doses with at least one dose after the 4th birthday?

Polio (IPV) ***If deficient, date resolved***_____

_____Is there a minimum of 4 doses with at least one dose after the 4th birthday?

OR

_____Are there 3 doses with one after the 4th birthday **AND**

_____Are there at least 6 months (**168 days/24 weeks**) between dose 2 and dose 3?

Measles, Mumps, Rubella (MMR) ***If deficient, date resolved***_____

_____Is there a minimum of 2 Measles, 2 Mumps and 1 Rubella (MMR)?

_____Was the 1st dose administered at age **12 months/365 days** or older?

_____Is there at least 1 month (**28 days/4 weeks)** between dose 1 and dose 2?

Note: If the MMR and the Varicella are not given on the same day, the doses must be 4 weeks/28 days apart.

Hepatitis B ***If deficient, date resolved***_____

_____Is there a minimum of 3 doses?

_____Is there at least 1 month **(28 days/4 weeks)** between the 1st and 2nd doses?

_____Are there at least 2 months **(56 days/8 weeks)** between the 2nd and 3rd doses?

_____Are there at least 4 months **(112 days/16 weeks)** between the 1st and 3rd doses?

_____Is the 3rd dose given after age 6 months (**168 days/24 weeks)**?

Varicella (Chickenpox) ***If deficient, date resolved***_____

_____Has the student had 2 doses of the vaccine?

_____Was the 1st dose administered at age **12 months/365 days** or older?

_____Is there at least 1 month (**4 weeks/28 days)** between dose 1 and dose 2?

OR

_____Is there documentation by a physician that the student has had the disease (chickenpox)?

Hepatitis A (HAV) ***If deficient, date resolved***_____

_____Is there a minimum of 2 doses?

_____Was the first dose given at age 12 months or older?

_____Are there at least 6 months (**168 days/24 weeks**) between the 1st and 2nd doses?

VACCINES ADMINISTERED EQUAL TO OR LESS THAN 4 DAYS BEFORE THE MINIMUM INTERVAL OR AGE ARE VALID.

Person reviewing record: _____ **Date:** _____

***See page 2 for School Physical Checklist**

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Revised 1/31/2024

KINDERGARTEN PHYSICAL CHECKLIST

***applies to *Commonwealth of Virginia School Entrance Health Form* only**

_____ *****Is Part I (Health Information Form, page 1) filled out?
***If not, date resolved*_____**

_____*Is the Health Information Form signed by the person completing Part I (page 1)?
***If not, date resolved*_____**

_____*Is either the **"do"** or **"do not"** blank checked in the box at the bottom of the Health Information Form (page 1)?
***If not, date resolved*_____**

_____ *Has the physician, nurse practitioner or physician's assistant filled out the "Summary of Findings box (located above the signature box) and any recommendations (if applicable) on page 4?
***If not, date resolved*_____**

_____Is there a physical examination **signed** by a licensed physician, nurse practitioner, or physician's assistant?
***If not, date resolved*_____**

_____Is the physical examination **dated**?
***If not, date resolved*_____**

_____Was the physical exam done within one year of the pupil first entering public kindergarten?
***If not, date resolved*_____**

IMMUNIZATION EXEMPTIONS

Medical Exemptions

_____Is there a statement signed by a licensed professional stating contraindication to one or more vaccines?

Religious Exemption

_____Has the parent signed and had notarized the Certificate of Religious Exemption form (CRE-1)?

NOTIFY THE SCHOOL NURSE OF ANY STUDENTS WITH THE ABOVE MENTIONED EXEMPTIONS.

***CONDITIONAL ENROLLMENT**—A child whose immunizations are incomplete may be admitted conditionally, provided the parent/guardian has documentation at the time of enrollment indicating that the child has received at least one dose of the required immunizations (applies to all) and has a written schedule for completing the remaining doses within 90 calendar days of the opening of school. Hepatitis A and Hepatitis B conditional enrollment period is 180 calendar days due to the extended time interval between doses.*

Person reviewing record: _____ Date: _____

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Revised 1/31/2024

Thank you for your interest in This is Quitting! Attached is a flyer for our program. We ask that you **do not alter these materials in any way.**

A few other things to keep in mind:

- Distribution of the flyers – we have found that a peer-to-peer approach is most effective when trying to disseminate information about vaping cessation. We highly encourage you to get the flyers into the hands of teens and young adults to spread the word about the program to their peers.

- We will be creating new materials for the program and uploading them to our website. Be sure to check back to see what's new!

- If you have any further questions about the program, please don't hesitate to reach out to help@thisisquitting.com.



YOU CAN QUIT VAPING. TEXT DITCHVAPE TO 887-09 FOR HELP.

truth THIS IS QUITTING

READY TO QUIT VAPING?

Try This Is Quitting, a free, text-to-quit program.



CONFIDENTIAL HELP.

Your quitting journey stays between you and TIQ.

ADVICE FROM REAL PEOPLE.

You'll receive tips and motivation from TIQ's built-in support system of successful quitters.

24/7 SUPPORT.

TIQ is there whenever you need help with stress, slips, or cravings — no matter the time of day.

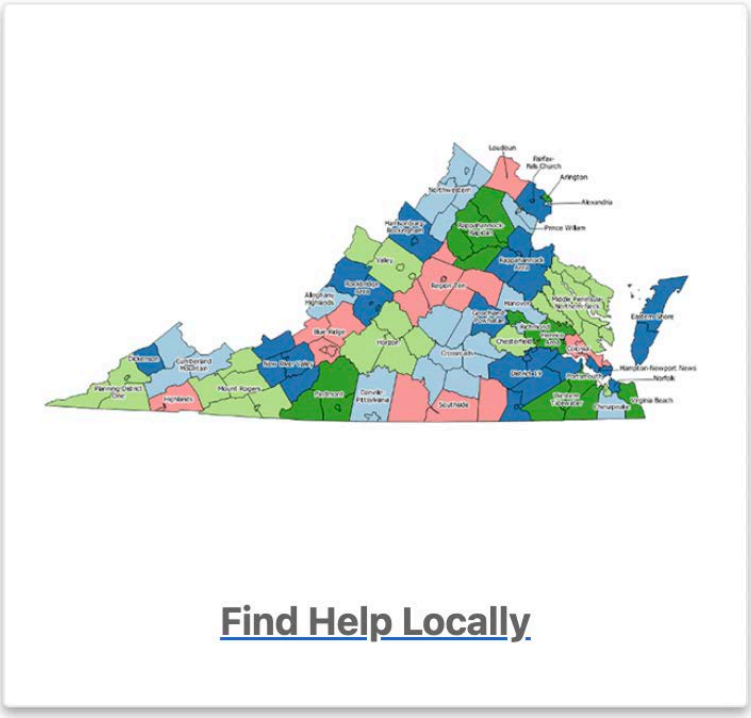
FREE OF CHARGE.

TIQ is completely free, so you can focus on quitting, not costs.

TEXT DITCHVAPE TO 88709 TO JOIN THE GROWING WAVE OF YOUNG PEOPLE GETTING HELP FROM THIS IS QUITTING.

truth THIS IS QUITTING

The Virginia Department of Behavioral Health and Developmental Services supports individuals by promoting recovery, self-determination, and wellness in all aspects of life.



Community service boards (CSBs) provide support for school communities. To access local resources, visit the CSB directory:

vacsb.org/csb-bha-directory/.