Texas Catholic Conference
Education Department
Catholic School
Health Manual
2013

Acknowledgements

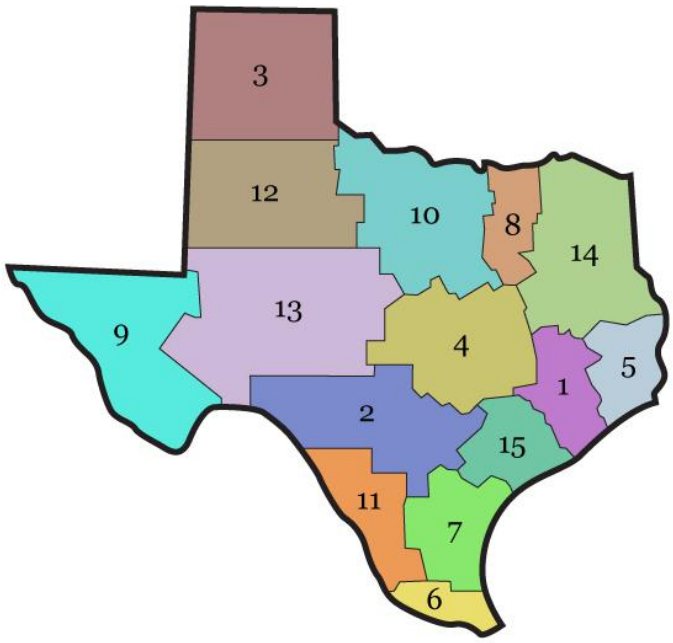
Texas Catholic Conference Education Department

This edition of the TCCED School Health Manual is dedicated with to:

All the faithful women and men who serve to strive to meet the health needs of our Catholic School Communities and with special appreciation to Lucia Romo/Diocese of Fort Worth for translating the BBP power point and quiz into Spanish.

With gratitude and thanks,

Nancy Vaughn Eder, RN
School Nurse Consultant
Diocese of Fort Worth
W: 817.560.3300
C: 817.229.6101
neder@fwdioc.org



Diocese of Texas

1. Archdiocese of Galveston-Houston
2. Archdiocese of San Antonio
3. Diocese of Amarillo
4. Diocese of Austin
5. Diocese of Beaumont
6. Diocese of Brownsville
7. Diocese of Corpus Christi
8. Diocese of Dallas
9. Diocese of El Paso
10. Diocese of Fort Worth
11. Diocese of Laredo
12. Diocese of Lubbock
13. Diocese of San Angelo
14. Diocese of Tyler
15. Diocese of Victoria

Table of Contents

TCCED SCHOOL HEALTH MANUAL

Section 1. Requirements and Regulations

ACCREDITATION

Catholic Schools in Texas seek accreditation through the Texas Catholic Conference Accreditation Commission once every seven (7) years, with interim reports being filed on a regular basis.

- Individual Catholic School accreditation schedules will be set by TCCED.
- Compliance with Health Services guidelines and policies is monitored during an accreditation visit.
- The Health Services Review[1] is designed to prepare the Catholic School for examination of its School Health Program.
- This manual provides minimum standards for School Health for the Catholic Schools and the children they serve.

[1] See Health Services Review, Section 4, *Forms*

ANNUAL STUDENT HEALTH SCREENINGS

Screening requirements

Texas State required screenings	Who is required to be screened	Timeline requirements
Vision and Hearing	4 years old by September 1 Any other first time entrants (4 years through 12th grade) Grades K-5, 1,3,5,7	Within 120 days of admission or before the end of the first semester
Spinal	All students in grade 6 unless screened in grade 5. And; all students in grade 9 unless screened in grade 8.	As early as possible in the school year.
Acanthosis Nigricans (ESC regions 1, 2, 3, 4, 10, 11, 13, 15, 18, 19, 20)	All students in grades 1, 3, 5, 7	As early as possible in the school year

Screener requirements

Only state approved screeners who have taken and passed a Texas Department of State Health Services approved screener's workshop will perform screenings. A copy of the screener's certification must be kept on file in the local school office as well as the Diocesan school office. Certification is valid for five years. The state certified screener has access to all necessary state screening forms.

Screener Certification

Screeners obtain certification through attending an approved class.

For vision, hearing and spinal screening, the Texas Department of State Health Services is the approved certifying agency. Education Service Centers and regional instructors provide training. To access a class call your local Education Service Center (ESC) or the Texas Department of State Health Services.

For acanthosis nigricans screening, University of Texas-Pan American Border Health Office is the monitoring agency and has online training certification. This online training and certification is accessed at: http://rfes.utpa.edu. Reporting is online and due by 1st Friday of June of each school year. Password required for reporting and can be obtained from: http://rfes.utpa.edu

Texas laws and regulations

A. Student screening for vision and hearing problems are state regulation pursuant to the Special Senses Communications and Disorders Act of 1983.

B. Student screening for spinal curvature is state regulation according to TAC, Section 37.141-37.152.

C. Acanthosis Nigricans screening is state regulation according to the Texas Health and Safety Code, Chapter 95.

D. Applicable regulatory information is available on the web at http://www.dshs.state.tx.us

ASBESTOS HAZARD MANAGEMENT

AHERA requirements: www.dshs.state.tx.us/asbestos/default.shtm

In order to promote and protect the health of students, staff and visitors in Catholic Schools, and in accordance with the Asbestos Hazard Emergency Response Act (AHERA) of 1986, each Catholic School must comply with all asbestos management regulations and requirements as contained in the most current official, professional asbestos management inspection report for the school and, additionally, will insure compliance with training and communications requirements as specified in the AHERA.

A. The Catholic School principal is responsible for compliance with asbestos related regulations, training and recommendations. A janitor and/or maintenance person at the school may be the designated person for training compliance. In the event that compliance with any regulation or requirement is deemed impossible by the principal, the office of the superintendent must be notified in writing immediately.

B. The office of the superintendent will work with other diocesan entities as appropriate (i.e. the diocesan construction office) and will cooperate with individual schools to facilitate compliance as follows:
   1. Monitoring federal and state asbestos legislation relating to schools, and communicating with schools as changes occur
   2. Consulting with schools, advise schools and assist schools as necessary with training coordination, containment, professional inspections, removal, and management regarding asbestos and asbestos containing building materials (ACBMs)

C. Schools found, during an initial inspection, to contain **no** ACBMs should have the inspection report and management plan on file in the school.
   1. Should have the initial management plan as well as subsequent inspection reports, both professional and routine-visual, on file in the school.
   2. Must have, at a minimum, the principal and maintenance personnel trained annually, in professional asbestos management classes, to perform necessary and required management procedures in the school.
   3. Should have visual inspections every six months to document any renovation or major repairs completed during that time frame. Any new materials used during a renovation or major repair would be classified as an assumed ACBM until they are documented by testing or MSDS data sheets with an approved letter from an architect or engineer. Retain documentation in an easily accessible location for 30 years.
   4. Must have professional asbestos management inspections as required (usually every three years) and retain documentation of inspections for 30 years.
   5. Must refer to the management plan in the event of disruption of or damage to any existing or assumed ACBMs in the school (i.e., remodeling, construction, repairs, leaks, etc.) and must perform work in accordance with asbestos hazard regulation and recommendations.

D. Schools found during an initial inspection to contain ACBMs:
   1. Should have the initial management plan as well as subsequent inspection reports, both professional and routine-visual, on file in the school.
   2. Must have, at a minimum, the principal and maintenance personnel trained annually, in professional asbestos management classes, to perform necessary and required management procedures in the school.
   3. Should have visual inspections every six months to document any renovation or major repairs completed during that time frame. Any new materials used during a renovation or major repair would be classified as an assumed ACBM until they are documented by testing or MSDS data sheets with an approved letter from an architect or engineer. Retain documentation in an easily accessible location for 30 years.
   4. Must have professional asbestos management inspections as required (usually every three years) and retain documentation of inspections for 30 years.
   5. Must refer to the management plan in the event of disruption of or damage to any existing or assumed ACBMs in the school (i.e., remodeling, construction, repairs, leaks, etc.) and must perform work in accordance with asbestos hazard regulation and recommendations.

Updated 9-26-11

BLOODBORNE PATHOGENS

Catholic schools are required by the Federal Occupational Safety and Health Administration (OSHA) to comply with standards for control of Bloodborne Pathogens under the Code of federal regulations [CFR] Part 1910.1030, Subpart Z. The purpose of the requirement is to reduce the occupational transmission of infections caused by microorganisms sometimes found in human blood and other body fluids, primarily Hepatitis B, Hepatitis C and HIV/AIDS.

Catholic Schools are required to have and follow a Bloodborne Pathogens Exposure Control Plan, and to conduct and document annual Bloodborne Pathogens training for all faculty and staff.

Exposure Control Plan

In 1993 the TCCED Superintendents approved a Bloodborne Pathogens Exposure Control[2] plan for use in Catholic Schools in Texas. The plan requires the school administrator to, among other duties, identify those employees who "in the course of fulfilling their job duties, have a likelihood of coming into contact with blood or other potentially infectious materials." It is essential that the school administrator have knowledge of the contents of the Exposure Control plan.

Staff training

Employees [including volunteers] will be trained at the time of initial assignment to tasks where exposure may occur, and annually, during work hours. Additional training will be provided whenever there are changes in tasks or procedures, which affect employee's occupational exposure. A four page reproducible training booklet and quiz[3], (recommended for use with a training power point) is found in this manual. Employee training must be documented and documentation must be retained in the school for three years from the date on which the training occurred.

[2] TCCED Approved Bloodborne Pathogens Exposure Control Plan, Section 3, *References and Resources*
[3] Bloodborne Pathogens in the Educational Setting, training booklet, Section 3, *References and Resources*

CAR SEATS

Background and purpose

Each year nearly 1,600 children die in motor vehicle accidents. Motor vehicle accidents are the leading cause of unintentional injury-related death among children ages 14 and younger. Unrestrained children are more likely to be injured, to suffer more severe injuries, and to die in motor vehicle crashes than children who are restrained.

On September 1, 2009 legislation was passed to strengthen current child passenger safety protections by mandating that children younger than eight years old, unless they are four feet, nine inches in height, must be properly secured while riding in an operating vehicle in a child passenger safety seat system in accordance with the instructions of the manufacturer of the safety seat system.

Amends Sections 545.412(a) and (b), Transportation Code, as follows:

(a) Provides that a person commits an offense if the person operates a passenger vehicle, transports a child who is younger than eight, rather than five, years of age, unless the child is taller than four feet, nine inches, rather than less than 36 inches in height, and does not keep the child secured during the operation of the vehicle in a child passenger safety seat system according to the instructions of the manufacturer of the safety seat system.

(b) Provides that an offense under this section is a misdemeanor punishable by a fine of not more than $25, rather than not less than $100 or more than $200. Requires a municipality or county, notwithstanding any other law, to remit each fine collected under this section to the comptroller of public accounts for deposit in a separate account in the general revenue fund that is authorized to be appropriated only to the Texas Department of Transportation and used to purchase child passenger safety seat systems and distribute them to low-income families. Provides that Chapter 133 (Criminal and Civil Fees Payable to the Comptroller), Local Government Code, applies to a fine collected under this section.

Seat Belts

“Click it or Ticket” Program 2010

Law enforcement officials statewide are participating in the "Click It or Ticket" campaign to increase safety belt use. All drivers and all passengers in the vehicle must be properly restrained or run the risk of a fine up to $250.

CHILD ABUSE

Reporting

In addition to the moral obligation of Catholic Schools to protect and value children as Jesus did, school personnel are mandated reporters of child abuse and neglect under provisions of Chapter 261 of the Texas Family Code. The agency, which receives reports in Texas, is the Texas Department of Family and Protective Services. This agency has the authority to investigate a report of child abuse or neglect by presenting valid ID to school personnel. Notification should be made to the school principal and as well as requesting a secure room for the interview. A report may also be made to local law enforcement authorities. The law specifies sanctions for school personnel who do not make a report if they have "cause to believe" that a child is being abused or neglected. The person to whom a child reports abuse or who suspects abuse may not delegate the responsibility for reporting to another person. (T.F.C. Ch. 261)

Sec.261.406. INVESTIGATIONS IN SCHOOLS

(a) On receipt of a report of alleged or suspected abuse or neglect of a child in a public or private school under the jurisdiction of the Texas Education Agency, the department shall perform an investigation as provided by this chapter.
(b) The department shall send a copy of the completed report of the department's investigation to the Texas Education Agency, the State Board for Educator Certification, the local school board or the school's governing body, the superintendent of the school district, and the school principal or director, unless the principal or director is alleged to have committed the abuse or neglect, for appropriate action. On request, the department shall provide a copy of the report of investigation to the parent, managing conservator, or legal guardian of a child who is the subject of the investigation and to the person alleged to have committed the abuse or neglect. The report of investigation shall be edited to protect the identity of the persons who made the report of abuse or neglect. Other than the persons authorized by the section to receive a copy of the report, Section 261.201(b) applies to the release of the report relating to the investigation of abuse or neglect under this section and to the identity of the person who made the report of abuse or neglect.
(c) Nothing in this section may prevent a law enforcement agency from conducting an investigation of a report made under this section.
(d) The Board of Protective and Regulatory Services shall adopt rules necessary to implement this section.

In the State of Texas the telephone number for making a report is 1.800.252.5400.

Reporting can be done online: txabusehotline.org

Child Abuse training

Annual training of educators to recognize and respond to signs of abuse or neglect in students should be conducted according to diocesan policy.

Child Abuse policy

In order to protect the students, the school, the diocese and the church, each diocese or school is required to have and follow a child abuse policy, which addresses identification and reporting, school personnel training, and classroom child abuse resistance education.

EMERGENCY READINESS AND RESPONSE

Emergency response personnel

Each school must have a minimum of two fulltime persons currently certified in American Red Cross First Aid and two fulltime persons currently certified in either American Red Cross or American Heart Association CPR or comparable nationally recognized agency. The certified personnel must be on the school premises for the entire day. It is recommended that all faculty and staff members in a school be offered the opportunity to become certified in CPR/AED and First Aid. Check with your diocese to determine if online CPR/AED and 1st aid training is an accepted form of renewal.

Each school is required to have a "First Aid" book in the clinic/office for reference.

Basic AED information (automated external defibrillator)

On June 16, 1999, the Governor of the State of Texas signed House Bill 580. This legislation "establishes training and maintenance procedures for persons who acquire and use AED's in places other than a hospital or a medical setting...{and} limits the liability of a person who is trained to use AED's, provided that the person is acting in good faith."

- **Training requirements**

Each user of the AED must receive training in CPR and AED use "given or approved by the Texas Department of State Health Services".

- **Good Samaritan Law**

"A person who in good faith administers emergency care, including using an automated external defibrillator, at the scene of an emergency but not in a hospital or other health care facility or means of medical transport is not liable in civil damages for any act performed during the emergency unless the act is willfully or wantonly negligent."

- **Compliance requirements**

A Diocese or School that acquires an automated external defibrillator shall ensure that:

1. each user of the automated external defibrillator receives training ...in:
2. cardiopulmonary resuscitation; and
3. use of the automated external defibrillator;
4. a licensed physician is involved in the training program to ensure compliance with the requirements of the contents of this chapter." The licensed physician must write a prescription for the AED itself and when used the data is downloaded and sent to the physician or group that interprets it. CPR/AED training is done by individuals who are certified to be trainers.

Refer to Section 483.041, Health and Safety Code.

RECOMMENDED HEALTH SERVICES PROTOCOL FOR TREATING STAFF MEMBERS

This purpose of this recommended protocol is to define what the school nurse or assistant can do for the staff of a Catholic School in Texas.

The school nurse or trained assistant can assist school staff members with the following:

- Check blood pressure
- Check heart rate
- Check temperature
- Hearing and vision screenings
- Check wound for signs and symptoms of infection
- Assessment as deemed appropriate by scope of practice
- Will assist with on the job injuries

Neither the school nurse nor the assistant can diagnosis or suggest treatment for any illness.

If the clinic personnel checks one of the above mentioned vital signs and finds them out of the “normal” parameters, the district staff member will be advised by the clinic personnel to seek treatment from their physician. The findings will be confidential.

For any emergency situation, the school clinic personnel will call 911 for assistance.

IMMUNIZATIONS

Immunization Policy

Every student enrolled in a Catholic School in the State of Texas shall be immunized against vaccine preventable diseases caused by infectious agents in accordance with the immunization schedule adopted by the Texas Department of State Health Services. A student who fails to present the required evidence shall not be accepted for enrollment. The ***only exception*** to the foregoing requirement is a medical exemption signed by a licensed physician (M.D. or D.O.) authorized to practice in the State of Texas.

Immunizations are not in conflict with the Catholic faith. Conscientious objections or waivers, which may be permissible for attendance in public schools, do not qualify as an exemption in Catholic Schools in Texas. (Atty. Gen. Op. GA-0420)

This policy was adopted by Texas Catholic Conference Education Department, December 2008.

Immunization requirements for the 2013-2014 school year can be found:

Online: www.dshs.state.tx.us/immunize/default.shtm OR http://www.immunizetexas.com

For current immunization information and minimum requirements, changes and explanations after this manual was printed, contact the Immunization Division, Texas Department of State Health Services.

Phone: 512.458.7284 ext. 2316 OR 1.800.252.9152

Regional Texas Department of State Health Services: The Texas Department of State Health Services maintains regional offices for the 11 Public Health Regions. Regional offices can assist with minimum immunization requirement information and literature and in some cases may provide immunization clinics in your school. To determine your region:

Online: www.dshs.state.tx.us/regions/

Phone: 1.888.963.7111 (toll free) or 512.458.7111

Provisional enrollment

All immunizations should be completed by the first date of attendance. The law requires that students be fully vaccinated against the specified diseases. A student may be enrolled provisionally if the student has an immunization record that indicates the student has received at least one dose of each specified age-appropriate vaccine required by this rule. To remain enrolled, the student must complete the required subsequent doses in each vaccine series on schedule and as rapidly as is medically feasible and provide acceptable evidence of vaccination to the school.

A school nurse or school administrator shall review the immunization status of a provisionally enrolled student every 30 days to ensure continued compliance in completing the required doses of vaccination. If, at the end of the 30-day period, a student has not received a subsequent dose of vaccine, the student is not in compliance and the school shall exclude the student from school attendance until the required dose is administered and proof of immunization has been provided to the school.

VACCINE BRAND/TRADE NAMES and Abbreviations Reference List, updated 2/27/13

Vaccine	Brand/Trade Name
Adecel	Tdap for ages 11-54 years
DPV	Oral polio vaccine
DTaP	Tripedia
DTaP	ACEL-IMMUNE
DTaP	Infanrix
DTaP	Daptacel (infants – 6 years of age)
Dtap-Hib	Tetramune (no longer used)
DtaP-Hib	TriHiBit
Hepatitis A	VAQTA
Hepatitis A	Havrix
Hepatitis B-Hib	Comvax
Hepatitis B (HBV)	ENGERIX
Hepatitis B	RECOMBIVAX HB
Hib	PedvaxHIB
Hib	HibTITER
Hib	ActHIB
IPV	IPOL
Kinrix	DTaP and IVP (5^{th} and 4^{th} dose combo)
MCV	Meningococcal conjugate (Menetra)
Measles	Attenuvax
Menhibrix	Meningococcal and HIB, 4 doses, age 6 weeks to 18 months
Menveo	Meningococcal conjugate
MMR	MMR II
MMRV	Measles, Mumps, Rubella and Varicella
Mumps	Mumpsvax
Pediarix	DTap/HBV/IPV
Pentacel	DTap – Hib – IPV
Pneumococcal	Pnu-Immune
PPV-23 Pneumococcal Conjugate	Pneumovax
Pro-Quad	MMRV (given for 2^{nd} MMR and varicella)
PVC-7/Pneumo, phasing out, starting 5/10 to PCV 13	Prevnar
Rotateq	Vaccine for rotavirus
Rubella	Meruvax II
TWINRIX and TWINRIX Junior	Combined hepatitis A and hepatitis B
Varicella (VZV)	Varivax

Section 2. Practices and Procedures

ADMINISTRATION OF THE SCHOOL HEALTH PROGRAM

Philosophy

The Catholic School Health Program is intended to enhance the student's ability to utilize his or her intellectual potential and to make responsible decisions affecting present and future physical, emotional, spiritual and social well-being. Diocesan School Health programs in Texas Catholic Schools are congruent with the educational philosophy, policies and mission of the Catholic School.

Goals of the School Health Program

- ❑ To increase each student's ability to maximize his or her intellectual potential by modifying or eliminating health related barriers to learning
- ❑ To increase the number of effective educational days per student and staff member (decrease absenteeism)
- ❑ To decrease the incidence of communicable disease
- ❑ To promote present and future health through education and referral
- ❑ To protect children and staff members by providing a safe and healthy school environment

Components of a Comprehensive School Health Program in Texas Catholic Schools

- ❑ Health Services
- ❑ Health Education
- ❑ Environmental Health

Activities of a School Health Program

The school health program should:

- ❑ Augment health instruction, which guides students toward reaching full capacity as individuals who make responsible decisions about personal, family, and community health
- ❑ Advocate for and help provide an environment conducive to the promotion and maintenance of health
- ❑ Detect and provide basic first aid care for any physical condition occurring during school hours which impedes learning or threatens optimum health
- ❑ Provide a liaison between the school, home, community agencies, physicians, and other health personnel
- ❑ Promote and advocate for children's physical, mental, and emotional health in the school, the home and the community
- ❑ Achieve acceptable levels of compliance with state and local health regulations
- ❑ Maintain and utilize current individual and collective health data
- ❑ Maintain and protect the confidentiality of school health information and records
- ❑ Provide learning and growth experiences for staff members
- ❑ Evaluate the effectiveness of the health program

Responsibilities for the School Health Program

The student’s health is primarily and ultimately the responsibility of the parents who are responsible for:

1. Providing the school with all information pertinent to the health and well-being of their child
2. Providing the school with information regarding immunizations as required by the state, local, and diocesan policy
3. Taking necessary action, including retrieval of students, when school authorities report to a parent an illness or injury which occurs during school hours; (In a life-threatening emergency, the principal or the principal's designee will take appropriate action to obtain medical assistance for the student)
4. Insuring that proper medical attention is sought for health problems that may be discovered on routine health screenings at the school

Diocesan Health Consultant / Administrator

The health consultant is a registered nurse responsible for training, consultation and supervision in school health programs. Areas of emphasis include:

1. Facilitation of health services
2. Consultation and facilitation for health education
3. Environmental health monitoring
4. Facilitation of compliance with governmental health regulations
5. Provision of information and referral based on interfacing with community resources

Principal

The principal of the school, as the chief administrator, is responsible for:

1. Insuring that qualified staff are available to fulfill health requirements
2. Administering or designating a person (s) to administer medications if necessary
3. Notifying or designating a person to notify a student's parents of an illness or injury occurring at school
4. Insuring compliance with local, state and federal health regulations

School Nurse

A registered nurse or a licensed vocational nurse employed by the school to act in the capacity of the school nurse is subject to the Nurse Practice Act of the Board of Nurse Examiners, State of Texas, and may perform nursing functions only under the supervision and standing orders of a licensed physician and only with a current Texas license. A registered nurse or licensed vocational nurse, properly trained and certified in screening procedures and emergency response, may perform screenings, emergency response procedures, immunization surveillance and other non-nursing procedures without physician supervision. The Texas Board of Nurse Examiners performs verification of licensure.[4]

The duties of the nurse include:

- ❑ Serve as health advocate for the child
- ❑ Assess student and school health needs
- ❑ Assume responsibility for planning and management for acute, chronic and emergency health problems including appropriate referral and follow up
- ❑ Provide relevant counseling and guidance to assist children and parents in assuming responsibility for health maintenance of the child
- ❑ Assist with communicable disease control through implementation of programs for student immunization, management of suspected and diagnosed cases of infectious disease and infestations, and foster education in communicable disease prevention for students and faculty
- ❑ Possess knowledge and skills specifically relating to appraisal and health management of children
- ❑ Maintain accurate, updated records of health information on all students, and make provisions for timely and accurate management of incoming and outgoing records and reports
- ❑ Coordinate and/or provide required and optional health screenings
- ❑ Monitor supply and equipment needs for the health program and communicate accordingly
- ❑ Continue professional growth through workshop and professional association activities
- ❑ Maintain state certification for acanthosis nigricans, vision and hearing and spinal screening
- ❑ Maintain valid, current CPR/AED certification

Health Coordinator / Aide / Assistant / Representative

The health coordinator is appointed by the principal and is responsible for insuring that required health screenings are performed, followed-up and documented according to state regulations by certified screeners. Additionally, they may monitor immunizations, maintain health records, complete state and diocesan statistical reports and perform other health service related duties for which they are trained.

Health Screener

A health screener is a person who is certified[5] by the State of Texas to perform required screenings (including vision, hearing, acanthosis nigricans and spinal) and may assist in recording and documenting screening and follow-up findings on student's health records.

Teacher

The teacher is responsible for observing students and referring suspicious symptoms to the school nurse or principal.

[4] Nurse Licensure Verification Form, Section 4 *Forms*

[5] For information about certification classes call:
Vision and Hearing Screening – Texas Department of State Health Services – 512.458.7420
Spinal Screening – 512.458.7700
Acanthosis Nigricans Screening – 956.665.8900

CHRONIC ILLNESS

The chronically ill student

From the first day of school, a comprehensive health plan for each chronically ill student should be developed jointly by teachers, nurses, principals, parents, and physicians to coordinate information and methods of management in school.

Self-help techniques to build confidence encourages the student to remain in school and to participate as fully as possible should be implemented.

Teachers should recognize that the intellectual and cognitive abilities of chronically ill students are usually within the same range as other students, although their ability to function may be limited either temporarily or permanently by illness or medication. Although illness or repeated absences may make it necessary to receive some work late, teachers should have high expectations, and may need to modify performance strategies for chronically ill students.[6]

Students with Asthma

Students with asthma[7] have very individualized needs, medications, exercise limits and medical regimes. The diagnosis of asthma should be noted on the emergency card, and on the student's cumulative health record. Asthma Plan of Action[8] should be in place in the school for each asthmatic student and all adults supervising the student should have access to the plan.

Students with Diabetes

As soon as possible after a student is diagnosed with diabetes, and before the student returns to school there must be a meeting of (at a minimum) the parent, principal, teacher(s) coach, physician (or designee) to agree on a plan of care,[9] including responding to a diabetic crisis, during the school day.[10] *Chapter 168 of the Health and Safety Code pertains only to public schools and does not apply to private schools. Catholic Schools are considered to be in the private sector and if someone who is not licensed performs diabetic services, they would be subject to violations of various laws. This said; Catholic Schools are not covered by Civil Immunity under the law as public schools/employees are.*

Inclusion

Inclusion of students with handicaps, chronic illness, acute (non-infectious) health problems and special needs is possible with cooperative planning and creative use of community, parish and school resources. An accommodation plan should be prepared and followed for such students.

Catholic Schools strive to teach as Jesus did, and to offer an educational opportunity to all persons who seek a Catholic education. Catholic schools, however, have limited resources for providing for the educational needs of students who have a physical, educational, emotional or mental disability. Based on the resources of the school, the discretion of the principal, and the cooperation of the student's parent/guardian, a student's educational plan in the Catholic School may be modified to allow the student the greatest possible opportunity for educational success in the Catholic School. Such modification or accommodation does not take the place of *Special Education* as defined in the Individuals with Disabilities Act. (IDEA-B)

[6] Student accommodation plan form, Section 4, *Forms*
[7] Information on asthma, Section 3, *References and Resources*
[8] Asthma Plan of Action, Section 4, *Forms*
[9] Sample Diabetic Care Plan, Section 4, *Forms*
[10] Insulin monitoring forms, Section 4, *Forms*

COMMUNICABLE DISEASE

General Information about Communicable Disease

- Immunizations required by the State Department of Health must be observed
- Students should remain at home when they exhibit the first symptoms of a disease
- When a student in school is suspected of having a communicable disease,[11] he/she should be separated from other students until he/she can be sent home

Guidelines for Excluding Students from School

Exclusion Guidelines	**Return to School Guidelines**
Oral temperature of 100° or above	Fever free for 24 hours
Vomiting, nausea or severe abdominal pain	Symptom free for 24 hours
Marked drowsiness or malaise	Symptom free
Sore throat, acute cold or persistent cough	Symptom free
Red, inflamed or discharging eyes	Written physician release
Wound, skin and soft tissue infections	Exclude until drainage is contained and covered with a clean dry bandage
Swollen glands around jaws, ears or neck	Written physician release
Suspected scabies or impetigo	Written physician release
Any skin lesion in the weeping stage	Covered and diagnosed as non-infectious
Earache	Symptom free
Pediculosis	Lice and nit free (Superintendents of the Catholic Schools in Texas support this implementation, effective March 2009 and reviewed January 2013)
Other symptoms suggestive of acute illness	Written physician release

[11] Communicable disease chart, Section 3, *References and Resources*

IS IT A COLD OR THE FLU?

Check your symptoms and ask your doctor for advice.
Remember, a **FLU SHOT** is your best protection against the flu.

Symptoms	Cold	Flu
Fever	Rare in adults and older children, but can be as high as 102° F in infants and children	Usually 102° F, but can be up to 104°
Headache	Rare	Sudden onset and can be severe
Muscle aches	Mild	Usual and often severe
Tiredness and weakness	Mild	Can last 2 or more weeks
Extreme exhaustion	Never	Sudden onset and can be severe
Runny nose	Often	Sometimes
Sneezing	Often	Sometimes
Sore throat	Often	Sometimes
Cough	Mild hacking cough	Usual and can become severe

www.cdc.gov/nip/flu

Things to keep in mind for school-age children

- Do NOT give aspirin to child or teenager who has the flu (Refer to Section 3, Reyes Syndrome)
- Most antihistamines cause sleepiness. If a child still has a stuffy nose when she returns to school, parents may want to ask their child's doctor to prescribe a non-sedating antihistamine.
- Encourage children to cover coughs and sneezes, wash hands frequently, and keep hands away from eyes, nose and mouth.
- A sick child is advised to stay at home during the first days of illness when symptoms are most severe and infection is most contagious. Children can return to school when symptoms are improving and no fever has been detected for 24 hours.

General things to keep in mind for schools

- Any employee, student, teacher, or staff suspected of having the flu should not attend school.
- Wash hands several times a day using soap and warm water for 15-20 seconds. (singing happy birthday twice is generally the recommended time) Teach young children and remind all ages to wash their hands.
- The flu can be spread from coughs or sneezes. Teach all ages to cover their mouth when coughing or sneezing. Tissues should be thrown away immediately. Hand sanitizer can be used in the classroom to avoid disruptions.
- Schools may be asked or required to report flu absences to their local health department or their individual Catholic Schools offices for tracking. Reporting outbreaks assist in disease surveillance and understanding the impact on the community.
- Staff and students, especially those with medical conditions should get the flu shot.
- Closure of individual schools in the event of an outbreak has not proven to be an effective way of stopping the flu, but the decision would be made by the principal and superintendent. Unless the local health authorities deem school closure necessary.
- In school, clean commonly used surfaces, such as door handles, tables for eating and desk with disinfectant. (Bleach solutions or commercial disinfectants are appropriate.)

EMERGENCY READINESS AND RESPONSE

First Aid

First-aid is always administered for two primary reasons. The first concern is to recognize and provide immediate basic support for serious life-threatening illnesses or injury. The second is to prevent infection and further illness. First-aid is intended to make sure the student is safe and as comfortable as possible until professional medical care can be obtained.[12]

For minor wounds, the American Red Cross only recommends mild soap and water. Major wounds requiring medical attention do not need to be cleansed, but immediate medical care must be sought. For specific first aid procedure, please refer to an approved First Aid manual (i.e., American Red Cross First Aid and Safety, Johnson and Johnson Step by Step First Aid Guide, or The School Health Handbook by Newton, Adams and Marcontel.)

Use of Insect Repellents (Amended 8/28/12)
Students DO NOT need to carry insect repellent to school. The risk of misuse or exposure to students allergic to the product far outweighs any potential benefit. Parents should consider reapplying a mosquito repellent if students are participating in after-school activities and will be outside in the evening hours. CDC recommends to "keep repellents out of reach of children and not allow young children to apply insect repellent to themselves."
National Pesticide Information Center (NPIC): 1-800-858-7378 or npic.orst.edu
School employees and coaches are not to purchase or apply or provide insect repellent for students.

Use of Sunscreen (Amended 8/28/12)
Sunscreens are regulated by the FDA and are to be treated at school like any other medication, with the appropriate medication permission form on file in the school office. See section 2, page 29 regarding medication administration.

Emergency Transport of Student

In the event that a student must be transported for emergency medical care and parents cannot be contacted, a copy of the original parent's release to obtain medical care (usually on student's emergency card or computer generated parent validated form) and a school staff member must accompany the student and stay with the student until a parent is present.

Special Emergency forms[13]

- ACCIDENT REPORT. An accident report must be completed and kept on file for every incident occurring on school premises for which professional medical care was sought. This includes school personnel, students and visitors.
- ANIMAL BITE REPORT. An animal bite report must be completed with one copy kept on file in the school and given to victim or parent (if student). All bites must be reported to Local Animal Control Agency.
- HEAD INJURY INFORMATION SHEET. A head injury sheet must be given to a parent after any incident-involving trauma to the head or neck of a student, no matter how minor the injury may seem. Documentation in the injury and illness log that the form has been given to the parent is recommended.
- MEDICATION INCIDENT REPORT. A form providing for written documentation and follow-up when an incident involving a medication error has occurred. (This form is to be kept in a file separate from the permanent student academic or health records.)
- STUDENT EXPOSURE INCIDENT FORM. A student exposure to bloodborne pathogens must be documented and reported to the parent/guardian.

[12] See recommended lists of first aid supplies, Section 3, *References and Resources*
[13] Special emergency forms, Section 4, *Forms*

QUALITY ASSURANCE

To insure that optimal health and safety are an integral part of Catholic Schools' educational program, the school health program should be monitored annually, either through self-evaluation against professionally determined criteria or by a school health professional.[14]

[14] Health Services Review form, Section 4, *Forms*

HEALTH RECORDS

Individual student health records

Permanent records are to be kept on all students. Define where they are located, who has access to them and confidentiality practices. Diocesan policy should determine the length of time documents are retained. Computer records are acceptable if all criteria listed in this section are included. A paper copy is to be kept the student file upon transfer or graduation.

INDIVIDUAL CUMULATIVE HEALTH RECORDS document pertinent health and immunization history of the student. The cumulative health record follows the student throughout his/her school years. It must contain the following:

- ❑ Student's name
- ❑ Parent/Guardian's Name
- ❑ Home Address
- ❑ Home Phone
- ❑ Birth Date
- ❑ Physician's Name
- ❑ Record of immunization history
- ❑ Physical condition/chronic conditions (including allergies)
- ❑ Screening results

EMERGENCY CARDS are updated annually or as necessary and need to include the following:

- ❑ Students name
- ❑ Persons to contact in case of emergency
- ❑ Parent/guardian's names and phone numbers
- ❑ Home address and phone number
- ❑ Allergies
- ❑ Medical conditions
- ❑ Parent/guardian's place of employment
- ❑ Parent/guardian's employment phone number
- ❑ Signed consent/release for emergency medical treatment

OTHER (OPTIONAL) STUDENT RECORDS

1. Physical Examination - It is recommended that all students have a physical examination upon entering school and annually if participating in interscholastic sports (following current Diocesan policy).

2. Health History - It is also recommended that a health history or update be completed each year.

School health records

ACCIDENT AND ILLNESS LOG.[15] A daily record of health related incidents and illnesses occurring at school. Must include:

- ❑ Name and grade of student
- ❑ Complaint
- ❑ Assessment information
- ❑ Treatment (if any)
- ❑ Disposition

DAILY MEDICATION LOG.[16] A flow chart recording each dose of medication administered to the student by school personnel.

[15] Sample log page, Section 4, *Forms*
[16] Sample medication log page, Section 4, *Forms*

Texas Department of State Health Services Statistical forms (Online DSHS)

1. Annual Report of Immunization Status (Fall)
2. Annual Screening Reports (Vision, Hearing, and Spinal) (Spring)

The University of Texas-Pan American Border Health Office

1. Annual Acanthosis Nigricans Report (Online, 1st Friday of June of each school year)

Personnel Records

1. Emergency Card
2. Tuberculosis Testing Certificates (as required by individual diocese and/or county)

Incident Records[17]

1. Accident Report
2. Animal Bite Report
3. Head Injury Report
4. Medication Incident Report
5. Student Exposure to Bloodborne Pathogens

Confidentiality of Records

For the protection of the student, the school and the diocese, policies and practices should be in place to insure the confidentiality of all student and personnel records. [18]

Release of student health records

Immunization and health records are confidential medical records and the parent must sign a release of records for these records to be transferred to another school and the route of transmission, fax, scanned and emailed, regular mail or handed to the parent should be specified and documented and kept on file.

Retention of Health Related documents and Records

A diocesan policy stipulating the length of time health related records and documents must be retained by the school should be in place.

[17] Sample incident records, Section 4, *Forms*
[18] See Federal Rights and Privacy Act information, Section 3, *References and Resources*

MEDICATION ADMINISTRATION AT SCHOOL

Policy governing administration of medications at school

The diocesan Catholic Schools Office should:

- ❑ Develop its medication administration policy in cooperation with medical/pharmaceutical professionals, parents, and school personnel
- ❑ Obtain legal/diocesan consultation regarding its medication administration policy
- ❑ Present the policy to the diocesan Catholic Schools advisory/governing body for approval with approval being recorded in the minutes of the meeting wherein the policy was presented
- ❑ Review the policy regularly with school staff regarding specifics and conditions of the policy

A safe, effective policy governing the administration of medications in school should include, but need not be limited to the following elements:

- ❑ General conditions under which medication will be administered at school. (i.e. only when there is no other recourse; only with completed, signed parent/guardian request for administration of medication)
- ❑ Parent/Guardian is responsible to provide the medication, by bringing the medication to school and then to pick the medication up when the medication is completed or at the end of the school year
- ❑ Non-allowance of students self-dispensing or students carrying medications on their person at school
- ❑ General requirements (specific contents of the parental request form)
- ❑ Procedure for administration of prescription medication, documentation and conditions applying to prescription labels
- ❑ Procedure for administration and documentation of non-prescription medications
- ❑ Procedure for administration of "PRN" (when necessary) medications or treatments
- ❑ Storage of medications, locked medication cabinet

Safe practices for administration of medications at school

- ❑ The principal of a school will designate a responsible person to supervise the storing and administration of medications at school[19]
- ❑ Only medication which is necessary for the child to remain in school will be given during school hours with medication being administered at home whenever possible
- ❑ Only medication prescribed by a licensed physician, dentist, Nurse Practitioner or Physician's Assistant will be administered by authorized school personnel
- ❑ No stock medications will be kept in the clinic for student use
- ❑ Signed parental and/ or physician consent congruent with diocesan policy, for either prescription or non-prescription medication must be obtained. The consent form should contain, at the least, the following elements:
    - Name of student
    - Name of medication
    - Dosage of medication
    - Times medication is to be given
    - Route of administration
    - Disclaimer statements:
        - Medication will be administered by non-medical personnel
        - Hold school harmless for adverse drug reactions and side effects of properly administered medication
        - Parent responsible for maintaining adequate supply of medication at the school
    - Parent/Guardian signature

- ❑ Substitution of medication from one student's supply for another, (even if it is the same medication) is never permitted

- ❑ In the event that school personnel have questions or concerns regarding the administration of medication to a student, or possible medication abuse, the employee should consult with the principal, the physician, and the parent. Process and outcome must be documented

[19] Medication administration designation form, Section 4, *Forms*

- ❑ Storage of medication will be in a locked cabinet or drawer. In the case of medication requiring refrigeration, the refrigerator must also be kept locked

- ❑ Most medications have expiration dates and these dates need to be monitored (i.e. inhalers) Expired medications will not be administered

- ❑ The parent is responsible to bring all medication to the school clinic/office, and to pick up unused medicine or it will be properly destroyed. Medication is not kept from year to year in the school clinic/office

- ❑ Medication that is received in an unlabeled container or plastic bag will not be accepted

- ❑ Administration of medication will be recorded on a medication log with date, time, and initials of person giving the medication.[20] The student is responsible for coming to the office and asking for his/her medication. This includes both daily and PRN medications. These documents are to be kept in accordance with each individual diocesan document retention policy

- ❑ The use of nebulizer treatments in schools, for the treatment of asthma should be done with extreme caution. Non-medical personnel should not be responsible for the administration of the nebulizer treatment without careful training. The parent is ultimately responsible for the care of their asthmatic child

- ❑ Once a vial of insulin (or other medication in a vial) is started (opened), date the vial and discard in 30 days

Parent/Guardian medication administration release/instructions

The essential elements of a parent/guardian medication administration release are:

1. Name of student
2. Name of medication
3. Dosage to be given (single dose amount) (no. of pills, teaspoons, etc.)
4. Time (clock time) to be given
5. Date(s) to be given (Month, day and year) or range of dates (i.e., on school days from August 2013 through June 2014.)
6. Appropriate instructions on the medication that is being requested at school
7. Appropriate disclaimers, i.e.,
    - ❑ I understand that the medication(s) will be administered by a person who is not medically trained;
    - ❑ I agree to hold the school harmless for the proper (according to above directions) administration of the medication provided by the parent/guardian and for adverse drug reactions or side effects;
    - ❑ I agree to be responsible for maintaining an adequate supply of medication at the school to meet the child's need.
8. Parent/guardian signature
9. Date of parent guardian signature
10. Signature of physician as required by individual diocese on medication release

[20] Sample medication logs, Section 4, *Forms*

Prescription medications

Prescription medication will be properly identified with the prescription label from a pharmacy. This label will include:

1. student name
2. medication name
3. directions concerning dosage
4. route of administration (i.e., oral, topical, right eye, left eye, IM (intramuscular), etc.)
5. time that the medication is to be given
6. length of time medication to be given (duration)

Non-prescription medications

Non-prescription medication (over-the-counter) must be in original container, with visible directions, and displaying the students' name. Parent request for administration of such medications must be consistent with directions for use on the package.

With the use of cough drops, they must be in the original container, and labeled with the child's name, and written directions from the parent. Parent request for administration of cough drops must be consistent with directions for use on the package.

Guidelines for disposing of unused medication

The following are recommendations to follow when parents do not pick up their child's medications from school. This is to be documented on the child's medication log with the route of disposal.

The White House Office of National Drug Control Policy (ONDCP) working with the FDA has issued the following directions. (June 2008)

www.fda.gov/consumer/updates/drug_disposal062308.html

1. Do not flush medications down the toilet unless the information on the label specifically instructs you to do so.
2. Syringe/medications (i.e., insulin, epinephrine pens) must be placed in an approved sharps container and disposed of via bio-hazard trash pickup. Do not put this in the regular trash for disposal.
3. Inhalers and aerosol products may be discarded in the regular trash unless there is a hazardous waste warning and this will require discarding this in the bio-hazard trash/sharps container.
4. If no instructions are given on the label for disposal, pills can be taken out of the original container and mixed in a coffee can with coffee grounds or kitty litter, and then discarded in the regular trash. Discard the container in the trash after identifying information has been scratched out or removed on the label (s).

Please check with your local health department about the "Take Back Meds Program" that has developed across the country for unwanted/expired medications and share this information with your school families.

PEDICULOSIS *(HEAD LICE)*

Reviewed, without change by the Superintendents of the Catholic Schools in Texas, January 2013

Head lice can spread rapidly. Students found to have head lice must be excluded from school immediately. It is strongly recommended that the school follow a “nit free” policy for re-admittance to school. “Nit-free” means the child is to be free of nits and lice on their head. The child is required to be checked by school personal before returning to class.

Head lice are transmitted through close, personal contact. Also, through the use of common brushes, combs, curlers, and hair ornaments, and the sharing of hats, headbands, or other head apparel. Despite opinions to the contrary, head lice are found in frequently shampooed hair and on persons with good personal hygiene habits.

Each female head lice lay 50 to 150 eggs. Since these eggs hatch within one week, the infestation builds rapidly. Check the hair in bright light, preferably sunlight, as the lice are small, grayish-white insects, one sixteenth to one eighth inch long. They are dependent upon human blood for sustenance. The nits or eggs are smaller, yellowish white particles attached to the hair shaft with a waxy, waterproof substance.

If lice are present, the entire family should be inspected and undergo simultaneous treatment. You may phone a physician for treatment and advice or see the pharmacist in a local drug store. Some medications and medicated shampoos will only kill the adult lice. Others will kill both the adult lice and the eggs, which is recommended. Depending on the severity, number of applications, and person methods of application, all eggs are not always killed or eliminated. Combing of the hair with a fine tooth comb (some medications include it) is recommended after the medication has been applied (follow directions). In more severe cases it may require the manual removal of each egg. It is strongly recommended that schools follow a “nit-free” policy - that is, students are not allowed back into the classroom until the hair and scalp are free of nits (eggs). Make a careful visual check to insure that all eggs have been removed. Many lice shampoo preparations recommend a second shampooing 7-10 days after the first.

If head lice have been experienced, it is recommended that beds, bedding (sheets, pillows, blankets, etc.) rugs, upholstered furniture, etc., be inspected. There are prepared sprays on the market that can help eliminate the problem.[21]

In recent years, as head lice have become increasingly resistant to traditional pharmaceutical interventions, many non-traditional treatments, such as oil or mayonnaise, are being purported as effective. It is strongly recommended that parents be advised to seek medical or pharmaceutical advice before trying one of the "new" home remedies, some of which may be unsafe or ineffective.

Additionally, there is now concern in the medical community about the toxicity of shampoos and treatments containing pesticides. According to the National Pediculosis Association the surest, most effective method of controlling head lice is manual removal of lice and nits.

[21] Sample Head-Lice parent letter and class letter, Section 4, *Forms*

Section 3. References and Resources

BED BUGS

What are bed bugs?

Bed bugs are small, wingless insects that have not been known to transmit disease. Adult bed bugs have flat, oval shaped bodies. They are between 1 to 7 millimeters in length (about the size of an apple seed). The size of an adult bed bug varies, because their bodies become larger after a blood meal. After eating they change to a reddish color. Bed bugs are usually active at night and bite humans and animals while they are sleeping. Bed bugs can live several months without feeding.

Can bed bugs make you sick?

Bed bugs are not known to transmit disease, but many people have mild to severe allergic reactions to the bites. Bed bug bite marks usually appear on the face, neck, arms, hands, but can appear on other body parts. The marks appear as slightly swollen areas that can itch or be irritating.

Bed bugs and School and Daycares

Bed bugs prefer an environment where they can hide during the day and come out at night to feed. Most schools and daycare settings do not offer this type of environment; however, bed bugs can hide in clothing and personal belongings such as backpacks and lunch bags. This provides them an opportunity to migrate and spread to other individuals.

Bed bug prevention

Schools are required to have a school Integrated Pest Management Program (IPM) in place that should address all forms of pests. It usually takes multiple visits by a licensed pest control operator who has experience in elimination of bed bugs. Over the counter foggers and pesticides will not eliminate bed bugs.

Trained staff should be available to identify bed bugs in the classroom, on children's items, and be able to identify bed bug bites on children. Please treat students respectfully and handle the situations discreetly. Information should be sent to students for their families and educational seminars should be held for the benefit of the school community.

Reference: Texas Department of State Health Services- Public Health Sanitation Program, 2/2011

EMERGENCY READINESS AND RESPONSE

Recommended first aid facilities

1. The first aid room and first aid kits should be in a centralized, convenient location.

2. A room should be available for isolation and/or rest for ill or injured students. A bed or a cot should be available.

3. Emergency telephone numbers should be posted conspicuously near a telephone.

4. A lavatory with hot and cold water should be available in or near the first aid room.

5. The first aid room and first aid kits should be equipped with an adequate amount of the proper first aid supplies based on needs and usages for the particular facility. The equipment should comply with the Red Cross Manual "Community First Aid and Safety," or another recognized first aid authority and a copy of a first aid manual should be readily available.

6. A registered nurse or licensed vocational nurse working under the direction of the registered nurse or person certified in first aid should be readily available at all times. First Aid certification should be through an authorized, recognized agency such as the American Red Cross. Per TCCED, guidelines, 2 fulltime employees are required to be certified in 1st Aid and CPR.

7. A written plan of action to provide emergency medical treatment to seriously ill or injured persons should be established, and emergency telephone numbers should be posted and readily available.

8. The first aid room should be kept clean at all times.

9. First aid supplies should be replaced as used so that adequate supplies will be available at all times **.**

Recommended first aid supplies for schools

1. Sterile gauze dressings, 4x4 inches, individually wrapped, for cleansing and roller bandage, two-inch wide, for bandaging sterile dressing over wounds or splints
2. Assorted adhesive dressings, including butterfly bandages
3. Roll of 1-inch wide adhesive tape
4. Roll of inch wide tape (paper or cloth)
5. Cotton balls (preferably 100% cotton)
6. Cotton tipped applicators
7. Mild soap for cleansing wounds
8. Blunt scissors
9. Tweezers
10. Oral thermometer (digital) and thermometer sheathes, or digital aural (ear) thermometer or temporal
11. Baggies for ice (single use)
12. Flashlight and batteries
13. Eye irrigation supplies
14. Blanket
15. Plastic covered pillow
16. Safety pins

17. Paper towels
18. Triangular bandages(s)
19. Elastic bandages (2 inch and 3 inch)
20. Plastic biohazard waste bags/box in secured spot
21. Disposable latex or latex-free gloves

Recommended first aid items to be kept on hand by coaches

1. Disposable latex or latex-free gloves
2. Paper towels
3. Paper bags (lunch size)
4. Plastic trash Bags
5. Knee and elbow bandages
6. Regular band-Aids (brands very)
7. Cotton balls
8. Antiseptic towelettes
9. Small envelopes for teeth
10. Ice
11. Plastic, ziploc-style baggies
12. Ace bandages, 2 inch, 3 inch, 4 inch
13. Basic first aid manual
14. Copy of emergency cards for each athlete
15. Accident, head injury and animal bite forms readily available

First aid items recommended for each classroom

1. Disposable latex or latex-free gloves
2. Paper towels
3. Plastic trash Bags
4. Knee bandages
5. Regular bandages (ex. Band-Aids)
6. Cotton balls
7. Antiseptic towelettes
8. Small envelopes/containers for teeth

ENVIRONMENTAL HEALTH

Lead in drinking water

Federal legislation passed in 1990 requires that schools test for and remedy lead contamination in drinking water. Pursuant to that passage of the law, Halsey-Taylor, the most popular manufacturer of school water fountains, published lists of models that were known to contain lead and conducted a wide-scale replacement program. Halsey-Taylor can be contacted at: 1.630.574.3500 or www.halseytaylor.com/

Lead pipes and solder can also contribute lead contamination to drinking water. The EPA (Environmental Protection Agency) requires that schools have on record proof of a one-time test for all drinking water supplies. These lead contamination tests are conducted by an environmental engineer or by an environmental laboratory, and are generally very reasonably priced. Local health and/or water departments can offer referrals for testing.

Indoor air quality

Various physical symptoms can develop in individuals who work or study in buildings where the quality of ambient air is compromised by poor ventilation, chemical fumes, paints, pesticides, cleaning agents, sewer gases, contaminated air conditioning/heat ducts, and combustion appliances. Such a condition is often referred to as "sick building syndrome." Complaints can include headache, nausea, lethargy dizziness, eye, nose and throat irritation, difficulty in concentrating and other similar symptoms. Because of their smaller body mass, children are especially susceptible to the contaminants in air. Corrective methods for poor indoor air quality include reducing exposure from known sources, ensuring adequate ventilation, and "air cleaning."

Your local health department or an environmental engineer can advise you if you suspect "sick building syndrome" in your school.

Ozone pollution

Ozone pollution is caused by the interaction of sunlight with air pollutants released by motor vehicles and factories. Ozone levels tend to be highest in more densely populated areas and in the warmer sunlight filled days. [23]
Ozone pollution can make breathing difficult, especially for those with known respiratory problems such as allergies, asthma, emphysema, and heart disease and seasonal illnesses. According to the American Academy of Allergy, Asthma and Immunology one in three persons is at risk of suffering ozone-related health problems. Since children breathe more rapidly than adults, they breathe more pollution per pound of body weight, and because their breathing passages are smaller they are more liable to become blocked when irritated. Precautions must be taken, especially for children and asthmatics. The following cautions are recommended:

- Keep track of air quality information on weather forecasts and on web sites.(www.tceq.state.tx.us/)
- Avoid outdoor activities and exercise when ozone levels are high or during an announced "ozone action day." (Ozone levels are typically highest in the afternoon)
- Insure that all buildings are adequately air conditioned and that air conditioning filters are clean and well-maintained
- Require that coaches and teachers keep children, especially children with known respiratory problems, inside during times when ozone levels are high

MSDS Sheets
Material safety data sheets are required to be maintained by the maintenance department. This reference is handy to have when a child may ingest soap or other agents that are required to have MSDS sheets.

Use of Insect Repellents (Amended 8/28/12)
Students DO NOT need to carry insect repellent to school. The risk of misuse or exposure to students allergic to the product far outweighs any potential benefit. Parents should consider reapplying a mosquito repellent if students are participating in after-school activities and will be outside in the evening hours. CDC recommends to “keep repellents out of reach of children and not allow young children to apply insect repellent to themselves.”
National Pesticide Information Center (NPIC): 1-800-858-7378 or npic.orst.edu
School employees and coaches are not to purchase or apply or provide insect repellent for students.

.

[23] Heat and Heat Index Guidelines and Cold Weather, section 3, *References and Resources*

MENTAL ILLNESS AND CHILDREN

United States Surgeon General David Satcher released a report in January 2001 describing a mental health crisis in children. Mental Illness, severe enough to hinder children from learning or developing appropriately is quite common. But fewer than one in five affected children get the help they need. Mental disorders are a major untreated problem in children. Insurance coverage for mental health is spotty at best. The report urges better access to care and suggests mental health training for doctors, teachers, welfare and juvenile justice workers. Recognizing and treating conditions such as depression can be a powerful contribution to children's lives.

- **Depression**

Depression in early childhood is defined as a pattern of depressed irritable mood with diminished interest or pleasure in developmentally appropriate activities, diminished capacity to protest, excessive whining, and diminished social interactions and initiative. This is accompanied by disturbances in sleep or eating and lasts for at least 2 weeks.

Depression affects up to one in 40 children. It involves the interplay of a genetic predisposition to depression, an imbalance of brain chemicals and events in child's life.

There is a strong link between mental disorders in parents and their children. When parents have major depression, their children are at increased risk for emotional and behavioral problems of their own. Depression in parents is associated with depression, social phobia, disruptive behavior disorder, separation anxiety disorder, multiple anxiety disorder, and/or poor social functioning in children.

Children may have many of the same symptoms as adults. In general, though, children are more likely to develop phobias, anxieties, physical complaints, behavior problems and hallucinations. In addition, the pattern of symptoms in children can vary by age.

Depression in parents and caregivers can worsen depression in children and vice versa.

The symptoms of depression usually develop over several days or weeks. Without treatment, the depression usually lasts between six months and a year. These children will often become depressed more than once.

Whenever there is concern that a child might be depressed, an evaluation is important. This might include blood tests or EEG's and structured interviews to support the diagnosis.

Depression in children may be treated with antidepressant medication and/or child therapy, such as cognitive behavioral therapy. The response to treatment in children can be quite good.

In addition, nurturing attention, adequate sleep and good nutrition can be helpful.

- **OCD**

It was once thought that obsessive-compulsive disorder was rare in children, but a careful evaluation published in the *Child and Adolescent Psychiatry Clinics of North America* in 1999 found that between 2% and 3% of all children will have the disorder sometime in childhood. The peak age is puberty, but even young children develop the disorder. Obsessions are ideas that dominate the mind and disrupt life; compulsions are irresistible impulses to perform some action outside one's conscious choice. The final issue of the *Journal of the American Medical Association* (JAMA) for the year 2000 lists the five most common obsessions and compulsions in children. Here are the five top obsessions:

- concern with dirt, germs, or environmental toxins
- concern that something terrible will happen such as fire, death or illness
- symmetry, order or exactness
- scrupulosity (religious obsessions)
- lucky/unlucky numbers and concern or disgust with body wastes or secretions (tie)

Comments: Alan Green, MD, FAAP 2001

- **Suicide**

Warning signs of suicide may include:

- verbalized suicide threats
- statements revealing a desire to die
- plans made regarding how suicide will be carried out
- previous suicide attempts
- acting daredevil acts; exhibit truancy or delinquent behavior
- hyperactive or manic behavior
- overeating or oversleeping
- sudden changes in behavior (withdrawal, apathy, moodiness)
- observable changes in peer relationships (social withdrawal, frequent absences, sudden difficulty with academic material)
- depression (crying, sleeplessness, loss of appetite, hopelessness)
- impulsive reactions connected with anger or acute humiliation
- frequent clinic visits with somatic complaints
- final arrangements (such as giving away personal possessions)

- **Eating Disorders**

Eating disorders, such as anorexia nervosa, bulimia nervosa and binge eating disorder are serious conditions. Children can become so preoccupied with food and weight that they focus on little else.

- Warning signs include: a sudden loss in appetite, frequent vomiting or use of laxatives may indicate an eating disorders.

- **Substance abuse**

Some children use drugs and alcohol to try and cope with their feelings. Please encourage the parents to consult their child's physician with the concerns about the child's behavior, both at home and at school.

How can we help?

As school health professionals and educators, we have the children in our care for 7-12 hours a day, depending on before school and after school care and activities.

Supporting and nurturing the child in Christ filled environment is truly offered in our Catholic Schools. This can be accomplished by providing consistent care and education of the child and meeting their individual needs.

Finding resources for parents/guardians is the key. Having school counselors is a luxury for some schools and if one is not available at your school, perhaps there is someone you can contact at another school in your Diocese. Talk with your principal, there may be people who can be contacted on the Diocesan level. Another idea is to check with the nearest children's hospital, asking for the psychiatric department. The intake person will be willing to share their vast knowledge with you.

Working with the parents/guardians to determine specific insurance needs and the nurse can provide information about Tex Care Health Insurance (Medicaid, CHIP or other private insurance).

1.877.543.7669 or www.CHIPmedicaid.org

REYES SYNDROME

Reye's Syndrome is a very serious disease that you should know about. Some people develop Reye's Syndrome as they are getting over a viral illness, such as the flu or chicken pox. Reye's Syndrome usually affects people from infancy through young adulthood; however, no age group is immune. Although Reye's generally occurs when someone is recovering from any viral illness, it can develop 3 to 5 days after the onset of the illness. Its main targets are the liver and brain, it is noncontagious, and too often is misdiagnosed as encephalitis, meningitis, diabetes, poisoning, drug overdose, or sudden infant death.

Early diagnosis is crucial. An individual should be watched during the next 2 to 3 weeks following a viral illness for these symptoms, usually occurring in this order:

*Relentless or continuous vomiting
*Listlessness (loss of pep and energy with little interest in their environment)
*Drowsiness (excessive sleepiness)
*Personality change (such as irritability, slurred speech, sensitivity to touch)
*Disorientation or confusion (unable to identify whereabouts, family members or answer questions) *Combativeness (striking out at those trying to help them)
*Delirium, convulsions or loss of consciousness

Reye's Syndrome should be suspected in anyone who vomits repeatedly. Phone your doctor immediately if these symptoms develop. Voice your concern about Reye's Syndrome. If your physician is unavailable, take the person to an Emergency Room promptly. Two liver function tests (SGOT, SGPT) can be done to determine the possibility of Reye's Syndrome. There is a 90% chance of recovery when the syndrome is treated in its earliest stages by physicians and nurses experienced in the treatment of Reye's.

Studies have shown that using aspirin or aspirin-containing medications to treat the symptoms of viral illnesses increases the chance of developing Reye's Syndrome. (Avoid: Aspirin, Pamprin, Excedrin and Aleve) If you or a member of your family has a viral illness, do not use aspirin or aspirin-containing medications.

In fact, you should consult your physician before you take any drugs, particularly aspirin or anti-nausea medicines, to treat flu, chicken pox or <u>any</u> viral illness. Anti-nausea medicines may mask the symptoms of Reye's Syndrome. (Avoid: Pepto-Bismol, Maalox, Kaopectate and Alka-Seltzer)

The National Reye's Syndrome Foundation (NRSF), the U.S. Surgeon General, the Food and Drug Administration and the Centers for Disease Control and Prevention recommend that aspirin and combination products containing aspirin not be taken by anyone under 19 years of age during fever-causing illnesses.

Aspirin is part of the salicylate family of medicines. Another name for aspirin is acetylsalicylate; some drug labels may use the words acetylsalicylate, acetylsalicylic acid, salicylic acid, salicylate, etc., instead of the word aspirin. Currently, there is no conclusive data as to whether other forms of salicylates are associated with the development of Reye's Syndrome. Until further research has answered this question, the NRSF recommends that products containing any of these substances not be taken during episodes of viral infections.

The NRSF is a non-profit, tax-exempt organization with affiliates located in 45 states. The NRSF has pioneered the movement to disseminate knowledge about the disease in an effort to aid in early diagnosis and also provides funds for research into the cause, cure, care, treatment and prevention of Reye's Syndrome.

For additional information, please contact: National Reye's Syndrome Foundation
426 N. Lewis Street
PO Box 829
Bryan, OH 43506-0829

Phone: 1-800-233-7393

www.reyessyndrome.org

Medications Containing Aspirin (Acetylsalicylate) and Aspirin-Like Products

Epidemiologic research has shown an association between the development of Reye's Syndrome and the use of aspirin-type products for treating symptoms of influenza-like illnesses and chicken-pox. The National Reye's Syndrome Foundation, U.S. Surgeon General, the Food and Drug Administration, and Centers for Disease Control and Prevention recommend that aspirin and combination products containing aspirin not be given to children or teenagers who are suffering from one of these illnesses. This listing shows products containing aspirin or salicylate compounds. THIS IS NOT A COMPLETE LIST! Some medication labels may use the words acetylsalicylate, acetylsalicylic acid, salicylic, salicylamide, phenyl salicylate, etc., instead of the word aspirin. There is not data as to other forms of salicylate other than aspirin associated with the development of Reye's Syndrome, but until further research has answered this question, we recommend products listing these substances not be used at all in children and adolescents, because a virus may already be present before symptoms appear. Product ingredients may be reformulated periodically, so always check the label. When in doubt ask your doctor or pharmacist.

NON-PRESCRIPTION PRODUCTS	
Alka-Seltzer*	Bayer
Anacin*	Whitehall Robins
Ascriptin*	Novartis
Bayer Aspirin*	Bayer
BC Powder*	Block
Bufferin*	Bristol-Myers
CVS Aspirin*	CVS Pharmacy
Doan's*	Novartis
Ecotrin*	SK Beecham
Excedrin*	Bristol-Myers
Goody's Aspirin*	Block
Kaopectate*	Pharmacia
Maalox*	Novartis
Norwich Aspirin*	Chattem
Rite Aid Aspirin*	Rite Aid
Pamprin*	Chattem
Pepto-Bismol*	Proctor and Gamble
St. Joseph*	Schering-Plough
Vanquish*	Bayer
YSP*	Carlsbad Technology

PRESCRIPTION PRODUCTS	
Acuprin 81 Adult Low Dose Aspirin	Richwood
Aggrenox Capsules	Boehringer-Ingelheim
Butalbital, Aspirin, Caffeine & Codeine Phosphate Capsules, USP	Watson
Carisoprodol and Aspirin Tablets	Par
Damason-P 5	
Darvon Compound-65 9	Lily
Disalcid Capsules and Tablets	3M
Easprin Delayed-Released Tablets	Lotus Biochemical
Empirin with Codeine No.32	
Endodan Tablets, USP CII	Endo Generics
Equagesic Tablets	Wyeth-Ayerst
Fiorinal Capsules and Tablets	Novartis
Fiorinal with Codeine Capsules	Novartis
Fiortal with Codeine Capsules	Geneva
Gelpirin Tablets	Alra
Halfprin Tablets	Kramer
Helidac therapy	Prometheus Labs
Lortab ASA Tablets	UCB
Magan Tablets	Savage

PRESCRIPTION PRODUCTS (Cont.)	
Magsal Tablets	U.S. Pharmaceutical
Methocarbamol & Aspirin Tablets	Par
Mono-Gesic Tablets	Schwarz
Myogesic	U.S. Pharmaceutical
Norgesic Forte Tablets	3M
Norgesic Tablets	3M
Oxycodone and AspirinTablets C-II	Watson
Panasal 5/500 5 PC Cap 9	
Percodan Tablets	Endo Labs
Propoxyphene Compound 65 Capsules (CIU)	Teva
Robaxisal Tablets	Robins
Roxiprin Tablets	Roxane
Salflex Tablets	Carnrick
Salsalate Tablets	Duramed
Soma Compound Tablets	Wallace
Synalgos-DC Capsules	Wyeth-Ayerst
Talwin Compound	Sanofi-Wintrhop
Trilistate Liquid & Tablets	Purdue Frederick

*To conserve space on our list, we have listed non-prescription products by brand name only. Please be aware these products come in many forms, strengths and flavors. Be sure to check the label for the Reye's Syndrome warning and/or any of the ingredients names listed in the above paragraph.

The following is a list of Antiemetics. Antiemetics are used to stop nausea. While Antiemetics do not contain aspirin, they can be associated with Reye's Syndrome because medications used to stop nausea can mask one of the first symptoms of Reye's. When every second counts in diagnosing Reye's it is vital for parents to question use of Antiemetics when prescribed during a viral illness. Aloxi Injection, Anzemet Injection and Tablets, Emend Capsuls, Kytril Injection, oral solution or Tablets, Marinol Capsules, Phenergan Suppositories and Tablets, Transderm Scope Transdermal Theraputic System, Zofran Injection, premixed, oral solution, Tablets and Orally disintegrating Tablets.

The following topical products are listed as they also contain forms of salicylates, while these products are not ingested through the mouth, certain ingredients may be absorbed through the skin and therefore a potential risk where Reye's Syndrome is concerned. Be sure to check ingredient labels. These products are not ingested and as such, not required to carry the aspirin warning.

- Acne Cleaners
- Acne Creams
- Arthritis Pain Rubs
- Astringents
- Cosmetics
- Dandruff Shampoos
- Exfoliating Moisturizers
- Facial Scrubs
- Facial Masques
- Lotion (Hand & Body
- Muscle Pain Relief Creams
- Perfume
- Sun Block
- Wart Removers
- Wintergreen Scented Oils

For More Information Contact the NRSF: National Reye's Syndrome Foundation, 426 N. Lewis Street, PO Box 829, Bryan, OH 43506-082

Toll Free: (800) 233-7393 Web: www.reyessyndrome.org E-Mail: nrsfKreyessyndrome.org

SICKLE CELL DISEASE

Sickle Cell Disease (SCD) is an inherited blood disorder of which there are several types, the most common being Sickle Cell Anemia. (Hb SS Disease) Approximately 1 in 400 African-American babies are born with this disease. Approximately 1 in 1000 African American babies have Sickle C Disease and the last is Sickle Beta Thalassemia. SCD is found predominantly in the African-American population but is also seen in people of other countries bordering the Mediterranean Sea, especially Italy and Greece and parts of the Middle East and Central India.

SCD is an inherited blood disorder caused by an abnormality in the red blood cell and the person with CSD, the red blood cells are abnormal in shape, and the cells clog in the blood vesicles. This clogging can lead to pain and organ and tissue damage. Additionally the sickle cell life span is only 6-14 days, as normal red blood cells lasts approximately 120 days and this leads to chronic anemia in the child.

Children with SCD are at increased risk for developing infections, and some types of infections are life threatening and require antibiotics. When a child with SCD shows any signs of having an infection, please notify their parent who can in turn notify their physician immediately.

Signs/Symptoms are:

- Child complains of pain
- Child unwilling to use extremity
- Swelling

Stroke:

- Seizures
- Paralysis
- Unsteady walk
- Slurred speech
- Changes in vision
- Weakness

Infection:

- Fever 101^{o} degrees or higher
- Rapid breathing
- Unusual sleepiness
- Coughing
- Irritability
- Paleness
- Difficulty breathing

Other symptoms that should be reported:

- Rapid breathing or heartbeat
- Pain in left side of abdomen
- Headache
- Fainting
- Chest Pain
- Congested cough

Activity: A child with SCD should be able to participate in physical activity when they are not having a painful episode or ill. It is important that the child participates as much as possible. It is VERY IMPORTANT to prevent dehydration in children with SCH. They will need plenty of fluids before, during and after any activity. They need to avoid becoming overheated or fatigued. Due to their chronic anemia, they may need more frequent rest times, and avoid being exposed to cold temperatures.

An accommodation plan from the physician and parent will guide the school with a plan of care, tailored for this child.

References: Texas Department of State Health Services, 2011
National Institutes of Health, Division of Blood Diseases and Resources

FERPA (Family Education Rights and Privacy Act)

FERPA is the protector of the privacy information entered into a student's record, including health related information. (NOT HIPPA) (See explanation in the preamble, on page 82483 of the Federal Register for December 28, 2000. Vol. 65, no. 250)

FERPA applies to any public or private entity that receives federal funds from a program administered by the Department of Education. Parents have the right to review their child's "education record," defined as "those records, files, document and other materials which contain information directly related to a student, and are maintained by a person acting for such agency or institution." When a student becomes 18 years of age or is attending college, the right to view the record transfers to the student. Parents may request corrections of the records, with opportunity for a hearing if necessary.

With some exceptions, personally identifiable information in a student's record, except "directory information" may not be released by the school to a third party without a parent's written consent. Directory information is defined to mean "the student's name, address, telephone listing, date and place of birth, major field of study, participation in officially recognized activities and sports, weight and height of members of athletic teams, dates of attendance, degrees and awards received, and the most recent previous educational agency or institution attended by the student." Public notice must be given of the content of the directory information, with a reasonable time for parents to refuse to allow release of the data.

In 2002, Congress amended FERPA to require schools to provide students' names, addresses and telephone numbers to military recruiters who request it typically for junior and senior high school students. There are some other exceptions to the privacy requirement.

- A school may release information including disciplinary actions taken against a student, to school officials, including teachers, who have a "legitimate educational interests."
- The education record can be sent to another school or school system in which the student seeks to enroll, upon condition that parents are notified and receive a copy of the record and opportunity to challenge it.
- FERPA allows a school to release personally identifiable student data for purposes of federal, state or local audits: for law enforcement; and for some education research (provided the information will be destroyed when no longer needed.)
- Student education records can be released without prior consent in an emergency when the information is necessary to protect the health or safety of the student or other person, and during the investigation of acts of terrorism.
- "Need to know" regulations in Section 99.31 (a) state that an educational agency or institution may disclose personally identifiable information from an education record of a student without prior consent "if the disclosure is to other school officials, including teachers, within the agency or institution has determined to have legitimate educational interests." It is possible that state law or local practice may require prior consent, but FERPA does not.

When FERPA does not apply

When health care is made available to students on school property but is provided by a non-school institution or agency such as a hospital or community health center, health records of students who use the facility are retained by the health care providers and are subject to the privacy requirements of HIPPA, meaning they cannot be released to school personnel or other third parties without parental permission. These records will therefore not be entered into the student's "education record" by school personnel and their privacy is protected by HIPPA, not FERPA.

HIPPA AND SCHOOLS

There are 3 areas where HIPPA may impact schools.

1. Do you have a school-based health center (not the school nurse) operated by a hospital, clinic or government health department?

2. Do you have a school nurse? Does the nurse submit claims to pay for his or her services? Are those claims submitted electronically?

3. Do the schools in your Diocese receive medical data about students directly from health care providers such as doctors and hospitals?

Only if you answered yes to all three of these questions is there a need for you to become more familiar with HIPPA and its requirements. HIPPA's provisions are triggered when a provider of health care (the nurse) submits claims electronically.

References:
InFocus, January 13, 2003 Health and Healthcare in Schools, Vol. 4, No.4, June 2003
Minnesota Department of Education, Information Policy Analysis Division, May 2006

Thanks to Carol Reynolds, retired Catholic Charities Fort Worth, Texas

Texas Notifiable Conditions

24/7 Number for Immediately Reportable– 1-800-705-8868

Report confirmed and suspected cases.

Unless noted by *, report to your local or regional health department using number above or find contact information at http://www.dshs.state.tx.us/idcu/investigation/conditions/contacts/

A – I	When to Report	L – Y	When to Report
***Acquired immune deficiency syndrome (AIDS)**[12]	Within 1 week	***Lead, child blood, any level & adult blood, any level**[6]	**Call/Fax Immediately**
Amebiasis[3]	Within 1 week	Legionellosis	Within 1 week
Amebic meningitis and encephalitis	Within 1 week	Leishmaniasis	Within 1 week
Anaplasmosis	Within 1 week	Listeriosis[3]	Within 1 week
Anthrax[3, 4]	**Call Immediately**	Lyme disease	Within 1 week
Arbovirus infection[3,5]	Within 1 week	Malaria	Within 1 week
***Asbestosis**[6]	Within 1 week	**Measles (rubeola)**	**Call Immediately**
Babesiosis	Within 1 week	**Meningococcal infections, invasive**[3]	**Call Immediately**
Botulism (adult and infant)[3,4]	**Call Immediately**	Mumps	Within 1 week
Brucellosis[3,4]	**Within 1 work day**	**Pertussis**[3]	**Within 1 work day**
Campylobacteriosis	Within 1 week	***Pesticide poisoning, acute occupational	Within 1 week
***Cancer**[7]	See rules	**Plague (*Yersinia pestis*)**[3]	**Call Immediately**
Chagas' disease	Within 1 week	**Poliomyelitis, acute paralytic**	**Call Immediately**
***Chancroid**	Within 1 week	**Poliovirus infection, non-paralytic**	**Within 1 work day**
Chickenpox (varicella)[8]	Within 1 week	**Q fever**	**Within 1 work day**
***Chlamydia trachomatis* infection**	Within 1 week	**Rabies, human**	**Call Immediately**
***Contaminated sharps injury**[9]	Within 1 month	Relapsing fever	Within 1 week
***Controlled substance overdose**[10]	**Call Immediately**	**Rubella (including congenital)**	**Within 1 work day**
Creutzfeldt-Jakob disease (CJD)	Within 1 week	Salmonellosis, including typhoid fever	Within 1 week
Cryptosporidiosis	Within 1 week	**Severe Acute Respiratory Syndrome (SARS)**	**Call Immediately**
Cyclosporiasis	Within 1 week	Shigellosis	Within 1 week
Cysticercosis	Within 1 week	*Silicosis	Within 1 week
*Cytogenetic results (fetus and infant only)[11]	See rules	**Smallpox**	**Call Immediately**
Dengue	Within 1 week	*Spinal cord injury[12]	Within 10 work days
Diphtheria	**Call Immediately**	Spotted fever group rickettsioses[3]	Within 1 week
*Drowning/near drowning[12]	Within 10 work days	**Staph. aureus, vancomycin-resistant (VISA and VRSA)**[3]	**Call Immediately**
Ehrlichiosis	Within 1 week	Streptococcal disease (group A, B, *S. pneumo*), invasive	Within 1 week
Escherichia coli infection, Shiga toxin-producing[3,4]	Within 1 week	*Syphilis – primary and secondary stages[1,13]	Within 1 work day
***Gonorrhea**	Within 1 week	*Syphilis – all other stages[1,13]	Within 1 week
Haemophilus influenzae type b infections, invasive[3]	Within 1 week	*Taenia solium* and undifferentiated *Taenia* infection	Within 1 week
Hansen's disease (leprosy)[3]	Within 1 week	Tetanus	Within 1 week
Hantavirus infection[3]	Within 1 week	*Traumatic brain injury	Within 10 work days
Hemolytic Uremic Syndrome (HUS)[3]	Within 1 week	Trichinosis[3]	Within 1 week
Hepatitis A(acute)	**Within 1 work day**	**Tuberculosis (includes all *M. tuberculosis* complex)**[4,14]	**Within 1 work day**
Hepatitis B, C, and E (acute) [3]	Within 1 week	**Tularemia**[3]	**Call Immediately**
Hepatitis B identified prenatally or at delivery (acute & chronic)[3]	Within 1 week	Typhus	Within 1 week
Hepatitis B, perinatal (HBsAg+ < 24 months old) [3]	**Within 1 work day**	**Vibrio infection, including cholera**[3]	**Within 1 work day**
***Human immunodeficiency virus (HIV) infection**[1,2]	Within 1 week	**Viral hemorrhagic fever, including Ebola**	**Call Immediately**
Influenza-associated pediatric mortality	**Within 1 work day**	**Yellow fever**	**Call Immediately**
Influenza, Novel	**Call Immediately**	Yersiniosis[3]	Within 1 week

In addition to specified reportable conditions, ***any outbreak, exotic disease, or unusual group expression of disease that may be of public health concern should be reported*** *by the most expeditious means available*

***See condition-specific footnote for reporting contact information**

1 Please refer to specific rules and regulations for HIV/STD reporting and who to report to at: http://www.dshs.state.tx.us/hivstd/healthcare/reporting.shtm.
2 Labs conducting confirmatory HIV testing are requested to send remaining specimen to a CDC-designated laboratory. Please call 512-533-3132 for details.
3 Reporting forms are available at http://www.dshs.state.tx.us/idcu/investigation/forms/. Investigation forms at http://www.dshs.state.tx.us/idcu/investigation/ Call as indicated for immediately reportable conditions.
4 Lab isolate must be sent to DSHS lab. Call 512-776-7598 for specimen submission information.
5 Reportable Arbovirus infections include neuroinvasive and non-neuroinvasive California serogroup including Cache Valley, Eastern Equine (EEE), Dengue, Powassan, St. Louis Encephalitis (SLE), West Nile, and Western Equine (WEE).
6 Please refer to specific rules and regulations http://www.dshs.state.tx.us/epitox/default.shtm.
7 Please refer to specific rules and regulations for cancer reporting and who to report to at http://www.dshs.state.tx.us/tcr/reporting.shtm.
8 Varicella reporting form at http://www.dshs.state.tx.us/idcu/health/vaccine_preventable_diseases/forms/NewVaricellaForm.pdf. Call local health dept for copy with their fax number.
9 Not applicable to private facilities. Initial reporting forms for Contaminated Sharps at http://www.dshs.state.tx.us/idcu/health/infection_control/bloodborne_pathogens/reporting/.
10 Contact local poison center at 1-800-222-1222. For instructions, forms, and fax numbers see http://www.dshs.state.tx.us/epidemiology/epipoison.shtm#rcso.
11 Report cytogenetic results including routine karyotype and cytogenetic microarray testing (fetus and infant only). Please refer to specific rules and regulations for birth defects reporting and who to report to at http://www.dshs.state.tx.us/birthdefects/BD_LawRules.shtm.
12 Please refer to specific rules and regulations for injury reporting and who to report to at http://www.dshs.state.tx.us/injury/rules.shtm.
13 Laboratories should report syphilis test results within 3 work days of the testing outcome.
14 MTB complex includes *M. tuberculosis, M. bovis, M. africanum, M. canettii, M. microti, M. caprae, and M. pinnipedii.* Please see rules at http://www.dshs.state.tx.us/idcu/disease/tb/reporting

Texas Department of State Health Services – Business Hours 1-800-252-8239 / After Hours 512-776-7111

E59-11364 (Rev. 01/13) Expires 1/31 /14 -- Go to http://www.dshs.state.tx.us/idcu/investigation/conditions/ or call your local or regional health department for updates.

COMMUNICABLE DISEASE CHART FOR SCHOOLS AND CHILD-CARE CENTERS, revised 3/2013

The major criterion for exclusion from attendance is the probability of spread of disease from person to person.
A child could have a noncommunicable illness yet require care at home or in a hospital.

Condition	Methods of Transmission	Incubation Period	Signs and Symptoms	Exclusion[1]	Readmission Criteria[1]	Reportable Disease[2,3]	Prevention, and Treatment, and Comments
AIDS HIV Infection	Direct contact with blood and body fluids	Variable	-Weight loss, generalized swelling of the lymph nodes, failure to thrive, chronic diarrhea, tender spleen and liver -Individuals can be asymptomatic.	No, unless determined necessary by health-care provider[4]	Not applicable	Yes, but schools are not required to report	- Use standard precautions* - Educate adolescents about viral transmission through sexual contact and sharing of equipment for injection
Amebiasis	-Eating fecally-contaminated food or drinking fecally contaminated water	Range 2-4 weeks	-Intestinal disease may vary from asymptomatic to acute dysentery with bloody diarrhea, fever, and chills.	Yes	Treatment has begun	Yes	Teach effective hand washing [+]
Campylo-bacteriosis	-Eating fecally-contaminated food	Range 1-10 days Commonly 2-3 days	Diarrhea, abdominal pain, fever, nausea, vomiting	Yes	Diarrhea free [5] and fever free [6]	Yes	-Teach effective hand washing [+]
Chickenpox (Varicella) (also see Shingles)	-Contact with the chickenpox rash -Breathing in respiratory droplets containing the pathogen after an infected person exhales, sneezes, or coughs	Range 10-21 days Commonly 14-17 days	-Fever and rash can appear first on head and then spread to body -Usually two or three crops of new blisters that heal, sometimes leaving scabs -Disease in vaccinated children can be mild or absent of fever with few lesions, which might not be blister-like	Yes	Either 1) lesions are dry or 2) lesions are not blister-like and 24 hours have passed with no new lesions occurring	Yes	-**Vaccine available and required** [7] -Pregnant woman who have been exposed should consult their physician
Common cold	-Breathing in respiratory droplets, containing the pathogen after an infected person exhales, sneezes, or coughs -Direct contact with respiratory secretions from an infected person -Touching a contaminated object then touching mouth, nose or eyes	Range 1-5 days Commonly 2 days	Runny nose, watery eyes, fatigue, coughing and sneezing.	No, unless fever	Fever free [6]	No	-Teach effective hand washing [+] and good respiratory hygiene and cough etiquette [+] -Colds are caused by viruses; and antibiotics are not indicated
Conjunctivitis Bacterial or Viral (Pink Eye)	-Touching infected person's skin, body fluid, or a contaminated surface	Bacterial: Range 1-3 days Viral: Range 12 hours to 12 days	Red eyes, usually with some discharge or crusting around the eyes	Yes	Permission and/or permit is issued by a physician or local health authority [8] or until symptom free	No	-Teach effective hand washing [+] -Allergic conjunctivitis can be confused with bacterial and viral conjunctivitis

Condition	Methods of Transmission	Incubation Period	Signs and Symptoms	Exclusion[1]	Readmission Criteria[1]	Reportable Disease[2,3]	Prevention, Treatment, and Comments
Coxsackie Virus Diseases (Hand, Foot, & Mouth)	-Breathing in respiratory droplets containing the pathogen after an infected person exhales, sneezes, or coughs -Touching feces or objects contaminated with feces, then touching mouth	Range 3-5 days	-Rash in mouth, hands (palms and fingers), and feet (soles)	No, unless fever	Fever free[6]	No	-Teach effective hand washing[+] and use standard precautions
Crypto-sporidiosis	-Eating fecally-contaminated food or drinking fecally-contaminated water	1-12 days, Commonly 7 days	-Diarrhea, which may be profuse and watery, preceded by loss of appetite, vomiting, abdominal pain -Infected persons might not have symptoms but can spread the infection to others	Yes	Diarrhea free[5] and fever free[6]	Yes	-Teach effective hand washing[+]
Cyto-megalovirus (CMV) infection	-Mucous membrane contact with saliva and urine	Range unknown under usual circumstances	-Usually only fever	No, unless fever	Fever free[6]	No	-Teach effective hand washing and use standard precautions[*] -Pregnant women who have been exposed should consult their physician
Diarrhea	-Eating fecally-contaminated food or drinking fecally-contaminated water, or having close contact with an infected person	Variable	-Three or more episodes of loose stools in a 24 hour period	Yes	Diarrhea free[5]	Yes, for certain conditions[5]	-A variety of bacterial, viral, and parasitic agents can cause diarrhea -Teach effective hand washing[+]
Escherichia coli (E.coli) Infection Shiga Toxin-Producing	-Eating fecally-contaminated food or drinking	Range 1-10 days Commonly 3-4 days	-Profuse, watery diarrhea, sometimes with blood and/or mucous and abdominal pain fever and vomiting	Yes	Diarrhea free[5] and Fever free[6]	Yes, if Shiga toxin-producing	-Teach effective hand washing[*]
Fever	Variable by condition	Variable	-A temperature of 100^{o} Fahrenheit (37.8^{o} Celsius) or higher -Measure when no fever suppressing medications are given	Yes	Fever free[6]	No	-Children should not be given aspirin for symptoms of any viral disease, confirmed or suspected, without consulting a physician
Fifth disease (Human Parvovirus)	-Breathing in respiratory droplets containing the pathogen after an infected person exhales, sneezes, or coughs	Range 4- 20 days	-Redness of the cheeks and body -Rash can reappear -Fever does not usually occur	No, unless fever	Fever free[6]	No	-Pregnant woman who have been exposed should consult their physician -Teach effective hand washing[+] good respiratory hygiene and cough etiquette[+]

Condition	Methods of Transmission	Incubation Time	Signs and Symptoms	Exclusion[1]	Readmission Criteria[1]	Reportable Disease[2,3]	Prevention and Treatment and Comments
Gastro-enteritis Viral	-Eating fecally-contaminated food or drinking fecally-contaminated water or having close contact with an infected person	Range a few hours to months Commonly 1-3 days	-Nausea and diarrhea -Fever does not usually occur	Yes	Diarrhea free[5] and Fever free[6]	No	-Teach effective hand washing* -Can spread quickly in child-care facilities
Giardiasis	-Close contact with an infected person, drinking fecally-contaminated water	Range 3-25 days or longer Commonly 7-10 days	-Nausea, bloating, pain, and foul-smelling diarrhea; can recur several times over a period of weeks	Yes	Diarrhea free[5]	No	-Treatment is recommended -Teach effective hand washing+ -Can spread quickly in child-care facilities
Head lice (Pediculous)	-Direct contact with infected persons and objects used by them	Commonly 7-10- days	-Itching and scratching of scalp -Presence of live lice or pinpoint-sized white eggs (nits) that will not flick off the hair shaft	No	Not applicable	No	-Treatment is recommended -Teach importance of not sharing combs, brushes, hats, and coats -Check household contacts for evidence of infestation
Hepatitis A	-Touching feces or objects contaminated with feces, then touching mouth	Range 15-50 days Commonly 25-30 days	-Most children have no symptoms; some have flu-like symptoms or diarrhea -Adults can have fever, fatigue, nausea and vomiting, anorexia, and abdominal pain -Jaundice, dark urine, or diarrhea might be present	Yes	One week after onset of symptoms	Yes, within one work day	**-Vaccine available and required[7]** -Teach effective hand washing+ -Infected persons should not have any food handling responsibilities
Hepatitis B	-Direct contact with blood and body fluids	Range 2 weeks – 9 months Commonly 2-3 months	-Gradual onset of fever, fatigue, nausea, or vomiting, followed by jaundice -Frequently asymptomatic in children	No	Not applicable	Yes, acute only	**-Vaccine available and required[7]** -Do not share personal hygiene items -Use standard precautions* -Educate adolescents about viral transmission through sexual contact and sharing of equipment for injection
Herpes simplex (Cold sores)	-Touching infected person's skin, body fluid, or contaminated surface	First infection, 2-17 days	-Blisters on or near lips that open and become covered with a dark crust. -Recurrences are common	No	Not applicable	No	-Teach importance of good hygiene - Avoid direct contact with lesions -Antivirals are sometimes used

Condition	Methods of Transmission	Incubation Time	Signs and Symptoms	Exclusion[1]	Readmission Criteria[1]	Reportable Disease[2,3]	Prevention and Treatment and Comments
Impetigo	-Touching an infected person's skin, body fluid or contaminated surface -Breathing in respiratory droplets containing the pathogen after an infected person exhales, sneezes, or coughs	Variable, Commonly 4-10 days	-Blisters on skin (commonly hands and face) which open and become covered with a yellowish crust -Fever does not usually occur	No, unless blisters and drainage cannot be contained and maintained in a clean dry bandage	Blisters and drainage can be contained and maintained in a clean dry bandage	No	-Teach effective hand washing*
Infections (Wound, Skin, or Soft Tissue)	-Touching infected person's skin, body fluid, or a contaminated surface	Variable	-Draining wound	None, unless drainage from wounds or skin and soft tissue infections cannot be contained and maintained in a clean dry bandage	Drainage from wounds or skin and soft tissue infections can be contained and maintained in a clean dry bandage	No	-Restrict from activities that could result in the infected area becoming exposed, wet, soiled, or otherwise compromised -Do not share personal care items -Disinfect reusable items -Use proper procedure for disposal of contaminated items
Influenza (Flu)	-Breathing in respiratory droplets containing the pathogen after an infected person exhales, sneezes, or coughs -Direct contact with respiratory secretions from an infected person -Touching a contaminated surface then toughing mouth, nose, or eyes	Range 1-4 days	-Rapid onset of fever, headache, sore throat, dry cough, chills, lack of energy, and muscle aches -Children can also have nausea, vomiting, or diarrhea	Yes	Fever free[6]	No, except for pediatric influenza deaths, novel influenza, or outbreaks[9]	-**Vaccine available and recommended**[7] Annually for all persons ages 6 months and older -Teach effective hand washing* and good hygiene and cough etiquette*
Measles (Rubeola)	Breathing in respiratory droplets containing the pathogen after an infected person exhales, sneezes or coughs	Range 7-21 days Commonly 2-12 days	-Fever, followed by runny nose, watery eyes, and dry cough -A blotchy red rash, which usually begins on the face, appears between the third and seventh day	Yes	Four days after onset of rash	Yes, call immediately	-**Vaccine available and required**[7] -Pregnant women who have been exposed should consult their physician
Meningitis, Bacterial	-Direct contact with respiratory secretions from an infected person -Breathing in respiratory droplets containing the pathogen after an infected person exhales, sneezes, or coughs	Variable Commonly 2-10 days	Sudden onset of fever and headache -May have stiff neck, photophobia, and/or vomiting	Yes	Written permission and/or permit is issued by a physician or local health authority[8]	Yes, for certain pathogens[3] and outbreaks[9]	- **Vaccine available and required**[7] for Haemophilus influenza type B, meningococcal disease, and pneumococcal disease -Teach effective hand washing* and good respiratory hygiene and cough etiquette* -Only a laboratory test can determine if meningitis is bacterial

Condition	Methods of Transmission	Incubation Time	Signs and Symptoms	Exclusion[1]	Readmission Criteria[1]	Reportable Disease[2,3]	Prevention and Treatment and Comments
Meningitis, Viral (Aseptic Meningitis)	-Varies by virus causing illness -May include: - Direct contact with respiratory secretions from an infected person -Breathing in respiratory droplets containing the pathogen after an infected person exhales, sneezes, or coughs -Touching feces or objects contaminated with feces or virus, then touching the mouth	Variable Commonly 2-10 days	-Sudden onset of fever and headache -May have stiff neck, photophobia, and/or vomiting	No, unless fever	Fever free[6]	Yes, for certain pathogens[3] and outbreaks[9]	-Teach effective hand washing[*] and good respiratory and hygiene and cough etiquette[*] -Viral meningitis is caused by viruses; antibiotics are not indicated -Only a laboratory test can determine if meningitis is viral
Meningo-coccal Infections (Meningitis and Blood Stream Infections caused by *Neisseria meningitidis*	-Direct contact with respiratory secretions from an infected person -Breathing in respiratory droplets containing the pathogen after an infected person exhales, sneezes, or coughs	Range 2-10 days Commonly 3-4 days	-Sudden onset of fever, intense headache, nausea, and often vomiting, stiff neck, and photophobia -May have a reddish or purplish rash on the skin or mucous membranes	Yes	Until effective treatment and approval by health-care provider[4]	Yes, call immediately	-**Vaccine available and required**[7] -Prophylactic antibiotics might be recommended for close contacts -In an outbreak, vaccine might be recommended for persons likely to have been exposed
Mono-nucleosis, Infections (Epstein Barr Virus)	-Spread by oral route through saliva, e.g. kissing, mouthing toys, etc.	Commonly 30-50 days	-Variable -Infants and young children are generally asymptomatic -Symptoms, when present, include fever, fatigue, swollen lymph nodes, and sore throat	Yes	Physician approval or [3]until fever free[6]	No	-Minimize contact with saliva and/or nasal discharges -Teach effective hand washing[*] -Sanitize surfaces and shared items -No athletic sports without health-care provider approval
Mumps	-Breathing in respiratory droplets containing the pathogen after an infected person exhales, sneezes, or coughs	Range 12-25- days Commonly 14-18 days	-Swelling beneath the jaw in front of one or both ears	Yes	Five days from onset of swelling	Yes	-**Vaccine available and required**[7]
Otitis Media (Earache)	-Can follow an infectious condition, such as a cold, but not contagious itself	Variable	-Fever, ear pain	No, unless fever	Fever free[6]	No	-Antibiotics are indicated for acute otitis media
Pertussis (Whooping Cough)	-Breathing in respiratory droplets containing the pathogen after an infected person exhales, sneezes, or coughs	Range 4-21 days Commonly 7-10 days	-Low-grade fever, runny nose, and mild cough lasting 1-2 weeks, followed by coughing fits, "whooping" sound followed on inspiration, and often vomiting after coughing	Yes	Completion of five consecutive days of appropriate antibiotic therapy	Yes, within one work day	-**Vaccine available and required**[7] -Teach respiratory hygiene and cough etiquette[+] -Vaccine and/or antibiotics might be recommended for contacts

Condition	Methods of Transmission	Incubation Time	Signs and Symptoms	Exclusion[1]	Readmission Criteria[1]	Reportable Disease[2,3]	Prevention and Treatment and Comments
Pharyngitis, Nonstrepto-coccal (Sore Throat)	-Not always contagious -If contagious, transmission varies by pathogen -Can include: - Direct contact with respiratory secretions from an infected person -Breathing in respiratory droplets containing the pathogen after an infected person exhales, sneezes, or coughs - Touching feces or objects contaminated with feces or virus, than touching mouth	Variable	-Fever, sore throat, often with large, tender lymph nodes in neck	No, unless fever	Fever free[6]	No	-Non-streptococcal pharyngitis is caused by a virus; antibiotics are not indicated -Teach effective hand washing[*] and good respiratory hygiene and cough etiquette[+]
Pinworms	-Touching feces or objects contaminated with feces, then touching mouth	Range 2 weeks ->2months Commonly 4-6 weeks	-Perianal itching	No	Not applicable	No	-Treatment recommended -Teach effective hand washing[*] -Check household contact for infestations
Ringworm (Body or Scalp)	-Touching an infected person's skin, body fluid, or a contaminated surface	Range 4-21 days	-Slowly spreading, flat, scaly, ring-shaped lesions on skin -Margins can be reddish and slightly raised -May cause bald patches	No, unless infected area cannot be completely covered by clothing or a bandage	Infected area can be completely covered by clothing or a bandage or treatment has begun	No	-Ringworm is caused by a fungus -Treatment is recommended -Teach importance of not sharing combs, brushes, hats, and coats
Respiratory Syncytial Virus (RSV)	-Direct or close contact with respiratory and oral secretions	Range 2-8 days Commonly 4-6 days	-Mostly seen in children younger than 2 years of age -Cold-like signs or symptoms, irritability, and poor feeding -May present with wheezing and episodes of turning blue when coughing	No, unless fever	Fever free[6]	No	-Teach effective hand washing[*] and good respiratory hygiene, and cough etiquette[+]
Rubella (German Measles)	-Breathing in respiratory droplets containing the pathogen after an infected person exhales, sneezes, or coughs	Range 12-23 days Commonly 14-18 days	-Cold-like symptoms, swollen and tender glands at the back of the neck, fever, changeable pink rash on face and chest	Yes	Seven days after onset of rash	Yes, within one work day	-**Vaccine available and required**[7] -Pregnant women who have been exposed should consult their physician

Condition	Methods of Transmission	Incubation Time	Signs and Symptoms	Exclusion[1]	Readmission Criteria[1]	Reportable Disease[2,3]	Prevention and Treatment and Comments
Salmonellosis	-Eating fecally-contaminated food or drinking fecally-contaminated water or having close contact with an infected person	Range 6-72 hours Commonly 12-36 hours	-Fever, abdominal pain, diarrhea	Yes	Diarrhea free[5] and fever free[6]	Yes	-Teach effective hand washing[*]
Scabies	-Touching infected person's skin, body fluid , or a contaminated surface	First infection 2-6 weeks	-Small raised an red bumps or blisters on skin with severe itching, often on thighs, arms, and webs of fingers	Yes	Treatment has begun	No	-Teach importance of no sharing clothing -Can have rash and itching after treatment but will subside
Shigellosis	-Eating fecally – contaminated food, drinking fecally-contaminated water, or having close contact with an infected person	Range 1-7 Days Commonly 2-3 days	-Fever, vomiting, diarrhea, which can be bloody	Yes	Diarrhea free[5] and fever free[6]	Yes	-Teach effective hand washing[*] -Can spread quickly in child-care facilities
Shingles	-Contact with fluid from blisters either directly or on objects recently in contact with the rash	Variable, often activated by aging, stress, or weakened immune system. Only occurs in people who have previously had chickenpox	-Area of skin, usually on one side of the face or body, has tingling or pain followed by a rash that may include fluid filled blisters -The blisters scab over in 7-10 days	Yes, if the blisters cannot be covered by clothing or dressing	Lesions are dry or can be covered	No	-Contact with the shingles rash can cause chickenpox in a child that has not had chickenpox -Shingles vaccine is available for persons 50 years and older
Sinus Infection	-Can follow an infectious condition, such as a cold, but not contagious	Variable	-Fever, headache, greenish to yellowish mucus for more than one week	No, unless fever	Fever free[6]	No	-Antibiotics are indicated only for long-lasting or sever sinus infections
Streptococcal Sore Throat and Scarlet Fever	-Direct contact with respiratory secretions from an infected person -Breathing in respiratory droplets containing the pathogen after an infected person exhales, sneezes, or coughs	Range 1-3 days	-Fever, sore throat, often with large, tender lymph nodes in neck -Scarlet fever-producing strains of bacteria cause a fine, red rash that appears 1-3 days after onset of sore throat	Yes	Effective antibiotic treatment for 24 hours and fever free[6]	No	-Streptococcal sore throat can only be diagnosed with a laboratory test -Teach effective hand washing[*] and good respiratory hygiene and cough etiquette[+]
Tuberculosis, Pulmonary	-Breathing in respiratory droplets containing the pathogen after an infected person exhales, sneezes, or coughs	Variable	-Gradual onset of fatigue, anorexia, fever, failure to gain weight, and cough	Yes	Antibiotic treatment has begun AND a physician's certificate or health permit obtained	Yes, within one work day	-Teach good respiratory hygiene and cough etiquette[+]

Condition	Methods of Transmission	Incubation Time	Signs and Symptoms	Exclusion[1]	Readmission Criteria[1]	Reportable Disease[2,3]	Prevention, and Treatment, and Comments
Typhoid Fever (*Salmonella* Typhi)	-Eating fecally-contaminated food or drinking fecally-contaminated water	Range 3->60 days Commonly 8-14 days	-Sustained fever, headache, abdominal pain, fatigue, weakness	Yes	Diarrhea free[5] and fever free[6], antibiotic treatment has been completed and 3 consecutive stool specimens have tested negative for *S.Typhi*	Yes	-Teach effective hand washing[*] -Disease is almost always acquired during travel to a foreign country

Footnotes

[1]Criteria include exclusions for conditions specified in the Texas Administrative Code (TAC), Rule 97.7, Diseases Requiring Exclusions from Schools. A school or a child-care facility administrator might require a note from a parent or health-care provider for readmission regardless of the reason for the absence. Parents in schools must follow school or district policies and contact them if there are questions. For day-care facilities, follow your facility's policies, contact your local Child-Care Licensing inspector or contact your local Licensing office. A list of the offices is available at: http://www.dfps.state.tx.us/Child_Care/Local_Child_Care_Licensing_Offices/ or refer to TAC Chapters 744, 746, and 747.

[2]Report confirmed and suspected cases to your local or regional health department. Report within one week – unless required to report earlier as noted on this chart. You can call (800) 705-8868 or locate appropriate reporting fax and phone numbers for your county at: http://www.dshs.state.tx.us/idcu/investigation/conditions/contacts.

[3]An up-to-date list of Texas reportable conditions and reporting forms are available at: http://www.dshs.state.tx.us/idcu/investigation/conditions/.

[4]Health-care provider – physician, local health authority, advance practice nurse, physician's assistant.

[5]Diarrhea free for 24 hours without the use of diarrhea suppressing medications. Diarrhea is 3 or more episodes of loose stools in a 24 hour period.

[6]Fever free for 24 hours without the use of fever suppressing medications. Fever is a temperature of 100^{o} Fahrenheit (37.8 ^{o} Celsius) or higher.

[7]Many disease are preventable by vaccination, which might be required for school or day-care attendance. The current vaccine requirements can be found at http://www.dshs.state.tx.us/immunize/school or call (800) 252-9152.

[8]Local Health Authority: A physician designated to administer state and local laws relating to public health:

(A) A local health authority appointed by the local government jurisdiction; or

(B) A regional director of the Department of State Health Services if no physician has been appointed by the local government.

[8]Outbreak/epidemic: The occurrence in a community or region of a group of illnesses of similar nature, clearly in excess of normal expectancy, and derived from a common or propagating source.

Communicable Disease Notes

When a Communicable Disease is Suspected

- Separate the ill child from well children at the facility until the ill child can be taken home.
- Inform parents immediately so that medical advice can be sought.
- Adhere to the exclusion and readmission requirements provided on this chart.
- Observe the appearance and behavior of exposed children and be alert to the onset of disease.
- Pregnant women should avoid contact with individuals, suspected of having chickenpox, cytomegalovirus, fifth disease, influenza, measles, and rubella. Seek medical advice if exposure occurs.
- In addition to the conditions described in this chart, the following symptoms might indicate an infectious condition; consider excluding or isolating the child:
    - Irritability
    - Difficulty breathing
    - Crying that doesn't stop with the usual comforting
    - Extreme sleepiness
    - Vomiting two or more times in 24 hours
    - Mouth sores

[*]**Hand Washing** (http://www.cdc.gov/handwashing/)

- Encourage children and adults to wash their hands frequently, especially before handling or preparing foods and after wiping noses, diapering, using toilets, or handling animals.
- Wash hands with soap and water long enough to sing the "Happy Birthday" song twice.
- Sinks, soap, and disposable towels should be easy for children to use.
- If soap and water are not available, clean hands with gels or wipes with alcohol in them.

Diapering

- Keep diapering areas near hand washing areas.
- Keep diapering and food preparation areas physically separate. Keep both areas clean, uncluttered, and dry.
- The same staff member should not change diapers and prepare food.
- Cover diapering surfaces with intact (not cracked or torn) plastic pads.
- If the diapering surface cannot be easily cleaned after each use, use a disposable material such as paper on the changing area and discard the paper after each diaper change.
- Sanitize the diapering surface after each use and at the end of the day.
- Wash hands with soap and water or clean with alcohol-based hand cleaner after diapering

Environmental Surfaces and Personal Items

- Regularly clean and sanitize all food service utensils, toys, and other items used by children.
- Discourage the use of stuffed toys or other toys that cannot be easily sanitized.
- Discourage children and adults from sharing items such as combs, brushes, jackets, and hats.
- Maintain a separate container to store clothing and other personal items.
- Keep changes of clothing on hand and store soiled items in a nonabsorbent container that can be sanitized or discarded after use.
- Provide a separate sleeping area and bedding for each child, and wash bedding frequently.

[+]**Respiratory Hygiene and Cough Etiquette** (http://www.cdc.gov/flu/protect/covercough.htm)

- Provide facial tissue throughout the facility.
- Cover mouth and nose with a tissue when coughing or sneezing.
- If tissue is not available, cough or sneeze into upper sleeve, not hands
- Put used tissue in the waste basket.
- Wash hands with soap and water or clean with alcohol-based hand cleaner after coughing or sneezing.

[*]**Standard Precautions**

Because we do not always know if a person has an infectious disease, apply standard precaution to ***every person every time*** *to assure that transmission of disease does not occur.*

- Wear gloves for touching blood, body fluids, secretions, excretions, contaminate items, and for touching mucous membranes and non-intact skin.
- Use appropriate hand washing procedures after touching blood, body fluids, secretion, excretions, contaminated items, and immediately after removing gloves.
- Develop procedures for routine care, cleaning, and disinfection of environmental surfaces.

Immunizations

Child-care facilities and schools are required to have an immunization record on file for each child enrolled to ensure that each child has received age-appropriate immunizations. For immunization information, contact your local health department, call (800) 252-9152, or visit: http://www.dshs.state.tx.us/immunize/school/.

Antibiotic Use

Antibiotics are not effective against viral infections. Because common colds and many coughs, runny noses, and sore throats are caused by viruses, not bacteria, they should not be treated with antibiotics. Even bacterial illnesses might not require antibiotic treatment. Except for conditions indicated in the readmission criteria, do not require proof of antibiotic treatment for readmission to school or day-care. Unnecessary or inappropriate antibiotic use can lead to the development of drug-resistant bacteria.

Texas Department of State Health Services

Stock No. 6-30 03/13

For a paper copy: http://www.dshs.state.tx.us/idcu/health/schools_childcare/ or call 512/776.7676

COMMUNICABLE DISEASE PANDEMIC MODEL RESPONSE PLAN

Level definition

1. Confirmed cases of human to human transmission of communicable disease.
2. Suspected case(s) on Church property or suspected/confirmed cases in local community.
3. Confirmed cases(s) on Church property.
   [Only essential personnel are required to report to work, church and school.]

Level 1

1. Emergency Team

- Director of Emergencies, monitor situation and update appropriate personnel
- Contact Diocesan Risk Management
- Contact Diocesan Media Relations
- Plan initiated for quarantine planning at all sites as necessary
- Essential personnel receive training on respiratory protection, check with local health authority for your county

2. Director of Emergency

- Communicate with local health department regarding planning and surveillance
- Alert Diocesan Emergency Team
- Establish communication with Diocesan leaders and managers
- Update emergency action plan with entire team and the Diocese Risk Management as situation evolves
- In conjunction with the Diocesan leaders, issue communication(s) to Parish communities regarding status of disease spread, self-protection and Parish response (email, website, town meetings)

3. Facility Services

- Identify building ventilation systems
- Establish facility decontamination procedures by cleaning staff
- Essential personnel receive fit test and training on regarding respiratory protection

4. Environment and Health Safety

- Assess respiratory protection plan and resources
- Verify contract with hazardous material company for biohazard waste disposal
- Train and fit essential personnel for respirators

5. Business Office

- Receive information from Director of Emergencies
- Review content of internal and external public information bulletins and announcements. Work with Media Relations to select appropriate Parish spokesperson(s) for media reporting
- Essential personnel receive training on respiratory protection
- Advise Leaders on restricting travel needs of staff at diocesan locations into areas of the communicable disease pandemic

6. Parish

- Based on U.S. State Department recommendations, Diocese recommends Parish community not to travel to affected countries
- Prepare a policy for closing down all or parts of the Parish
- Receive training on respiratory protection

7. Office of Communications

- Draft internal and external bulletins and announcements with Director of Communication

8. Human Resources

- Identify essential personnel
- Monitor faculty and staff travelers entering from effected regions
- Establish policies for absences unique to a pandemic and help locate back-up personnel
- Establish policies for flex-work
- Identify personnel available for telephone support work

Level 2

1. **Emergency Team**
    - Same as Level 1

2. **Director of Emergency**
    - Notify local Health Department as required
    - Notify Chancery Office
    - Ongoing communications with Parish Community regarding signs/symptoms, protocol for referral of suspected cases
    - Establish a location for an Emergency Operations Center
    - Initiate poster, website campaign on self-protection

3. **Facility Services**
    - Same as Level 1

4. **Environment and Health Safety**
    - Arrange for additional medical waste pickups

5. **Business Office**
    - Advise leaders on response options
    - Help establish a location for Emergency Operations Center

6. **Parish**
    - Evaluate information on institutional effects of the incident and set response priorities as appropriate

7. **Office of Communications**
    - Appoint liaison to interface with the Director
    - Write and record bulletins and updates on the Parish/Diocesan website
    - Write scripts for phone and/or email tree; gain approval from Director
    - Request all Parish members, faculty, staff and family members to report all flu cases to Director of Communication

8. **Human Resources**
    - Same as Level 1

Level 3

1. **Emergency Team**
    - In addition to Level 2 actions
    - Maintain contact amongst entire team
    - Advise Director of Communication to activate Emergency Operations Center
    - Essential personnel receive respirators

2. **Director of Emergency**
    - Recommend temporary closure of building(s) and suspend Parish activities to Bishop and his council
    - Implement Emergency Response Plan with Emergency Team
    - Ensure that each Operation group function is covered

3. **Facility Services**
    - Stand by to shut off utilities as directed by Incident Commander, if necessary
    - Begin decontamination procedures of facilities as needed
    - Essential personnel receive respirators

4. **Environment and Health Safety**
    - Distribute respirators to essential personnel

5. **Business Office**
    - Provide assistance with notifying staff and families as needed
    - Receive respirators

6. Parish

- Authorize temporary suspension or closure of Parish/buildings
- Essential personnel receive respirators

7. Office of Communications

- Organize phone banks, if necessary (phone banks can refer callers to emergency services, take messages, support rumor control)
- Implement Communications Response plan, coordinate press releases, and manage news teams and interviews, etc.

8. Human Resources

- Activate call-off policy, if directed
- Implement established policies

Disclaimer:

This document has been prepared with the assistance of Tarrant County Health Department to be used as a model.
It is by no means a required document to follow, but guidelines for each Diocese to review and formulate for their individual Communicable Disease Plan.

Nancy Eder, RN
School Nurse Consultant
Office of Catholic Schools
Diocese of Fort Worth
neder@fwdioc.org

INFLUENZA

Seasonal Flu

Seasonal flu is caused by influenza viruses that are similar to those already affecting people.

Symptoms include fever, cough, and runny nose and muscle pain. Deaths can be caused by complications such as pneumonia.

Healthy adults usually are not at risk for serious complications (the very young, the elderly, and those with certain underlying health conditions are at increased risk for serious complications).

Generally causes modest impact on society (e.g., some school closings, encouragement of people who are sick to stay home).

Pandemic Flu

This is caused by a new influenza virus that people have not been exposed to before. It is likely to be more severe, affect more people, and cause more deaths than seasonal flu because people will not have immunity to the new virus.

Symptoms similar to the common flu may be more severe and complications more serious.

Healthy adults may be at increased risk for serious complications.

A severe pandemic could change the patterns of daily life for some time. People may choose to stay home to keep away from others who are sick. Also, people may need to stay home to care for ill family and loved ones. Travel and public gatherings could be limited. Basic services and access to supplies could be disrupted.

Pandemic Flu Checklist for families

You can plan for influenza pandemic now.

1. Store a supply of water and food. Stores may be out of supplies. It is important to have extra water and canned food for each person in your family.

    - Food items to have on hand for an extended stay at home

        1. Ready to eat canned meats, fruits, vegetables and soups
        2. Protein or fruit bars
        3. Dry cereal or granola
        4. Dried fruit
        5. Crackers
        6. Canned juices
        7. Bottled water
        8. Canned or jarred baby food and formula
        9. Pet food
        10. Canned milk, powdered milk
        11. Staples, sugar, salt and pepper
        12. High energy foods, such as peanut butter, trail mix
        13. Comfort/stress food, such as cookies, hard candy, instant coffee and tea bags

2. As in other emergencies, have extra batteries on hand for power failures

    - Hand can opener (manual)
    - Batteries for: flash lights, radio and portable television and other electronic equipment
    - Soap and water
    - Garbage bags
    - Tissues, toilet paper, diapers, feminine hygiene products

3. Prescription and non-prescription medication and health supplies on hand. Be knowledgeable of your family's health care needs and what would be needed to take care of them at home.

    - Medical supplies
    - Blood pressure equipment
    - Diabetes monitoring supplies
    - Soap and water, disinfectant
    - Prescription medication
    - Medications for fever
    - Anti-diarrheal medication
    - Vitamins
    - Fluids with electrolytes
    - Antacid
    - Laxative

4. To limit the spread of germs and prevent infection:

    - Teach your children to wash hands frequently with soap and water
    - Teach your children to cover coughs and sneezes with tissues
    - Teach your children to stay away from others as much as possible if someone is ill at home and school or work
    - Stay home from school and work if you are ill

5. First Aid kit

    - Sterile adhesive bandages
    - 2 and 4 inch sterile gauze
    - Hypoallergenic adhesive tape
    - Scissors
    - Thermometer
    - Antiseptic
    - Assorted safety pins

Family Emergency Health Information Sheet

It is important to think about health issues that could arise if an influenza pandemic occurs, and how they could affect you and your loved ones. For example, if a mass vaccination clinic is set up in your community, you may need to provide as much information as you can about your medical history when you go, especially if you have a serious health condition or allergy.

Create a family emergency health plan using the following information. Fill in information for each family member in the space provided. Like much of the planning for a pandemic, this can also help prepare for other emergencies.

1. ***Family Member Information****:*

Family Member	Blood Type	Allergies	Past/Current Medical Conditions	Current Medications/ Dosages

2. ***Emergency Contacts****:*

Contacts	Name/Phone Number
Local personal emergency contacts	
Out-of-town personal emergency contacts	
Hospitals near: **Work**	
School	
Home	
Family Physician(s)	
State public health department (See list on www.pandemicflu.gov)	
Pharmacy	
Employer contact and emergency information	
School contact and emergency information	
Veterinarian	

References: www.pandemicflu.gov
American Red Cross
CDC

Additional School Sites for reference for Pandemic Influenza and continued monitoring of the H1N1 Pandemic of 2009

- http://www.flu.gov/planning-preparedness/school/
- http://www.cdc.gov/flu/protect/stopgerms.htm
- www.cdc.gov/flu/school/qa.htm
- http://www.itsasnap.org/index.asp
- http://cdc.gov/flu/school/
- www.who int/
  (World Health Organization)

BLOODBORNE PATHOGENS EXPOSURE CONTROL PLAN

(Approved, TCC, 11/93, Reviewed June 2011)

I. Introduction

The Occupational Safety and Health Administration (OSHA) Bloodborne Pathogens Standard (29 Code of Federal Regulations [CFR] Part 1910.1030, Subpart Z) was issued to reduce the occupational transmission of infections caused by microorganisms sometimes found in human blood and certain other potentially infectious materials. Although a variety of harmful microorganisms can be transmitted through contact with infected human blood, Hepatitis B Virus (HBV) and Human Immunodeficiency Virus (HIV) have been shown to be responsible for infecting workers who were exposed to human blood and certain other body fluids containing these viruses, through routes like needle stick injuries and by direct contact with mucous membranes and non-intact skin with contaminated blood/materials, in the course of their work. Occupational transmission of HBV occurs much more often than transmission of HIV. Although HIV is rarely transmitted following occupational exposure incidents, the lethal nature of HIV requires that all possible measures be used to prevent exposure of workers.

This exposure control plan has been adopted by the school in order to minimize and to prevent, when possible, the exposure of our employees to disease-causing microorganisms transmitted through human blood, and as a means of complying with the Bloodborne Pathogens Standard. All employees who are exposed to blood and other potentially infectious materials as a part of their job duties are included in this program. (See II. Exposure determination for a discussion of job categories and tasks that have been identified as having exposure.) This plan will be reviewed at least annually and updated as necessary. An employee may obtain a copy of this plan within 10 days of his/her request to the principal. Copies of the exposure control plan will be available in all school libraries, principals' offices, and in the office of the superintendent.

Basic components of the exposure control plan are:

I. Introduction
II. Exposure Determination
III. Methods of Compliance
IV. Hepatitis B Vaccination Policy
V. Procedures for Evaluation and Follow-up of Exposure Incidents
VI. Employee Training
VII. Record keeping Procedures

II. Exposure determination

All job categories in which it is reasonable to anticipate that an employee will have skin, eye, mucous membrane, or parenteral contact with blood or other potentially infectious materials (listed below) will be included in this exposure control plan. Exposure determination is made without regard to the use of personal protective equipment (i.e. employees are considered to be exposed even if they wear personal protective equipment.)

Other Potentially Infectious Materials (OPIM)

A. Body Fluids
   1. semen
   2. vaginal secretions
   3. pleural fluid
   4. pericardial fluid
   5. peritoneal fluid
   6. amniotic fluid
   7. any body fluid visibly contaminated with blood

B. Other Materials
   1. Any unfixed tissue or organ (other than intact skin) from a human (living or dead)
   2. HIV/HBV containing cell or tissue cultures, organ cultures, and culture medium
   3. Blood, organs or other tissues from experimental animals infected with HIV or HBV

Employees to be included

To be determined by individual dioceses and included as Appendix C in this document.

III. Methods of compliance

A. Universal Precautions

All blood or OPIM (as described in II. Exposure Determination) shall be handled as if contaminated by a blood borne pathogen. Under circumstances in which differentiation between body fluid types is difficult or impossible, all body fluids shall be considered potentially infectious materials.
Engineering and Work Practice Controls shall be used to eliminate or minimize employee exposure. Where occupational exposure remains after institution of these controls, personal protective equipment shall also be used. The following engineering controls will be utilized:

- Disposable gloves
- Sharps containers in designated health care areas and custodian supply closets
- Red Plastic Bags located in designated health care areas and custodian supply closets to be used for biohazardous waste only

The above controls will be maintained or replaced as needed.

B. Handwashing and Other General Hygiene Measures

Hand washing is a primary infection control measure, which is protective of both the employee and the patient. Appropriate hand washing must be diligently practiced. Employees shall wash hands thoroughly using soap and water whenever hands become contaminated and as soon as possible after removing gloves or other personal protective equipment. When other skin areas or mucous membranes come on contact with blood or other potentially infectious materials, the skin shall be washed with soap and water, and the mucous membranes shall be flushed with water, as soon as possible.

Food and drink shall not be kept in refrigerators, freezers, shelves, and cabinets or on counter tops or bench tops where blood or other potentially infectious materials are present.

Employees shall use practices to minimize splashing, spraying, spattering and generation of droplets while administering First Aid and/or during clean-up procedures involving blood or other potentially infectious materials.

C. Sharps Management

Sharps containers must be closable, puncture resistant, labeled or color-coded, leak-proof on sides and bottom, and maintained upright throughout use. Containers are to be easily accessible to personnel and located as close as feasible to the immediate area where sharps are used or found.

Retractable needles should be used whenever possible. (Recommended revision 4/01) Contaminated needles and other contaminated sharps shall not be bent, recapped or removed. Shearing or breaking of needles is prohibited.

Disposable sharps containers are to be located in locked, designated risk areas (i.e. science laboratories, health area) and custodian supply closets.

Overfilling of sharps containers creates a hazard when sharps protrude from openings. Nearly full containers must be promptly transported to a central biohazardous waste storage facility for appropriate disposal. Sharps containers must be replaced (never re-used.)

No specimens of blood or other potentially infectious materials shall be collected or stored in the school.

D. Personal Protective Equipment: General Guidelines

All personal protective equipment will be provided, repaired, cleaned, and disposed of by the employer at no cost to the employees. Employees shall wear disposable gloves when rendering first aid or cleaning up after blood or body fluid spill. At all times, it is expected that each teacher have at least a few pairs of gloves, one roll of absorbent paper towels, and at least one plastic bag in their classroom, that are easily accessible. Faculty and staff are responsible for obtaining these from the office.

If a garment is penetrated by blood or potentially infectious material, the garment shall be removed as soon as possible and placed in a designated container (plastic bag which is then placed into a red plastic bag) for laundering or disposal. All personal protective equipment shall be removed before leaving the work area; it shall be placed in designated containers for storage, washing, decontamination or disposal.

Employees are to place disposable items in a plastic bag at the work area. After gloves are discarded, this bag should be closed and hands washed. Items deemed biohazardous waste must be placed in a red plastic bag at the work area for immediate transport to a central biohazardous storage facility for appropriate disposal.

Contaminated protective and personal garments should be placed in a red plastic bag for appropriate disposal or laundering.

E. Protection for Hands

Gloves shall be worn in the following situations:

- When it can be reasonably anticipated that hands will contact blood or other potentially infectious materials, mucous membranes, and non-intact skin
- When handling or touching contaminated items or surfaces

Gloves are required when assisting with first aid involving an open lesion or body fluids. Gloves are required when cleaning up after blood or body fluids.

Disposable Gloves

- Replace as soon as feasible when gloves are contaminated, torn, punctured, or when their ability to function as a barrier is compromised
- Do not wash or decontaminate single use gloves for re-use

F. Housekeeping

The workplace will be maintained in a clean and sanitary condition. A written housekeeping procedure guide which gives appropriate methods and frequency of decontamination based upon the location within in the facility, the type of surface to be cleaned, type of soil present, and the tasks or procedures being performed must be followed and is attached in Appendix A. The Housekeeping/Cleaning Guidelines are located and shall be posted in the nurse's or principals and/or custodial office.

G. Contaminated Surfaces

Clean contaminated surfaces with 10% Bleach solution (9 parts water & 1 part bleach) disinfect immediately or as soon as feasible after any spill of blood or other potentially infectious materials.

Procedure:

1. Use gloves.
2. Place paper towel(s) on the spill.
3. Thoroughly soak the area with a 10% solution of bleach (1 oz. of bleach to 9 oz. Of water. This must be made fresh at the time of need because the effectiveness is lost after one day). This may be sprayed on the area or poured on the area.
4. Let solution set for about two minutes.
5. Scoop up paper towels with dry paper towel(s).
6. Discard in a clean plastic bag.
7. Repeat procedure.
8. Remove gloves and discard in the same plastic bag.
9. Wash your hands thoroughly.
10. Use second clean bottle of 10% bleach solution to spray on contaminated spray bottle and around clean up area. Let set for two minutes, and then dry with paper towel.
11. Discards not deemed biohazardous Waste should be placed in plastic bags for disposal. Discards deemed biohazardous Waste shall be placed in second red plastic bag for appropriate disposal. In all cases, remove most of the air from all plastic bags and be careful not to touch the inside of the bags. Tie a knot in all bags to close.

12. Red bags shall be taken to a central biohazardous waste storage facility and placed in an appropriately labeled container for appropriate disposal.
(Arrangements may be made with a local medical or laboratory facility for disposal)

H. Special Sharps Precautions

Clean up broken glass, which may be contaminated using mechanical means such as a brush and dustpan, tongs or forceps. DO NOT pick up directly with the hands.
Reusable sharps containers are not to be opened, emptied, or cleaned manually or in any other manner, which will expose employees to risk of percutaneous (skin) injury. **DO NOT** reach in to the container by hand, which stores contaminated sharps.

I. Regulated Waste

Includes:

- Liquid or semi-liquid blood or other potentially infectious materials; contaminated items that would release blood or other potentially infectious materials in a liquid or semi-liquid state if compressed
- Items that are caked with dried blood or other potentially infectious materials and are capable of releasing these materials during handling
- Contaminated sharps
- Pathological and microbiological wastes containing blood or other potentially infectious materials

J. Waste Containers

Any of the substances listed above must be placed in containers that are: closable; constructed to contain all contents and prevent leakage of fluids during handling, storage, transport or shipping.

In the school, waste deemed biohazardous shall also be placed in red plastic bags or appropriately labeled sharps containers.

Containers must be closed prior to moving/removal to prevent spillage or protrusion of contents during handling, storage, transport or shipping. If the outside of the container becomes contaminated, it is to be placed in a second container that must have the same characteristics as the initial container as discussed above. Biohazardous waste containers shall be immediately transported to a central biohazardous waste storage facility for appropriate disposal.

K. Laundry

Employees who handle contaminated laundry are to wear protective gloves and other appropriate personal protective equipment.

Contaminated laundry shall be handled as little as possible with a minimum of agitation. Do not sort/rinse laundry at site of use. Place in container/bag at site of use or garment removal. Wet contaminated laundry that may soak through or cause leakage from bag or container will be placed and transported in bags or containers that prevent soaking through and/or leakage of fluids to the exterior of the container.

Laundry deemed biohazardous shall be placed in red plastic bags or in containers labeled biohazardous.

Contaminated laundry will be cleaned at a local commercial laundry and will be labeled with a biohazard label.

L. Communication of Hazards to Employees

Employees will be informed of hazards through a system of biohazard labeling and red bagging as well as a training program that is discussed in Section VI of this written plan.

Warning labels shall be affixed to containers of regulated waste to store, transport or ship blood or other potentially infectious materials. Contaminated equipment shall also be labeled in this manner: information about the portions of the equipment that remain contaminated shall be added to the label.

Labels shall be fluorescent orange or orange-red with lettering or symbols in a contrasting color. The label is either to be an integral part of the container or affixed as dose as feasible to the container by method which prevents loss

or unintentional removal of the label. The label shall display the biohazard symbol and the text **BIOHAZARD**.

Red bags or red containers may be substituted for the warning label. The labels/color coding described here are not required when regulated waste has been decontaminated.

IV. Hepatitis B vaccination policy

A. General Statement of Policy

All employees who have been identified as having exposure to bloodborne pathogens (see employees to be included list) will be offered the Hepatitis B vaccination series at no cost to them. All employees will be offered post-exposure evaluation and follow-up at no cost should they experience an exposure incident on the job.

All medical evaluations and procedures including the Hepatitis B vaccination series, whether prophylactic (see USDL Release 92-436, July 6, 1992, Appendix B in re: first aid [and CPR] providers) or post exposure, will be made available to the employee at a reasonable time and place. This medical care will be performed by or under the supervision of a licensed physician, physician's assistant or nurse practitioner. Medical care and vaccination series will be according to the most current regulations of the U.S. Public Health Service. A copy of the bloodborne pathogens standard will be provided to the health care professional responsible for the employee's Hepatitis B vaccination, if requested.

An accredited laboratory at no cost to the employee will conduct all laboratory tests.

B. Hepatitis B Vaccination

The vaccination is a series of three injections. The second injection is given one month from the initial injection. The final dose is given six months from the initial dose. At this time a routine booster dose is not recommended, but if the U.S. Public Health Service, at some future date recommends a booster, it will also be made available to exposed employees at no cost.

The vaccine will be made available to identified employees after they have attended training on bloodborne pathogens and within 10 working days of initial assignment to a job category with exposure. The vaccination series will not be made available to employees who have previously received the complete Hepatitis B vaccination series; to any employee who has immunity as demonstrated through antibody testing; or to any employee for whom the vaccine is medically contraindicated.

Any exposed employee identified who chooses not to take the Hepatitis B vaccination will be required to sign a declination statement.

V. Procedures for evaluation and follow up of exposure incidents

An exposure incident is a specific eye, mouth, or mucous membrane, non-intact skin, or parenteral contact with blood or other potentially infectious materials that results from the performance of any employee's duties.

Employees who experience an exposure incident must immediately report their exposure to the principal. When an employee reports an exposure incident, he/she will immediately be offered a confidential medical evaluation and follow-up including the following elements:

- Documentation of the route(s) of exposure, and the circumstances under which the exposure incident occurred
- Identification and documentation of the source individual unless identification is infeasible

If the infectivity status of the source individual is unknown, the individual's blood will be tested as soon as feasible after consent is obtained. The exposed employee will be informed of the results of the source individual's testing.

The exposed employee's blood shall be collected as soon as feasible after consent is obtained, and tested for HBV and HIV status. If the employee consents to baseline blood collection, but does not give consent at that time for HIV serologic testing, the sample shall be preserved for at least 90 days. If, within 90 days of the exposure incident, the employee elects to have the baseline sample tested; such testing shall be done as soon as feasible.

The exposed employee will be offered post-exposure prophylaxis, when medically indicated, as recommended by the U.S. Public Health Service. The exposed employee will be offered counseling and medical evaluation of any reported illnesses.

The following information will be provided to the healthcare professional evaluating an employee after an exposure:

- A copy of 1910. 1030 blood borne pathogens standard
- A description of the exposed employee's duties as they relate to the exposure incident
- Documentation of the route(s) of exposure and circumstances under which the exposure occurred
- Results of the source individual's blood testing, if available
- All medical records relevant to the appropriate treatment of the employee including vaccination status

The School Principal shall obtain and provide the employee with a copy of the evaluating health care professional's written opinion within 15 days of the completion of the evaluation. The written opinion will be limited to the following information:

- The employee has been informed of the results of the evaluation
- The employee has been informed about any medical conditions resulting from exposure to blood or other potentially infectious materials which may require further evaluation or treatment

NOTE: All other findings shall remain confidential and shall not be included in the written report.

VI. Employee training

Employees will be trained regarding bloodborne pathogens at the time of initial assignment to tasks where exposure may occur and annually, during work hours. Additional training will be provided whenever there are changes in tasks or procedures, which affect employee's occupational exposure; this training will be limited to new exposure situation.

The training approach will be tailored to the educational level, job category, literacy, and language of the employees. The training plan will include an opportunity for employees to have their questions answered by the trainer. The Superintendent is responsible for making appropriate training available. Each school principal is responsible for insuring that all employees are trained and that appropriate documentation is completed and retained.

The following content will be included:

1. Explanation of the bloodborne pathogens standard
2. General explanation of the epidemiology, modes of transmission and symptoms of bloodborne diseases
3. Explanation of this exposure control plan and how it will be implemented
4. Procedures which may expose employees to blood or other potentially infectious materials
5. Control methods that will be used at the school to prevent/reduce the risk of exposure to blood or other potentially infectious materials
6. Explanation of the basis for selection of personal protective equipment
7. Information about the Hepatitis B vaccination program including the benefits and safety of vaccination
8. Information on procedures to use in an emergency involving blood or other potentially infectious materials
9. What procedure to follow if an exposure incident occurs
10. Explanation of post-exposure evaluation and follow-up
11. An explanation of warning labels and/or color coding

VII. Record keeping procedures

General
Procedures will be in place for maintaining both medical and training records. If the Catholic school should cease business, and there is no successor employer to receive and retain the records for the prescribed period, then the Director of National Institute for Occupational Safety and Health (NIOSH) will be notified at least three months prior to the disposal of the records. The records will be transmitted to NIOSH, if required, within the three-month period.

Medical recordkeeping
A medical record will be established and maintained for each employee with exposure. The record shall be maintained for the duration of employment plus 30 years in accordance with 29 CFR 1910.20.
The School Principal will be responsible for maintaining the medical records.
The record shall include the following:

- ❑ Name and social security number of the employee
- ❑ A copy of the employee's Hepatitis B vaccination status with dates of Hepatitis B vaccinations and any medical records relative to the employee's ability to receive vaccination
- ❑ A copy of the examination results, medical testing, and any follow-up procedures
- ❑ A copy of the healthcare professional's opinion
- ❑ A copy of the information provided to the healthcare professional who evaluates the employee for suitability to receive Hepatitis B vaccination prophylactically and/or after an exposure incident

Confidentiality of Medical Records
The record will be kept confidential. The contents will not be disclosed or reported to any person within or outside the workplace without the employee's express written consent, except as required by law or regulation. Employee medical records required under 1910.1030 shall be provided upon request for examination and copying to the subject employee and to the Commissioner of the Texas Workers Compensation Commission, Health and Safety Division in accordance with 29 CFR 1910.20.

Training Records
Training records shall be maintained for 3 years from the date on which the training occurred.

The following information shall be included:

- Dates of training sessions
- Contents or a summary of the training sessions
- Names and qualifications of trainer(s)
- Names and job titles of all persons attending

Training records shall be provided upon request for examination and copying to employees, to employee representatives, and to the Commissioner of the Texas Workers Compensation Commission, Health and Safety Division in accordance with 29 CFR 1910.20.

Review date: _____ Initials _____

Review date: _____ Initials _____

Review date: _____ Initials _____

Review date: _____ Initials _____

BLOODBORNE PATHOGENS FORMS

Exposure Incident Form

Employee Name _____

Employee Address _____

Patient Name _____

Patient Address _____

Exposure incident circumstances (Describe what happened)

_____

_____

_____

Route of Exposure (e.g. needle stick, splash, puncture wound, abraded skin)

_____

_____

Date and time of incident _____

_____
Signature

_____
Title

_____
Date

Note: Maintain this record for duration of employment plus 30 years.
Copy to physician if applicable

Informed Refusal of Post-exposure Medical Evaluation

I, _____ am employed by _____

as a _____. My employer has provided training to me

regarding infection control and the risk of disease transmission in my job.

_____

(Month/day/year)

I was involved in an exposure incident: (describe incident) _____

_____

_____

_____

My employer has offered to provide follow-up medical evaluation for me in order to assure that I have full knowledge of whether I have been exposed to or contracted an infectious disease from this incident.

However, I, of my own free will and volition, and despite my employer's offer, have elected not to have a medical evaluation. I have personal reasons for making this decision.

Comments (optional) _____

Signature _____

Name _____

Address _____

City _____ State _____ Zip _____

Date _____

Note: Maintain this record for duration of employment plus 30 years.

Post-Exposure Follow-up Evaluation

_____ has been evaluated and informed of the evaluation results and has
(Name)
been told of any medical conditions resulting from the exposure incident of _____ which
(Date)
does not require further evaluation or treatment.

I attest to the above and I have received a copy of the OSHA regulations and the Exposure Incident form.

Additional Comments: _____

_____

_____

_____

_____

_____ _____
Physician Signature Date

To be returned to the School Principal

Mandatory Hepatitis B Vaccination Declination Form

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis B vaccine, at no charge to myself. However, I decline Hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series at no charge to me.

Name _____

Position _____

Date _____

Comments (optional) _____

_____

_____

_____

Mandatory Hepatitis B Exemption Form

I hereby declare that I am exempt from the requirement for Hepatitis B vaccination because:

_____ I have already received the complete Hepatitis B vaccination series (verification attached)

_____I have demonstrated immunity through antibody testing (verification attached)

_____The vaccine offers medical contraindications for me (verification attached)

Signature _____

Name (print) _____

Position _____

Date _____

Information about Hepatitis B Vaccine

The Disease
Information about Hepatitis B Vaccine
Hepatitis B is a viral infection caused by Hepatitis B virus (HBV), which causes death in 1-2% of patients. Most people with hepatitis B recover completely, but approximately 5-10% become chronic carriers of the virus. Most of these people have no symptoms, but can continue to transmit the disease to others. Some may develop chronic active hepatitis and cirrhosis. HBV also appears to be a causative factor in the development of liver cancer. Thus, immunization against Hepatitis B can prevent acute hepatitis and also reduce sickness and death from chronic active hepatitis, cirrhosis and liver cancer.

The Vaccine
RECOMBIVAX HB [Hepatitis B Vaccine (Recombinant), MSDI is a non-infectious subunit viral vaccine derived from Hepatitis B surface antigen (HBsAG) produced in yeast cells. A portion of the Hepatitis B virus gene, coding for HBsAG, is cloned into yeast, and the vaccine for Hepatitis B is produced from cultures of this recombinant yeast strain. The vaccine against Hepatitis B, prepared from recombinant yeast cultures, is free of association with human blood or blood product. Full immunization requires 3 doses of vaccine over a six-month period although some persons may not develop immunity even after 3 doses. There is no evidence that the vaccine has ever caused Hepatitis B. However, persons who have been infected with HBV prior to receiving the vaccine may go on to develop clinical hepatitis in spite of immunization. The duration of immunity is unknown at this time.

Possible Vaccine Side Effects
The incidence of side effects is very low. No serious side effects have been reported with the vaccine. A few persons experience tenderness and redness at the site of injection. A low-grade fever may occur. Rash, nausea, joint pain and mild fatigue have also been reported. The possibility exists that more serious side effects may be identified with more extensive use.

If you have questions about Hepatitis B or the Hepatitis B vaccine, please ask.

CONSENT FORM

I have read the above statement about Hepatitis B and the Hepatitis B vaccine. I have had an opportunity to ask questions and understand the benefits and risks of Hepatitis B vaccination. I understand that three (3) doses of the vaccine are necessary to confer immunity. However, as with all medical treatment, there is no guarantee that I will become immune or that I will not experience an adverse effect from the vaccine. I request that the Hepatitis B vaccine be given to me.

	Date Vaccinated	Lot #
_____	_____	_____
Printed name of person to receive vaccine		
_____	_____	_____
Signature of person receiving vaccine		
	_____	_____

Date signed_____

Department_____Division _____Job Title _____

Employee Sharps Injury Log

The type and brand of device involved in the incident _____

_____

The department or work area where the incident occurred _____

_____

Explanation of how the incident occurred _____

_____

_____

Signature of Employee _____ Date_____

Witness _____ Date_____

The requirement to establish a sharps injury log shall apply to any employer who is required to maintain a log of occupational injuries or illnesses.

Note: Maintain this record for duration of employment, plus 30 years.

MAINTAIN IN CONFIDENTIAL LOCKED FILE

Training Roster Page 1

Training Topic_____ Date of Training _____

Name of Trainer(s) _____

Qualifications of Trainer(s) _____

Summary of Content _____

Name of Participant	Job Title

Training roster continuation page

Training Roster Page _____

Training Topic_____Training date _____

Name of Participant	Job Title

School Personnel are necessarily exposed occasionally to scraped knees, cuts and sick students. In the classroom and on the playground students of all ages hurt themselves and become sick. You need to be aware of the potential hazard of disease causing organisms (germs) to which you may be exposed in the line of your duties.

The Occupational Safety and Health Administration (OSHA) has developed a standard which insures that you and the school can work together to reduce the risk of contracting a bloodborne disease while in school. The federal regulation is designed for your protection and applies to anyone who can reasonably anticipate contact with blood or other potentially infectious body fluids while on the job.

The school is required to identify the personnel whose job duties expose them to blood and other potentially infectious body fluids, since not every person working in the school has a reasonable expectation of being exposed to blood borne pathogens. It is important, however, for everyone in the school to understand the dangers of infection and the procedures to minimize risk. A complete copy of the exposure control plan is available from the school principal.

BLOODBORNE DISEASES

Bloodborne Pathogens are disease-causing micro-organisms that are carried in the blood. Additionally, diseases carrying micro-organisms may also be present in other potentially infectious material (OPIM) including vomitus, feces, semen, vaginal secretions, brain and spinal cord fluid, synovial (joint) fluid, pleural (chest) fluid, pericardial (around the heart) fluid, amniotic fluid (pregnancy fluid), saliva in dental procedures, any body fluid visibly contaminated with blood, and all body fluids in situations where it is impossible to differentiate between body fluids.

MAJOR BLOODBORNE DISEASES

Hepatitis B

Hepatitis B (HBV) is the major infectious bloodborne hazard to you. It is a disease, which causes inflammation of the liver, leading to cirrhosis and almost certain death. The symptoms are:

- severe flu-like symptoms
- mild fever
- muscle-joint aches
- nausea, vomiting
- loss of appetite
- diarrhea
- jaundice (yellowing of the skin)

Many infected persons have no symptoms at all and are unaware that they are infected. The virus may be present in an infected person's saliva, blood and other body fluids, and may be spread to sexual partners, family members and unborn infants. Other modes of transmission include drug use or tattooing with contaminated needles and unsafe ear piercing.

The HBV is a stable virus that can live on environmental surfaces up to one (1) week. There is no specific treatment or cure. Immunization (vaccine) against HBV is preventative.

HIV

HIV is the Human Immunodeficiency Virus. It attacks the immune system, causing AIDS. There is no known vaccine to prevent infection. There is no cure and the disease is deadly.

The HIV can live on environmental surfaces for only a matter of minutes. It is transmitted through blood and other infectious materials and must be introduced directly into the blood for infection to occur. It is not spread by casual contact such as hugging, shaking hands or sharing bathrooms. People at risk for infection are those who participate in high-risk sexual behaviors and those who share IV needles and syringes.

A person infected with HIV may carry the virus for many years without developing symptoms. Early symptoms may include:

- fatigue
- fever
- diarrhea

Most people infected with HIV will develop AIDS.

MODES OF TRANSMISSION
Bloodborne Pathogens can enter your body through:

- Open cuts
- Nicks
- Skin Abrasions
- Dermatitis
- Acne
- The mucous membranes of your mouth, eyes or nose.

You can become infected by accidentally injuring yourself with a sharp object that is contaminated such as:

- Broken glass
- Sharp metal
- Needles
- Knives
- Exposed ends of orthodontic wires

Indirect transmission may occur when you touch a contaminated surface and transfer the infection to your:

- Mouth
- Eyes
- Nose
- Open skin

Contaminated surfaces are a major cause of the spread of HBV.

UNIVERSAL PRECAUTIONS
The concept of Universal Precautions requires, for your safety, that you consider every person, all blood and most body fluids to be a potential carrier of infectious disease. Treat all human blood and body fluids as if they were known to be infected with HIV, HBV or other bloodborne pathogens. It takes just one exposure to become infected.

REDUCING THE RISK OF INFECTION
There are five methods to be used in your school to reduce your risk of exposure to bloodborne pathogens on the job:

- Engineering controls
- Work practice habits
- Personal protective equipment
- Housekeeping
- Hepatitis B vaccine

ENGINEERING CONTROLS
Engineering controls are physical or mechanical systems that eliminate hazards. Their effectiveness depends on the person using them. Make sure you know about the location and use of engineering controls in your school.

- Special containers for regulated waste
- Sharps container
- Disposal system

WORK PRACTICE CONTROLS
Work practice controls are procedures you must follow to reduce exposure to bloodborne pathogens. The principal will identify specific personnel to deal with bloodborne hazards on a regular basis. These persons will have intense training in exposure control. They may include the person responsible for administering first aid, the custodian responsible for cleaning up body fluid spills, and the coach or P.E. teacher who can reasonably anticipate playground or playing field injuries.

Hand washing
One of the most effective controls for all pathogens is hand washing. If infectious materials get on your hands, the sooner it is washed off, the less chance there is of infection.

Hand washing reduces the risk of transferring contamination from your hands to other areas of your body or other surfaces.

Every time you remove your gloves you must wash your hands with non-abrasive soap and running water as soon as possible. If skin or mucous membrane comes in direct contact with blood, wash or flush the area with water as soon as possible.

If hand-washing facilities are not available (on a school bus for instance) your employer will provide an antiseptic hand cleanser or hand sanitizer. These are only a temporary measure. You must still wash your hands with soap and running water as soon as possible.

Personal Hygiene
Take care to minimize spraying, splattering and generation of droplets when attending to an injured student or co-worker, especially where blood is involved.
Do not eat, drink, smoke, apply cosmetics or lip balms or handle contact lenses where there is a reasonable likelihood of contamination or exposure.

PERSONAL PROTECTIVE EQUIPMENT (PPE)
Personal protective equipment protects you from contact with blood and other potentially infectious materials. The type you use will depend on your job and on the degree of exposure you anticipate. Equipment may include:

- Gloves
- Gowns or aprons
- Face shields
- Protective eye wear
- Mouthpieces for resuscitation

Each classroom and each P.E. teacher or coach should be equipped with latex gloves, paper towels and a plastic bag in case of accident.

If you must clean up blood or body fluids wear appropriate PPE, use a solution of one part bleach to nine parts water (10% solution) (see procedure for cleaning contaminated surfaces) and disinfect mops and cleaning tools after the job is done. Find out where the PPE is kept in your school. If, when wearing PPE, it becomes penetrated by blood or other potentially infectious materials, remove it as soon as possible.

Gloves
Gloves (latex) must be worn when it is reasonably anticipated that you may have hand contact with:

- Blood
- Any potentially infectious materials
- Mucous membrane or non-intact skin

It is important that gloves fit properly and that all equipment is free of physical flaws that would compromise safety. Never re-use, and never attempt to wash or disinfect disposable gloves.

Glove removal
Gloves should be removed when they become contaminated, damaged or immediately upon completing the task. To insure that no pathogens from the soiled gloves contact your hand, the following procedure for glove removal should be used:

1. With both hands gloved, grasp one glove on the exterior surface near the wrist, peel it off from top to bottom and hold it in the gloved hand
2. With the exposed hand, peel the second glove from the inside, tucking the first glove inside the second.
3. Dispose of the entire bundle promptly
4. Never touch the outside of the glove with bare hand
5. Wash hands with soap and running water as soon as possible

HOUSEKEEPING CONTROLS
Your custodial staff will have special instructions and a regular schedule for cleaning environmental surfaces. Other general guidelines include:

- All equipment and working surfaces must be cleaned and disinfected with a 10 % bleach solution as soon as possible after contact with blood or other potentially infectious materials
- Never pick up broken glass with bare hands (Always use tongs or a broom and dustpan)
- Place contaminated sharps and other potentially infectious waste in labeled or color-coded leak-proof puncture resistant containers that are closable and easily accessible to those who use them. Infectious containers should not be allowed to overfill
- Handle contaminated laundry as little as possible and with minimal agitation. Place soiled laundry into labeled or color-coded leak-proof bags or containers without rinsing

- Bins, pails, cans and similar receptacles that are reused and have a reasonable likelihood for becoming contaminated with blood or other potentially infectious materials shall be inspected regularly and decontaminated on a regularly scheduled basis

HBV VACCINATION

If you are exposed to blood or other potentially infectious materials as part of your job duties, the school must make the Hepatitis B preventative vaccination available to you at no cost. If you are in such a job and decline to take the vaccine, you must sign a declination document. Vaccination entails three injections over a six-month period. Today's vaccines are safe and effective.

In the event of an on-the-job exposure incident requiring a post-exposure vaccination, administration of the vaccine should begin within 24 hours of the exposure. The employer will bear the cost of the vaccination.

EXPOSURE INCIDENT

An exposure incident is a specific eye, mouth, other mucous membrane, non-intact skin, or puncture contact with blood or other potentially infectious materials. The following steps must be followed:

- Immediately wash area with soap and water
- If splashed in eyes or contact with mucous membrane occurs, flush area with water
- Report immediately to school principal
- Confidential medical evaluation and follow-up will be offered and paid for by the employer

Watch for fluorescent orange-red labels, red bags and containers with a biohazard symbol. This is your warning that the contents of the container contain blood or other potentially infectious materials.

Procedure for Cleaning Contaminated Surfaces

1. Use gloves. Use PPE as appropriate
2. Place paper towels on the spill
3. Thoroughly soak the area with a 10% solution of bleach (1 oz. Bleach to 9 oz. water. This must be made fresh at the time of need because the effectiveness is lost after one day). The solution may be poured or sprayed on the area.
4. Let the solution set for at least two minutes
5. Scoop up paper towels with dry paper towels and discard in a clean plastic bag
6. Repeat procedure
7. Remove gloves and discard in the same plastic bag
8. Wash hands thoroughly
9. Use a second clean bottle of 10% bleach solution to spray on the first contaminated bottle and around the clean up area. Let set for two minutes, then dry with a paper towel
10. Discards not deemed biohazardous waste shall be placed in plastic bags for disposal
11. Discards deemed biohazardous waste should be placed in second red plastic bag for appropriate disposal. In all cases, remove most of the air from all plastic bags and be careful not to touch the inside of the bags. Tie a knot in bags to close. Red bags shall be taken to a central biohazardous waste area and placed in appropriately labeled container for special disposal.

ACKNOWLEDGEMENT OF TRAINING

I have attended _____hour (s) of (general, intensive) Bloodborne Pathogens training and I have read and understand the training handout **"Bloodborne Pathogens in the Educational Setting."**

Employee's signature _____Date _____

Trainer's signature _____Date _____

This form is required by OSHA to be kept in the

Employee's permanent file, for a period of 3 years.

INFORMATION FOR PARENTS AND GUARDIANS

This school along with all other Catholic Schools across Texas is required by the Federal Occupational Safety and Health Administration (OSHA) to comply with standards for Control of Bloodborne Pathogens. Bloodborne pathogens are the organisms (germs), which spread Hepatitis B and HIV (the virus which causes AIDS) as well as many other diseases. Our employees have attended special trainings and this school is using specific techniques for reducing the risk of spreading disease caused by bloodborne pathogens, including:

- Employee/staff training in universal precautions, hand washing, sharps management, wearing personal protective equipment, regulated waste and decontamination of environmental surfaces
- Housekeeping procedures and schedules have been modified
- Specialized waste disposal practices are in use
- Employment procedures for Hepatitis B vaccination and exposure incident reporting have been established

A copy of the complete Bloodborne Pathogens Exposure Control Plan is available in the principal's office and you are welcome to review it.

If you have questions, please call the school.

BLOODBORNE PATHOGEN POWER POINT SLIDES

This document was prepared in spring 2011 to act as the training tool for all school personal and high school students. The power point and quiz is available on the TCCED Catholic Schools CD in both English (2011) and Spanish (2013) and by contacting Nancy Eder, RN at no charge, neder@fwdioc.org

Included in the power point:

Slide 1 – Bloodborne Pathogens

Slide 2 – Objectives
- What are bloodborne pathogens? Epidemiology, signs and symptoms
- How are they transmitted? Modes of transmission
- How can I protect myself? Universal precautions

Slide 3 – What are bloodborne pathogens?
- Any pathogen found in blood and body fluids that can cause disease
- The most commonly transmitted bloodborne diseases are
    1. HIV
    2. Hepatitis B
    3. Hepatitis C

Slide 4 – Exposure
- Modes of transmission
- Blood
- Body fluids, semen, vaginal secretions, cerebral spinal fluids, amniotic fluid, pericardial fluid, and fluid visibly contaminated with blood
- Broken skin, open sores, abrasions, cuts

Slide 5 – Human Immunodeficiency Virus
- HIV is the virus that causes AIDS
- Immune system loses its ability to fight reactions
- Virus can lay dormant, if infected may not show signs and symptoms for years
- Advancements in treatment have been made
- No Cure

Slide 6 – How is HIV transmitted?
- Infection can happen when accidently injure yourself with a sharp object
- Broken glass, sharp metal, needles, knives, exposed ends of orthodontics
- Open cuts, nicks, skin abrasions, dermatitis, acne, mucous membranes of your mouth, eyes and nose

Slide 7 – Hepatitis B
- Hepatitis means inflammation of the liver
- Hepatitis B is a virus that effects the liver
- Symptoms if apparent are “flu like” – weakness, fatigue, abdominal pain, nausea, vomiting
- Hepatitis B vaccine is available for prevention

Slide 8 – Hepatitis B Transmission
- Blood
- Intimate contact
- From infected mother to fetus

Slide 9 – Hepatitis C
- Most chronic bloodborne infection in the U.S.
- Causes scaring of the liver, can also cause liver cancer
- Symptoms similar to Hepatitis B – fatigue, jaundice, abdominal pain, loss of appetite
- NO vaccine for Hepatitis C

Slide 10 – Hepatitis C transmission
- Spread through blood and intimate contact
- Injection drug use
- Tattoos
- Blood transfusions and organ transplants before 1992
- Child born to infected mother

Slide 11 – How can I protect myself?

- Reduce the risk
- Handwashing!
- Universal Precautions – Treat all blood and body fluids as being contaminated and potentially infectious
- Gloves, sharps containers, biohazard bags

Slide 12 – Handwashing

1. Wet hands
2. Soap
3. Lather and scrub for 20 seconds
4. Rinse for 10 seconds
5. Turn off tap
6. Dry your hands

Don't forget to wash between your fingers, under your nails and the tops of your hands

Slide 13 – Personal Protective Equipment (PPE)

- Personal protective equipment protects you from contact with blood and other potentially infectious materials
- Equipment may include: Gloves, gowns or aprons, face shields, protective eye wear, mouth pieces for resuscitation

Slide 14 – Housekeeping

- If you must clean up blood or body fluids, wear appropriated PPE, gloves, mask, goggles, gown and shoe protectors if necessary
- Use a solution of 10% bleach for cleaning
- Disinfect mops and cleaning tools as soon as possible
- Never pick up broken glass with bare hands, use tongs or broom and dustpan
- Place contaminated sharps in puncture resistant sharps containers and other potentially infectious materials in biohazard bags

Slide 15 – Housekeeping Procedures

Procedure for Cleaning Contaminated Surfaces

1. Use gloves. Use PPA as appropriate.
2. Place paper towels on the spill.
3. Thoroughly soak the area with a 10% solution of bleach (1 oz. Bleach to 9 oz. water. This must be made fresh at the time of need because the effectiveness is lost after one day). The solution maybe poured or sprayed on the area.
4. Let the solution set for at least two minutes.
5. Scoop up paper towels with dry paper towels and discard in a clean plastic bag.
6. Repeat procedure.
7. Remove gloves and discard in the same plastic bag.
8. Wash hands thoroughly.
9. Use a second clean bottle of 10% bleach solution to spray on the first contaminated bottle and around the clean up area. Let set for two minutes, and then dry with a paper towel.
10. Discards not deemed biohazardous waste shall be place in plastic bags for disposal.
11. Discards deemed biohazardous waste, should be placed in a second red plastic bag for appropriate disposal. In all cases, remove most of the air from all plastic bags and be careful not to touch the inside of the bags. Tie a knot in bags to close. Red bags shall be taken to a central biohazardous waste area and placed in appropriately labeled container for special disposal. Each school has a Biohazard Waste Company on file to call.

Slide 16 - Exposure Incident

- If you come in contact with blood or other potentially infectious materials through eyes, mouth, other mucous membranes, non-intact skin or puncture; the following steps must be followed:
- Immediately was area with soap and water
- If splashed in eyes or contact with mucous membrane occurs, flush area with water
- Report immediately to school nurse or principal

Slide 17 – Prepared by:

Vandana Mall, UTA Senior Community Nursing Student
Comments by Nancy Eder, RN, School Nurse Consultant, Office of Catholic Schools
Diocese of Fort Worth, April 2011. Spanish translation: Lucia Romo, June 2013, Diocese of Fort Worth

BLOODBORNE PATHOGEN QUIZ

Name: _____ Date: _____

1. True or False

   All blood and body fluids should be treated as if they are contaminated.

2. Which of the flowing diseases does not have a preventative vaccine?

   A.) Hepatitis B

   B.) Hepatitis C

   C.) All of the above

3. True or False

   Hepatitis C can be transmitted through injection drug use, tattoos, and to a child born to an infected mother.

4. The most commonly transmitted bloodborne disease (s) are: (select all that apply)

   A.) HIV

   B.) Hepatitis A

   C.) Hepatitis B

   D.) Hepatitis C

5. HIV is the virus that causes:

   A.) AIDS

   B.) Hepatitis

   C.) Influenza

6. Which of the following statements is false?

   A.) HIV causes the immune system to lose its ability to fight infections.

   B.) If you are infected with HIV signs and symptoms may not be apparent for years.

   C.) There is a cure for HIV.

7. The most important thing you can do to protect yourself is?

   A.) Wearing gloves at all times

   B.) Running away from blood

   C.) Proper Handwashing

8. Proper handwashing includes:

    A.) Washing your hands for 20 seconds

    B.) Washing between your fingers and under your nails

    C.) Washing the tops of your hands

    D.) All of the above

9. Which of the following is not a mode of transmission?

    A.) Blood

    B.) Sweat

    C.) Body fluids

    D.) Broken skin

10. A virus that causes inflammation of the liver is?

    A.) HIV

    B.) H1N1

    C.) Hepatitis B

    D.) AIDS

Score: _____

A score of 70% is considered passing.

EXAMEN SOBRE AGENTES PAÓGENOS

Nombre: _____ Fecha: _____

1. Verdadero/Falso

   Todos los fluidos del cuerpo y la sangre deberían tratarse como si estuvieran contaminados.

2. ¿Cuál de las siguientes enfermedades no cuenta con una vacuna preventiva

   A) Hepatitis B

   B) Hepatitis C

   C) Todas las Anteriores

3. Verdadero/Falso

   Hepatitis C puede ser transmitida por inyecciones para el uso de drogas, tatuajes y por infección transmitida madre a hijo durante el embarazo.

4. La enfermedad transmitida por la sangre más comúnmente son: (Seleccione todos los que aplican)

   A) VIH

   B) Hepatitis A

   C) Hepatitis B

   D) Hepatitis C

5. VIH es el virus que causa:

   A) SIDA

   B) Hepatitis

   C) Influenza

6. ¿Cuál de los siguientes es falso

   A) VIH causa que el sistema inmune pierda la habilidad para pelear contra las infecciones

   B) Si estas infectado con VIH los signos y síntomas pueden no presentarse por años.

   C) Existe cura para el VIH.

7. ¿Que es lo más importante que puedes hacer para protegerte

   A) Usar siempre guantes

   B) Alejarse de la sangre

   C) Lavarse las manos correctamente

8. El lavarse las manos correctamente comprende:

    A) Lavarse las manos por 20 segundos

    B) Lavarse entre los dedos y bajo las uñas

    C) Lavarse las palmas de las manos

    D) Todas las anteriores

9. ¿Cuál de las siguientes **NO** es un modo de transmisión

    A) Sangre

    B) Sudor

    C) Fluidos del Cuerpo

    D) Heridas en la piel

10. El virus que cause la inflamación del hígado es:

    A) VIH

    B) H1N1

    C) Hepatitis B

    D) SIDA

BLOODBORNE PATHOGEN QUIZ KEY

1. True
2. B
3. True
4. A, C and D
5. A
6. C
7. C
8. D
9. B
10. C

Respuestas de Examen sobre Agentes Patógenos:

1. Verdadero
2. B
3. Verdadero
4. A, C and D
5. A
6. C
7. C
8. D
9. B
10. C

MANAGING ADD/ADHD IN THE CHILD CENTERED SETTING

"I am always ready to learn, although I do not always like being taught"
-Winston Churchill

Goal: To allow all children in the setting to function optimally by reducing the ADHD child's unintentional disruptions and reducing the time you must spend managing the ADHD child.

General Strategies

1. Use positive reinforcement to change behavior and motivate students
2. Educate the entire group about how everyone has strengths and weaknesses and differences
3. Establish the environment of kindness, respect and cooperation
4. Establish a buddy system
5. Handle medication discreetly
6. Determine each child's strengths, dominate learning styles and tailor your requirements
7. Use encouragement generously
8. Develop a sense of humor
9. Emphasize quality of work, not quantity
10. Adhere to a predictable schedule, and reinforce structure
11. Develop innovative, interesting daily activities
12. Be consistent

Specific Strategies

1. Remove distracting items from the room
2. Emphasize with color
3. Correctly place the ADHD child
4. Keep individual task periods short
5. Increase the distance between children
6. Do not use timers
7. Teach listening skills
8. Allow for physical movement
9. Establish eye contact
10. Use classical music
11. Vary voice tone and inflection
12. Help reduce the frustration of writing
13. Combine sight, sound and motor cues

ALLERGIES

Management of Life-Threatening Allergies

A) Identification of Children at Risk

- It is the responsibility of the anaphylactic or potentially anaphylactic child's parents to inform the school principal of their child's allergy
- All staff members need to be made aware of these children
- Each child should wear a MedicAlert® bracelet that states his or her allergy/allergies and the location of his/her auto-injector(s) (EpiPen®)
- A photograph and a description of each child's allergy should be kept *discreetly* in the child's teacher's Day Book and the School Nurse's office

B) Availability and Location of EpiPens®

- Anaphylactic or potentially anaphylactic children who have been issued a prescription for an EpiPen® shall deliver at least two (2) to the school nurse for use in case of an emergency
- Each child should wear a MedicAlert® bracelet that states his or her allergy/ies
- Children who are no longer allergic or no longer require an EpiPen® must present a letter of explanation from their allergist
- Additional EpiPens® should be brought on field trips. If the location is remote, it is recommended that the organizer of the field trip carry a cell phone as well

C) Treatment Protocol

- An individual treatment protocol needs to be established by the child's allergist**.** The school cannot assume responsibility for treatment in the absence of such a protocol. A copy of this should be delivered to the School Nurse
- To manage an emergency, a routine must be established and practiced

    a. One person stays with the injured individual at all times
    b. One person goes for help
    c. Administer epinephrine at the first sign of reaction, however slight (e.g. itching or swelling of the lips/mouth in food allergic children). *There are no contraindications to the use of epinephrine for a potentially life-threatening allergic reaction.* Note time of administration
    d. Call 911 and, regardless of the degree of reaction or response to epinephrine, transfer the child to an emergency room. Symptoms may recur up to eight hours after exposure to allergen. One calm and familiar person must stay with the child until a parent or guardian arrives. If the child is being driven to hospital, it is recommended that another individual accompany the driver to provide assistance
    e. Contact the child's parents

- Staff must be encouraged to listen to the concerns of the anaphylactic child. The child usually knows when s/he is having a reaction, even before signs are manifested

D) Training

- Each year there should be an awareness session and training for all staff, which includes a demonstration on the use of the EpiPen®

- Substitute teachers will be advised of at risk children in their class and emergency protocol for such children

E) Allergen Awareness / Allergen Avoidance

The question of banning anything in schools is controversial. We live in a world that is contaminated with potential allergens. Anaphylactic children must learn to avoid specific triggers. While the key responsibility lies with the anaphylactic individual and his family, in the case of a young anaphylactic child, the school community must also be aware.

In schools, there are serious allergic reactions to peanut and nuts. There are allergies to other foods and insect/wasp stings as well.

In the classrooms of anaphylactic children, care is taken to avoid allergens. Parents should consult with the teacher before supplying food or craft materials to these classrooms. In short, the risk of accidental exposure to a food allergen has been significantly diminished although it can never be completely removed.

Given that anaphylaxis can be triggered by minute amounts of allergen, food anaphylactic children must be encouraged to follow certain guidelines:

- Eat only food, which they have brought from home unless it is packaged, clearly labeled and approved by their parents
- Wash hands before eating
- Do not share food, utensils or containers
- Place food on a napkin or wax paper rather than in direct contact with a desk or table

FOOD ALLERGY REACTION TRAINING

Date: _____

Food Allergies can be life threatening.
Knowing how to:

1. **Prevent exposures** in the classroom/lunchroom,
2. How to **identify symptoms** of a serious reaction, and
3. **What to do** if a student shows signs of a reaction are vital to the safety of students who have food allergies.

Prevention

Identification of students with food allergies

- Cafeteria staff should be alerted and given a list of students with serious food allergies.
- Teachers will be given a list of students with serious food allergies, their specific allergy and what symptoms they have shown with past exposures
- The teacher or teacher's assistant will inform substitute teachers about students with food allergies
- It is recommended that students with severe food allergies wear a Medic Alert® bracelet identifying their allergy

Prevention of Exposure

- Students with food allergies should only consume food brought from home, both for lunch and snacks
- Parents of students with allergies can provide a "SAFE" snack list for teachers to share with parents of other children who wish to bring snacks for holiday parties, birthday parties, etc
- Students with food allergies should bring their own lunches and snacks for field trips as well
- Care should be taken not to use any kind of food for crafts or play, i.e. peanut butter play dough
- Care should be taken when going on field trips to ask if students will be exposed to food in exhibits, i.e. crushed nutshells, or peanut/nut products in exhibits
- Care should be taken to wash tables in lunchroom and tables in classroom after snacks and lunch
- Students with food allergies should not place their lunch directly on a table. A napkin or a piece of wax paper should be placed on the table
- Frequent hand washing should be encouraged, especially after lunch. A student who ate a peanut butter sandwich could cause a reaction even by touching a student with an allergy
- Stress "NO SHARING OF FOOD" frequently with students

How to identify a SERIOUS REACTION

Allergic reactions can present in a variety of different symptoms. Reactions can progress very quickly from mild symptoms to life threatening symptoms. ALL REACTIONS, NO MATTER HOW MILD THEY MAY SEEM, MUST BE TAKEN SERIOUSLY!

Common symptoms of a serious reaction:

- Hives or rash on skin
- Swelling of face, lips, or tongue
- Itching or burning in mouth or throat
- Vomiting or abdominal cramps
- Coughing, wheezing, or trouble breathing
- Weakness or dizziness

What to do for a child who shows any signs of a reaction:

1. Get student away from allergic substance
2. Get student to clinic or call for nurse if unable to get student to clinic
3. Administer found EpiPen® in cabinet above sink and note time given
4. Call 911
5. Call Parents
6. Give other meds as directed per Medication Request Form
7. Stay with student until EMS arrives
8. One staff member must accompany student to ER and stay until parent arrives
9. Document event on accident/injury form

It is important to treat any of the above signs of an allergic reaction as serious and DO NOT WAIT to bring child to clinic. DO NOT BE AFRAID TO ADMINISTER EPI PEN. This is a life saving drug!

What to do if a student with a food allergy has an exposure with no symptoms or mild symptoms.

Mild symptoms include itching or small-reddened area of skin.

For example: Joey is allergic to peanuts. A classmate ate a peanut butter and jelly sandwich and accidentally touched Joey on the arm. Joey complained of itching to his arm and you see some mild redness where he was touched.

1. Bring student to clinic
2. Note the time of the exposure
3. Have EpiPen® readily available
4. Call parents regarding exposure. Child must be picked up from school. A more severe reaction could develop, even several hours after the exposure. A child should be monitored for at least 4 hours after exposure
5. Check Medication Request form to see if student may have Benadryl. Give Benadryl per Medication Request form
6. Stay with student and monitor for more serious signs
7. IF SERIOUS SIGNS DEVELOP, GIVE EpiPen® IMMEDIATELY AND CALL 911
8. Document event on accident/injury form

Food Allergy Action Plan, *Forms*

ALLERGY TRAINING ROSTER

The following staff has completed the Food Allergy training

on _____and may administer the Epi Pen
(Date)

Name of Participant	Job Title

ANIMAL AND HUMAN BITES

Most animal bites are from cats and dogs and most have puncture wounds or lacerations with jagged edges; in severe bites, there may be pain and bleeding, and tissue may be torn away. Ignoring the wound may be extremely harmful because serious infections can come from bites of any animal.

Rabies is an acute, usually fatal viral disease of the central nervous system of animals. It is transmitted from animals to people by infected blood, tissue, or most commonly saliva. Common carriers of rabies are dogs, cats, foxes, skunks, bats, and raccoons. ALWAYS REFER TO A PHYSICIAN any break in the skin integrity. Refer to animal bite form in the form section, and notify your local animal control agency or police department of the incident. A student who is bitten will require preventive rabies shots.

Human bites

Human bites have the greatest potential for infection, and refer to a physician any break in the skin integrity. With human bites, consideration must be given for transmission of hepatitis B or, in rare cases immunodeficiency virus. (HIV) Refer to the form section for the student exposure form and accident report form.

Prevention of Tetanus

Due to each individual's requirements, advise the parents to obtain medical advice.

- No previous active immunization with tetanus toxoid: tetanus immune globulin and begin a series of tetanus toxoid
- Active immunization 10 years ago or longer: booster of adult tetanus toxoid (Td)
- Active immunization within the past 5 years: mild bite requires no booster; severe bite requires a booster adult Td
- Severe, neglected, old (over 24 hours), or dirty bite: adult Td, unless patient has had one in the previous 12 months

First Aid

In addition to observing universal precautions for wound care, animal bites should be treated as follows:

Obtain the description and location of the biting animal: breed, color, size, owner's name if known, and owner's home address if known. The animal will need to be confined for 10 days. Also notify the police or animal control center. If the bite is from a classroom pet, follow first aid suggestions and ask the animal control center, health department, or police department for advice regarding confinement of the animal.

For human bites, observe universal precautions for wound precautions for wound care and do the following:

1. Wash the wound with soap and running water for at least 15 minutes.
2. Apply a sterile dressing if there is bleeding. Remove the dressing when the bleeding stops. Leave the wound open to the air to dry.
3. Notify the parent, and recommend medical evaluation.

Human bites have a high potential for infection and may prophylactic treatment with antibiotics by a physician. Note: Covering a non-bleeding wound caused by an animal or human bite with a dressing can create a dark, warm, moist area in which germs may thrive. When at all possible, leave the wound open to air dry after cleaning.

Reference: The New School Nurse Health Handbook, 3rd edition
Human bite, use accident form, and as indicated, student exposure form
Animal bite form, for animal bites, Section 4, *Forms*

ASTHMA

The Disease
A disease obstructing airways in the body, it causes 25% of all chronic illness absence and affects 3 to 15% of all school children significantly. The disease constricts breathing passages, sometimes severely. The resulting shortness of breath may make a student panic or become very restless. Frequently, children on routine medication for asthma experience side effects such as nervousness, jumpiness, sleepiness or fatigue.

The typical symptom of an impending attack is wheezing, but often just coughing can signal an asthma attack. Other symptoms are drowsiness, withdrawal, irritability, and nervousness, especially in younger children.

Asthma is not contagious. Attacks may come on suddenly, and can frequently be reversed with the immediate use of an inhaler, rest, medication or other techniques prescribed by a physician. Asthma can be fatal, and kills many children every year.

Plan of Action
A plan of action[22] for teachers and staff to implement in the event of an asthma attack should be completed by the parent and physician, kept in a readily accessible place in the school, and followed carefully. The plan should be reviewed and updated at least every three months or after an acute episode.

Intervention
If an asthmatic child has trouble breathing, the teacher or nurse should try to get the youngster to relax and drink warm water, up to three cups five minutes apart. Very slow breathing up to five minutes also helps to relieve air trapped in lungs. Call the parent if attack does not seem to subside within a few minutes. Follow physician's orders regarding medication.

Exercise Induced Asthma
Over 50% of asthma attacks are caused by physical activity. Students should be encouraged to participate in all physical activities, but should be encouraged to self-monitor breathing and to take rests at intervals. Students with exercise induced asthma typically suffer an attack about 15 to 20 minutes after ceasing physical exertion, and should be monitored closely in the classroom they are assigned to following P.E., sports or recess.

[22] Asthma Plan of Action form, Section 4, *Forms*

CARDIAC INFORMATION FOR CHILDREN

- Chest pain can occur in children and teens at rest or with activity. Assess the quality of the pain, and the associated symptoms. Check the pulse, respiratory rate and blood pressure and document these findings in the student treatment log. Notify the parent/guardian.

- Dizziness and syncope (fainting) can also occur with children. This can occur with exercise, noise, anger, body position, being startled and activity. Visual changes can occur, palpitations, color changes, diaphoresis and chest pain. Document the pulse, respiratory rate, and blood pressure findings. Notify the parent/guardian.

- Has the child fainted after exercise?

- Has the child ever had extreme shortness of breath during exercise?

- Has the child had extreme fatigue associated with exercise (different from other children)?

- Has the child ever been diagnosed with an unexplained seizure disorder? Or exercise –induced asthma not well controlled with medication?

- Onset of palpitations can be slow or sudden in onset. Causes vary from anxiety, anemia, and fever/infection, hyperthyroidism and sinus and supraventricular tachycardia. Monitor P-RR-BP, document and notify the parent/guardian.

Warning Signs:

- Any family members who died suddenly of "heart problems" before age 50?

- Family members fainting (syncope) or seizure during exercise, excitement or startle?

- Or family member with unexplained fainting or seizure?

Additional Family History Questions/concerns:

- Enlarged Heart: Hypertrophic cardiomyopathy (HCM) or Dilated cardiomyopathy (DCM)
- Heart Rhythm problems: Long QT syndrome, Short QT syndrome, Brugada syndrome, Catecholaminergic ventricular tachycardia, Arrhythmogenic right ventricular cardiomyopathy (ARVC)
- Marfan Syndrome (aortic rupture)
- Heart attack, age 50 or younger
- Pacemaker or implanted defibrillator
- Deaf at birth (congenital deafness)

References:
Susan Hess, MD, Cook Children's Heart Center, Fort Worth, Texas
Project Adam, Laura Friend, Cook Children's Fort Worth, Texas

CHILD ABUSE AWARENESS FOR EDUCATORS

Definitions

Physical Abuse: Any non-accidental physical injury caused by the child's caretaker. Does not necessarily include the intent to injure; may be the result of over discipline or inappropriate punishment.

Sexual Abuse: Any contacts or interactions between a child and an adult in which the child is being used for the sexual stimulation of the perpetrator or another person.

Emotional Maltreatment: Blaming, belittling or rejecting a child; treating siblings unequally; persistent lack of concern by caretaker for child's welfare.

Neglect: Inattention to basic needs of a child such as food, clothing, shelter, medical care and supervision. This tends to be chronic.

Circumstances of Reporting In Texas
Laws governing the reporting of child abuse and neglect are found in Chapter 261 of the Texas Family Code. A report of child abuse is not an accusation or a proven fact, and Texas does not require a reporter to know or to be certain that a child has been abused or neglected. In Texas, the degree of certainty which must be met is that the person reporting has "cause to believe" (Chapter 261, Texas Family Code) that abuse or neglect has occurred or will occur. This standard is based on the reasonable persons convictions.
The agency, which receives the report, is the Texas Department of Family and Protective Services (Texas Child Protective Services division). They will investigate and will determine the nature and extent of the problem, evaluate the child's condition and safety, and if appropriate, initiate action to protect the child. In some cases, a law enforcement agency receives the report.

School Policy

Most schools and/or school districts have an official policy on how to report child abuse and neglect. Many schools have policies addressing practices to insure student and teacher protection. Teachers should be familiar with their local policy.

Privileged Communications

"In any proceeding regarding the abuse or neglect of a child or the cause of any abuse or neglect, evidence may not be excluded on the ground of privileged communication except in the case of communications between attorney and client."

Classroom Resources

Structured classroom anti-victimization programs such as "W.H.O. (We Help Ourselves)", "McGruff" and guidance curricula are available to schools. They provide the student with resistance skills on an age appropriate level.

The classroom teacher may be the student's most accessible resource for child abuse prevention and reporting. Teachers are encouraged to provide and model a classroom atmosphere, which encourages non-judgmental concern, communication and action.

Diocesan Requirements
Each Diocese in the State of Texas is required to have education for employees and volunteers before working in any position with children regarding child abuse and sexual misconduct. This is mandated by the U.S. Bishops. Refer to individual diocese for classes, background checks and requirements.

Points to Remember

A teacher may be the only nurturing and competent adult in a child's life.

Teachers are among the most effective advocates for children.

Recognizing abused children is often difficult and uncertain. The reporting statute regarding "cause to believe" may be somewhat vague and may not comfortably resolve the teachers dilemma as to reporting, however, the reporter should recognize that having "cause to believe" is a very low threshold to meet. One does not need “evidence” or “proof.” The statute is weighed in favor of protecting the child, even at the expense of an occasional report of abuse, which is not validated.

The following points are offered for those teachers who find themselves in a situation about which they are uncertain:

- Resolve doubt in favor of the child
- Discuss your observations and concerns privately with another staff person who is familiar with the child
- Trust your instincts, your "gut" feelings
- Remember that you do not have to prove the abuse is occurring; reporting is a request for an investigation into a suspected case of abuse
- Call Child Protective Services and request advice in determining "cause to believe"
- Remember that an educator who reports is on firm ground
- Believe the child who discloses and reassure that child that he/she has done the right thing by telling you

Since responsibility for setting the protective process in motion often falls to educators, other recommendations include:

- Understand the importance of early case finding
- Let your class know that they can talk to you, a counselor or a nurse about problems
- If you sense a child is trying with difficulty to talk to you, sit down with a simple project, crayons or puzzle and let the child know you will believe and help him or her with any problem
- Don't promise not to tell
- Assure the child that he or she is not in trouble for telling you
- Tell a child what to expect. If you don't know, say so, but let the child know that he or she can expect to be supported and helped
- Respect the child's privacy by not discussing the situation out of school
- You may not delegate reporting responsibility to another person

Immunities

(Chapter 261.106 Texas Family Code)
a.) "A person acting in good faith who reports or assists in the investigation of a report of alleged child abuse or neglect or who testifies or otherwise participates in a judicial process arising from a report, petition or investigation of alleged child abuse or neglect is immune from civil or criminal liability that might otherwise be incurred or imposed."

Reporting Procedures

Texas requires immediate reporting, by all persons, of suspected child abuse and neglect. However, professionals specifically are mandated to report no later than 48 hours from the moment of the abuse is discovered or suspected. "Professional," in the Texas reporting statute, is any "individual who is licensed or certified by the state, or who is an employee of a facility licensed, certified, or operated by the state, and who, in the normal course of official duties, for which a license or certification is required, has direct contact with children."

An oral report should be made immediately. The reporter will be asked to state, if known, names and addresses of the child (children) as well as parents or persons having custody of the child (children); the nature and extent of the child's injuries or abuse, including evidence of previous abuse or neglect; the names and ages, if known, of other children residing in the household; and any other information which may be helpful in establishing the cause of injury and protecting the child. Confidentiality is inherent in the reporting and investigating process.

In the State of Texas the telephone number for making a report is: 1.800.252.5400

Reporting can be done online: txabusehotline.org

Indicators of Physical Abuse

- Unexplained bruises and welts…
  - anywhere on body
  - in various stages of healing
  - clustered
  - forming regular patterns
  - reflecting shape of article used to inflict (cord, buckle)
  - on several different surface areas
  - regularly appear after absence, weekend, or vacation
- Unexplained burns ...
  - small burns, especially on soles. palms, back, buttocks
  - immersion burns (sock-like, glove-like)
  - patterned like electric burner, iron, etc.
  - rope burns on arms, legs, neck, or torso
- Unexplained fractures
- Unexplained lacerations or abrasions

- Wary of adult contact
- Apprehensive when other children cry
- Behavioral extremes: aggressiveness, or withdrawal
- Frightened of parents, or other significant persons
- Afraid to go home
- Reports injury by parents

Indicators of Emotional Maltreatment

- Speech disorders
- Lags in physical development
- Habit disorders (sucking, biting, rocking, etc.)
- Conduct disorders (antisocial, destructive, etc.)
- Neurotic traits (sleep disorders, inhibition of play)
- Psychoneurotic reactions (hysteria; obsession, compulsion, phobias, hypochondria)
- Behavior extremes: compliant, passive, aggressive, demanding
- Overly adaptive behavior, inappropriately adult or inappropriately infant

Indicators of Sexual Abuse

- Sexually transmitted disease in a child of any age
- Pregnancy at an early age
- Evidence of physical trauma to the genital area or mouth
- Odd or unusually shaped bruises; caused by sucking
- Complaints of itching, pain or discomfort around the genital area
- Torn, stained. or bloody underclothing
- Extreme passivity when touched
- An abrupt change in behavior
- Seductive behavior with classmates, teachers, other adults
- Promiscuity
- Touching to either extreme-either inappropriate sexual touch and behavior or extreme reluctance to be touched by an adult
- Knowledge of sex that is inappropriate for the child's age or developmental level; explicit knowledge of sex act
- An unusual interest or fixation with sexual acts or terminology
- Refusal to undress for physical education
- A child who attempts to run away from home repeatedly
- Depression, withdrawal, few friends
- Regressive behavior
- Denial of a problem with great lack of expression
- Reluctance to be with a certain person
- A child who is “too good” in class; passive and complacent
- Anger directed anywhere and everywhere; especially if child switches from one extreme to another
- Indirect hints, open disclosure statement, fishing for attention

Indicators of Neglect

- Begging, stealing food
- Extended stays at school (early arrival or late departure)
- Constant fatigue, listlessness, or falling asleep in class
- Alcohol or drug abuse
- Delinquency
- States there is no caretaker
- Consistent hunger, poor hygiene, inappropriate dress
- Consistent lack of supervision, especially in dangerous activities or over long periods
- Unattended physical problems or medical needs
- Abandonment

CONCUSSION IN CHILDREN

Signs and Symptoms of a Brain Injury

The signs of a brain injury (concussion) can be subtle. You should be alert for symptoms that may appear immediately and others that may not show up for days, weeks, or even months after the injury.

- Headaches or neck pain that do not go away
- Difficulty remembering, concentrating, or making decisions
- Slowness in thinking, speaking, acting or reading
- Getting lost or easily confused
- Feeling tired all the time, having no energy or motivation
- Mood changes (feeling sad or angry for no reason)
- Changes in sleep patterns (sleeping a lot more or having a hard time sleeping)
- Light-headedness, dizziness, or loss of balance
- Urge to vomit (nausea)
- Increased sensitivity to lights, sounds or distractions
- Blurred vision or eyes that tire easily
- Loss of sense of smell or taste
- Ringing in the ears

Dial 911 **immediately** if the child:

- Can't stop vomiting
- Is not speaking clearly, seems confused or doesn't know you
- Has trouble with vision (seeing double, blurry vision) or has pupils that are different sizes
- Has severe headache
- Has blood or clear fluid from the nose or ears
- Has trouble with balance or walking, or
- Has a seizure (convulsions, eyes fluttering, body going stiff, staring into space or a sudden onset of a fixed stare)

Contact the child's physician or your local emergency room if you notice any of these changes following the child's injury:

- Changes in sleep patterns
- Experiences changes in personality, behavior or mood, irritable or crankiness
- Changes in school performance
- Changes in attention or concentration
- Gets upset or frustrated easily
- Overreacts, cries or laughs too easily
- Vomiting
- Loss of balance or unsteady walking
- Lack of interest in favorite toys or activities
- Tiredness or listlessness

Do not let the child fall asleep for 5 hours. Sleepiness is a sign of a traumatic brain injury. If it is late at night or regular bedtime, wake the child every 1/2-hour for 5 hours. If the child is uncontrollably tired or you cannot wake the child, call 911 immediately.

For additional information, contact:

Texas Brain Injury Alliance
1-800-392-0040
http://www.texasbia.org/

Texas Traumatic Brain Injury Advisory Council
http://www.hhsc.state.tx.us/hhsc_projects/abj/Council.shtml

Head Injury Form, Section, *Forms*

DIABETES

Type 1 Diabetes and the School age child

Diabetes is the second most chronic childhood disease. A child with Type 1 (insulin-dependant) diabetes, the pancreas does not produce insulin, a hormone necessary to sustain life. The symptoms develop over a short period of time. They include blurred vision, increased urination, and constant hunger and weight loss, often associated with tiredness.

Students with Diabetes

As soon as possible after a student is diagnosed with diabetes, and before the student returns to school there must be a meeting of (at a minimum) the parent, principal, teacher(s) coach, physician (or designee) to agree on a plan of care,[23] including responding to a diabetic crisis, during the school day.[24] *Chapter 168 of the Health and Safety Code pertains only to public schools and does not apply to private schools. Catholic Schools are considered to be in the private sector and if someone who is not licensed performs diabetic services, they would be subject to violations of various laws. This said; Catholic Schools are not covered by Civil Immunity under the law as public schools/employees are.*

Low blood sugar (Hypoglycemia)

- Headache
- Sweating
- Shakiness
- Pale, moist skin
- Cold and clammy
- Extreme hunger
- Weakness/dizziness
- Fatigue/tiredness
- Rapid pulse rate
- Blurred vision
- Shallow breathing
- Inability to concentrate
- Loss of coordination
- Mental Confusion
- Seizure

Each child has a particular set of personal symptoms that you will come to recognize.

Treatment: Check the blood sugar with glucometer. Follow the child's plan of care for treatment. *If the child is awake and can swallow*, provide sugar immediately. Examples are: give 1/2 cup of fruit juice and glucose tablets as prescribed by the physician. The child should be feeling better within 10 minutes. Recheck blood sugar. Document on flow sheet and notify parent/guardian.

If the child has lost consciousness or is having a seizure, call 911. Check blood sugar, and administer glucagon as prescribed by the physician. Notify parent/guardian.

High blood sugar (Hyperglycemia)

- Increased thirst
- Weakness or fatigue
- Blurred vision
- Frequent urination
- Loss of appetite

Blood sugar levels can increase rapidly in children. Hyperglycemia can be caused by too much food, too little activity, not enough insulin, or illness or infection. Confirm with glucometer. Notify parent/guardian.

[23] Sample Diabetic Care Plan, Section 4, *Forms*
[24] Insulin monitoring forms, Section 4, *Forms*

Ketoacidosis

- Dehydration
- Labored breathing
- Vomiting
- Abdominal pain
- Fruity-smelling breath
- Weakness or fatigue

Ketoacidosis is a diabetic emergency. In most cases, but not all, very high blood sugar levels are also present. The child can lapse into coma, call 911 and immediately notify parent/guardian.

Daily routine of a child with Diabetes

Consistency is the key - regular meals and meal times, and regular insulin. In addition, the child will need to test his or her blood sugar level at various times of the day to determine food or insulin needs.

Diet

Children with diabetes can eat the same healthy foods as other children. The lunchroom manager should be aware of the child's diet restrictions, but usually the child is taught to select the right foods.

Frequent Snacks

A child with diabetes may require snacks at mid-morning, mid-afternoon and bedtime. Keeping these snacks and meals along with the insulin on time will help maintain proper balance and avoid low blood sugars.

Exercise

Children with diabetes can participate in all kinds of active sports. However, since exercise burns up a lot sugar, the child should have an extra snack of juice or crackers before planned strenuous exercise to avoid low blood sugar. Exercise should not be scheduled just before a meal.

Self-Monitoring of Blood Glucose

This is done several times a day, before meals and before bedtime. The usual procedure involves the child pricking the finger, putting a drop of blood on a chemically sensitive strip, and taking a blood sugar reading on a meter. Older children usually are able to do this themselves; younger children may need help. This should be done in the school clinic with adult supervision as needed, with appropriate documentation.

General Tips

If behavior problems arise as a result of an insulin reaction, you should not blame the child. Quick action on your part can prevent a medical emergency.

- Watch the child's behavior before meals and snacks
- Make sure meals are eaten on schedule
- Don't assign physical exercise just before a meal when the child may be in need of food
- Arrange an inconspicuous means of taking the mid-morning and/or afternoon snacks
- Keep a source of sugar readily available, and encourage the child to carry some form of sugar
- Make sure all necessary personnel are informed about the child and their diabetes
- Most children need a snack at night before bedtime

Useful websites:

www.ndep.nih.gov/diabetes/pubs/Youth_SchoolGuide.pdf
www.diabetes.org
www.jdrf.org

References:
Juvenile Diabetes Research Foundation International School Nurse News, September 2003
Sample Diabetic Care Plan, Worksheets, Section 4, *Forms*

EPILEPSY

The Disease

Epilepsy is a condition caused by a temporary malfunction of electrical brain waves. It is characterized by seizures, and is more commonly seen in children than adults. Epilepsy is frequently outgrown during the teen years. Cessation of breathing for a period of time during the seizure causes concern about deprivation of oxygen to the brain.

Typically, the most difficult part of the seizure for the victim is the embarrassment afterward, which requires sensitivity and support from teachers if it occurs at school. Discussions with other pupils to gain their understanding are helpful. Any type of seizure should be documented carefully.

The World Health Organization (WHO) classifies seizures as follows:

1. **Tonic-Clonic Seizures (Grand Mal)** often results in collapse, muscle rigidity and convulsive movements. Sometimes begins with as "aura", seeing a halo of light or having an unusual feeling prior to the seizure. Loss of consciousness occurs and saliva builds up in the mouth. May last one to three minutes. The victim may sleep thirty to sixty minutes afterward and may have residual muscle soreness.
2. **Jacksonian or Partial Seizures Seizure** may be limited to one side of the body and/or there is not a loss of consciousness or a period of deep sleep following the seizure.
3. **Absence Seizures (Petit Mal)** usually brief (10 to 20 second) episodes during which the victim suffers a period of cloudy consciousness and is completely out of contact. No loss of body muscle tone and usually no falling down. When the episode is over the victim usually resumes prior activity.
4. **Complex Partial Seizure** This seizure is brief in duration, lasting 1 to 10 minutes. It causes the victim to engage in a sudden spurt of coordinated motor activity that may appear purposeful and under complete voluntary control.

Treatment

For a grand mal seizure, do not attempt to restrain the victim. Let the convulsion run its course, making sure that the victim's head is protected from injury. **Do not attempt to put anything into the mouth of a person having a seizure.** The more stimulation a victim receives during a seizure, the longer a seizure will last. As the seizure ends, turn the victim onto their side to allow saliva or vomitus to drain out of the mouth. Allow the victim to sleep afterwards until he or she awakens.

A plan of action to be used in the event of seizure in school should be formulated by the parent, staff and physician of a student suffering from epilepsy. The plan should include conditions for parent notification and/or emergency medical assistance.

RECOMMENDATIONS FOR ADMINISTRATION OF "DIASTAT" AT SCHOOL

Information about Diastat, 5/2011

- Diastat is a medication that is currently being used rectally to treat students with prolonged seizures and loss of consciousness.

- Diastat is being ordered for school age students. Current Federal Law applies only to Public Schools at this time, mandating administration in public schools.

- If your school has a RN or LVN on duty that can administer Diastat, it should be in alignment with your individual Diocesan Medication Policy. The school principal is required to be notified with involvement of the parents to give permission and assist in the education of the child's teachers/school staff about epilepsy. The child's vital signs must be monitored until the parent arrives to pick up the child. As with any prescription medication each school must follow diocesan policy on medication administration and utilizing the appropriate permission forms.

- There is to be plan of care from the physician for administration of Diastat and if the physician would require 911 to be called when administered or if the parents are permitted to come and pick up their child.

Procedures for Administering Rectal Medications

1. Place student in side-lying or prone position (on stomach).
2. Lubricate suppository with water-soluble gel (i.e., K-Y Jelly).
3. Using a finger cot, gently insert the suppository into the rectum.
4. Do not insert finger more than ½ inch.
5. Hold buttocks together for 5-10 minutes. This will help to prevent quick expulsion of the medication, enhancing absorption.
6. Maintain privacy at all times for these students especially.

Recommendations are that Catholic Schools who do not have a RN or LVN on staff are not to administer Diastat at their individual schools. Once again, unlicensed personnel are not covered by civil immunity.

Reference: www.diastat.com

HEAT AND HEAT INDEX AND COLD WEATHER GUIDELINES

- **Guidelines for Elementary and Middle Schools**

When the Temperature-Heat-Index (**THI) reaches 95^{o} F**, limit outdoor activity to 10-15 minutes with proper hydration of the children. (recess, dismissal etc.) NO outdoor PE or diocesan sports/practice longer than 15 minutes is permitted.

Purple ozone days, no outside PE or recess for PK-8th grade (confirmed in your area)
Check for ozone: http://www.tnrcc.state.tx.us
Temperature and Temperature Heat Index can be found: http://www.weatherbug.com
No outdoor sporting events for middle schools if the area is a confirmed purple ozone area.

Red ozone days, a plan is recommended for children with known lung disease, example asthma to be retained indoors; however, if parents/doctor release students for outdoor activity a plan should then be in place to observe and monitor students as well as referring them to the clinic and /or office should distress symptoms appear.

Orange ozone days, monitor ozone sensitive children who are active outdoors as well as referring them to the nurse/school office if respiratory distress symptoms appear.

Cold weather days, when the temperature and/or the wind chill is below 32^{o} F, the children should be kept indoors for PE and recess. When the temperature is above 32^{o} F, the children should be properly dressed for outdoor activity.

- **Band**

Outdoor marching band, practice or game, are required to have proper hydration just as an athlete does. Consult your athletic coaches.
(Gatorade Sports Science Institute (GSSI) www.gssiweb.com or call 1-800-616-4774.)

When the THI reaches and exceeds 95-102^{o} F, members of the band must wear the dress down uniform. (Light clothing) Once the temperature humidity index exceeds 102^{o} F, indoor practice is required.

- **High School Athletics**

Everyone comes off the field when the THI reaches **105^{o} F**. When the THI exceeds **102^{o} F,** high school football will only be required to wear shorts and helmets. All off-season workouts must have a coach present. Refer to specific written plans at each high school. This includes, summer conditioning, education, nutrition, hydration, and parent courses and information.

- **Severe storms including lightning**

When lightning is detected within a distance less than or equal to 8 miles, all students are moved indoors. A 30-minute wait period following the last lightning strike recorded is required before students may return to outdoor sports/activities. Proper documentation is recommended.

National Lightning Detection Network: www.vaisala.com

HIV/AIDS

Refer to individual Diocesan Policy regarding AIDS and confidentiality. Educate staff and students accordingly.

HIV, the human immunodeficiency virus, is a pathogen that can be transmitted from one person to another in certain specific ways. A person can live with HIV infection for many years without experiencing symptoms of illness.

AIDS, or acquired immunodeficiency syndrome, is the advanced stage of HIV infection and a life-threatening medical condition. CDC defines the point at which HIV becomes a diagnosis of Aids. Symptoms of AIDS appear in an adult on the average of ten years after infection with HIV; most adults die within two years of an AIDS diagnosis. Disease often progresses more rapidly in infants and children.

Privacy

Pupils or staff members are not required to disclose HIV infection status to anyone in the education system per the Family Educational Rights and Privacy Act 1974. (FERPA, also known as the Buckley Amendment)

Education

Refer to the Bloodborne Pathogen section of this manual for further information about HIV/AIDS, OSHA regulations, staff development, procedure for cleaning up body fluid spills and universal precautions.

Reference: Someone at School has AIDS. (NASBE 1996)

During his visit to San Francisco, Pope John Paul II assured the Group at Mission Dolores Basilica that *"God loves those of you who are sick, those of you who are suffering from AIDS...with Unconditional love." (September 1, 1987)*

Calling Catholic health workers to meet the HIV/AIDS challenge, Pope John Paul II urged*, "besides your professional contribution and your human sensitivities toward all affected by this disease, you are called to show the love and compassion of Christ and His Church." (Phoenix, September 14, 1987)*

MIGRAINES IN CHILDREN AND YOUTH

Headaches are common in children and teenagers. Statistics show that by age 7, 40% of children have had headaches with 1.4% being migraine.

Some children have weekly headaches, others several times a year.

At the onset of a migraine, the blood vessels in the head first contract (shrink,) then swell, causing pain. Tension, bright lights, loud noises, strong smells, weather changes, fatigue, missed meals and emotional upset all may trigger a migraine.

The headaches may also be brought on by many common foods and beverages, including lunch meat, hot dogs, alcohol, beans, coffee or tea, cheese, chocolate, nuts, pickles, raisins and canned soup. Artificial sweeteners can trigger a migraine. Another food trigger that has been associated with migraines is MSG. Research is underway to determine the role of MSG and migraines. There are many food items that may contain MSG, such as bullion, broth, soup base, candy and gum and almost anything that says "natural flavorings." Restaurants will share their nutritional information with the consumer, just ask.

Many females suffer headaches before or during their monthly period.

The headache is usually worse on one side of the head than the other, and the child will often feel sick or vomit. An "aura" may be present, such as a change in vision (blurred vision, flashing lights). Some children may have nausea prior to the onset of a headache, especially in the younger children.

What to do

If the child's physician has prescribed medicine to treat or prevent their headaches, give as directed at the onset. Do not wait. At the first sign of a headache:

- Apply cold compresses or ice packs to the child's head
- Let the child lie down in a quiet, dark room for several hours at home
- Do not let the child read, but listening to soft music may help

Keep a record of foods that the child ate before each headache. Avoid foods, such as chocolate, cheese, and red wine.

Try to keep life as free of stress as possible. Teach children and youth to pace themselves and get adequate rest.

Seek care immediately if the headache gets worse or lasts more than 24 hours despite treatment. Immediate care is required if the child develops a high temperature or shows any signs of being faint, weakness, numbness, double vision, difficulty with speech or neck pain or stiffness.

References: PDR Encyclopedia of Medicine Child Youth Health
The School Nurse Health Handbook, Third Edition

GUIDELINES FOR THE USE OF A FINGER OXIMETER

A non-invasive method of determining SpO2 saturation of oxygen in the blood in respiratory compromised students

Theory of Operation

The pulse oximeter determines SpO2 and pulse by passing two wavelengths of low intensity light, one red and one infrared, through body tissue to a photo detector. During measurement, the signal strength depends on the color and thickness of the body tissue, the sensor placement, the intensity of the light sources, and the absorption of the arterial and venous blood (including the time varying effects of the pulse) in the body tissues. The pulse oximeter processes these signals, to identify the pulse rate and calculate oxygen saturation.

Interpretation

An individual care plan for each child should be in place with directives from their physician for norms when using a pulse oximeter.

Pediatric norms of SpO2 are 92% or above. However, a healthy individual with normal lung function and circulatory function should have a SpO2 of 96% or above. An individual with respiratory compromise (asthma, pneumonia, etc.) may have an elevated respiratory rate with a SpO2<95%. A SpO2<94% should be considered an urgent emergency situation and a SpO2<90% in an otherwise healthy individual is a critical emergency. An individual with longstanding lung or heart disease may adjust overtime to this situation and maintain a SpO2 less than 94. Their physician must establish their individual norms.

An individual that is hyperventilating will typically have an elevated respiratory rate and effort with normal airflow on examination of the lungs without wheezing with SpO2 of 99% or above.

This device is typically used by a professional trained to interpret the individuals clinical presentation combining information and observations obtained from their history, physical exam (including vital signs), present treatment regimen and other diagnostic data. An individual's acceptable normal values may vary depending o their underlying chronic condition and their physician should establish their individual norms.

Limitations of Use

Oxygen saturation alone can be a misleading indicator of respiratory status (lung and circulatory function) An individual with asthma or other chronic lung or heart conditions, could have a normal SpO2 (oxygen saturation), but also be retaining carbon dioxide due to air trapping or other respiratory compromise associated with these conditions. This could lead to acidosis and arrest. The SpO2 measurement must be evaluated in the context of the individual's respiratory rate and effort and their underlying condition. If there is uncertainty about the individual's status, further professional evaluation is necessary.
This device is intended for a spot check, to provide a measurement of the SpO2. It is not intended for continuous monitoring.

Attaching and Use of the Pulse Oximeter

1. Check the pulse oximeter
2. Clean or disinfect the pulse oximeter (see next section)
3. To turn the unit on, press the button located on the top of the unit
4. Attach the pulse oximeter to the patient by inserting the patient's finger into the device until the fingertip touched the stop guide
5. Make sure the finger is centered over the light detector
6. Document these results in the student treatment log, notify parent of abnormalities and take appropriate action/medication

Cleaning or Disinfecting of the Pulse Oximter

Clean or disinfect the unit before attaching to a new patient. Clean with soft cloth moistened in water or mild soap solution. To disinfect pulse oximeter, wipe with isopropyl alcohol.

Reference: Smiths Medical PM, Inc.
Dr. Justin Bartos, MD, comments

MODEL WELLNESS POLICY

The following document was updated by the Diocese of Fort Worth and approved by the Diocesan Council in April 2012.
Please use this as a guide to develop your individual diocese wellness plan. Much has changed since the initial one written years ago with the requirements of the federal government to meet the nutritional educational needs for all schools who receive federal funds for either a hot lunch program or the free or reduced milk program. Included are the changes for the next several years.
Committee members include: Administration, school faculty, students and parents. This policy is to be reviewed annually.

Quote from Mr. Jeff Martinez, DSAC member, Diocese of Fort Worth, May 17, 2011

- Healthier children, healthier minds, Healthier souls

Model Wellness Policy/ sample, reviewed May 2013

Purpose and Goal
There is a well-documented link between nutrition and learning: healthy eating patterns are essential for students to achieve their full academic potential, full physical and mental growth, and lifelong health and well-being. Schools have a responsibility to help students establish and maintain lifelong, healthy eating patterns, to reduce childhood obesity, and to make nutritious and enjoyable food choices. In addition, school staff is encouraged to model healthy eating and physical activity as a valuable part of daily life.

Classroom Nutrition Education: Includes standards and curriculum set forth by The Texas Department of Agriculture and Square Meals. With sequential health education taught or supervised by qualified teachers, nutrition education will demonstrate the interrelationship between good nutrition, physical activity, and health. Staff development is available at the local Education Service centers for teachers and food service staff on basic nutrition and nutrition education.
Schools are encouraged to use food as an integrator of education about human events, history, and celebrations, and should encourage classes to use food and cooking as part of a learning experience that sheds light on customs, history, traditions, and cuisine of various countries and cultures.
Whenever possible, schools shall, as a part of the core curriculum, integrate hands-on experiences in gardens, in kitchens, and on field trips teaching students how food reaches the table with the implications that has for students' health and future.
Inviting a local "chef" to school is another avenue that can be explored in school communities. It would be good to have them share their knowledge and skills to students so they could take an active interest in food, production, preparation and selection of healthy foods in order to lead productive and healthy lives.

Physical Activity: Schools shall provide a quality physical education program that meets the requirements set forth by Texas Catholic Conference and the Diocese of Fort Worth for each grade level. Schools are encouraged to institute programs for students to participate in that support physical activity in and out of school.
Participation in the President's Physical Fitness program is recommended for schools. Recess periods provided during the school day in which physical activity is encouraged and promoted. The schools should provide balls, jump ropes and other equipment to facilitate and encourage students to exercise while they play.

Foods of Minimal Nutritional Value, as defined by federal regulation, Square Meals: (FMNV)
Are not allowed to be provided to students anytime, anywhere on school premises by anyone until after the end of the last scheduled class of the school day. (Including guest speakers)
Soda water: Includes any carbonated beverage, including those added nutrients such as vitamins, minerals and protein.
Water ices: Includes any frozen, sweetened water such as popsicles and other "…sicles" and flavored ice with the exception of products that contain fruit or fruit juice.
Chewing gum: Includes any flavored products made from natural or synthetic gums and other ingredients that form an insoluble mass for chewing.
Certain Candies: Includes any processed food made predominantly from sweeteners or artificial sweeteners, including hard candies, jellies and gums, marshmallow candies, fondant, licorice, spun candy and candy-coated popcorn.

Nutrition policy exemptions

Elementary classrooms may serve one nutritious snack per day in the morning or afternoon, (not during regular meal periods for that class) under the teacher's guidance. The classroom snack may be provided by the school food service, the teacher, parents or other groups and should be at no cost to students. Prepackaged snacks must comply with the fat and sugar limits of the Texas Public School Nutrition Policy, and must be single-size servings. All snacks, (homemade and prepackaged) may not contain any FMNV's or consist of candy or dessert type items (cookies, cakes, cupcakes, pudding, ice cream or frozen desserts, etc.) However, this does not apply to snacks students bring from home solely for their own consumption.

Elementary Classroom Birthday Parties, includes foods otherwise restricted by the policy are permitted at student birthday parties. It is recommended such parties be scheduled after the end of the class lunch period so that these celebrations will not replace a nutritious lunch.

The nutrition policy does not apply to students who leave campus for campus-approved field trips or to travel to sanctioned athletic, band or other competitions. The school day is considered to have ended for these students. School activities, athletic functions, etc. that occur after the normal school day are not covered by the policy.

Certain exemptions are allowed for school nurses, students with special needs and up to three school wide events preapproved by campus officials. (NOTE: Federal regulations do not allow FMNV's to be sold or given away during meal periods where reimbursable meals are served/consumed, including during any exempted events.

Policy	***Elementary Schools*** (K - 5)	***Middle/Junior High*** (Grades 6 - 8)	***High Schools*** (Grades 9 - 12)
Competitive Foods (All food and beverages that are not provided by school food service)	Not allowed to be provided to students at anytime, anywhere on school premises until after the end of the school day	Not allowed anywhere on school premises from 30 minutes before to 30 minutes after meal periods. All food, beverages and snack items must comply with the nutrition standards and portion size restrictions in this policy.	Not allowed during meal period in areas where reimbursable meals are served and consumed. All food, beverages and snack items must comply with the nutrition standards and portion size restrictions in this policy.
Fats < 10% of total calories from saturated fat	***All schools*** Individual food items must not contain more than 23 grams of fat with an exception of one individual food item per week. No food items can exceed 28 grams of fat at any time. (See the full policy for peanut butter exemption.)		
Deep-Fat Frying	***All schools*** Must be eliminated as a method of on-site preparation at all schools		
French Fries and other previously fried potato products. (Baked potato products that have not been pre-fried, flash-fried or deep-fat fried may be served without restriction.)	Portions may not exceed 3 oz., may only be served three times per week, and may only be purchased by student's one serving at a time. Must be baked for on-site preparation.	Portions may not exceed 3 oz., may only be served three times per week, and may only be purchased by student's one serving at a time. Must be baked for on-site preparation.	Portions may not exceed 3 oz. and may only be purchased by student's one serving at a time. Must be baked for on-site preparation.
Meat/Meat Alternative (M/MA) daily and weekly minimum ranges	K - 5: 1 oz eq. min. daily (8 - 10 oz weekly)	Grades 6 - 8: 1 oz eq. min. daily (9 - 10 oz weekly)	Grades 9 - 12: 2 oz eq. min. daily (10 - 12 oz weekly)
Trans Fats	***All schools*** Zero grams trans-fat per portion beginning with the school year 2012 - 13, lunch program And zero trans-fat per portion beginning the school year 2013 - 14 breakfast program		
Fruits and Vegetables 2012-13 Lunch, offer fruit component daily 2014-15, Breakfast, fruit quantity increase to 5 cups/week (minimum 1 cup per day)	***All Schools*** ¾ cup – 1 cup of vegetables plus ½ -1 cup of fruit per day, weekly requirement for dark green/red/orange, beans/peas (legumes), starchy, other as defined in 2010 Dietary Guideline. (Quantity required SY 2012 - 13. Students are allowed to select ½ cup of fruit under OVS.)		
Milk	***All schools*** Only fat-free (unflavored or flavored) and 1% low-fat unflavored milk. (1 cup) Flavored milks must not contain more than 30 grams of sugar per 8 fl. oz.		

Fruit/vegetable juices	***Elementary schools only*** All beverages served in elementary schools must be milk, unflavored water and 100% fruit and/or vegetable juice. No electrolyte replacement beverages (sports drinks) may be sold. (See portion chart for frozen fruit slushes criteria.)		
Policy	***Elementary Schools*** (K - 5)	***Middle/Junior High*** (Grades 6 - 8)	***High Schools*** (Grades 9 - 12)
Grains Lunch – 2012-13 Breakfast – 2013-14	1 oz. eq. min. daily (8 - 9 oz weekly)	1 oz eq. min. daily (8 - 10 oz weekly)	2 oz eq.min. daily (10 - 12 oz weekly)
	8 servings per week (minimum of 1 serving per day)		
Whole Grains	2012 - 13 Lunch, implemented ½ of grains be whole grain rich and offer weekly grain ranges	2013 - 14 Breakfast, ½ of grains be whole grain rich and offer weekly grain ranges	2014 - 15, implemented for Lunch/ Breakfast. All grains must be whole-grain rich.
Food or beverage	***All Schools*** The maximum portion size and nutrient restrictions below apply to all foods and beverages served or made available via vending machines, fundraisers, snack bars, a la carte or any other service point. These restrictions do not apply to food items served as part of a reimbursable school meal unless they are individually sold.		
Chips (fried or baked)	***All Schools*** 1.5 oz. (no more than 7.5grams of fat per bag)		
Other (crackers, popcorn, cereal, trail mix, nuts, seeds, dried fruit, jerky, pretzels)	***All Schools*** 1.5 oz.		
Cookies/cereal bars	***All Schools*** 2 oz. Total fat must not exceed 30% of calories or 3 grams per 100 calories; saturated fat must not exceed 10% of calories or 1 gram per 100 calories; sugar must not exceed 10 grams per ounce. See full policy for grain/bread exemptions at breakfast.		
Bakery items (e.g., pastries, muffins)	***All Schools*** 3 oz. Total fat must not exceed 30% of calories or 3 grams per 100 calories; saturated fat must not exceed 10% of calories or 1 gram per 100 calories; sugar must not exceed 10 grams per ounce. See full policy for grain/bread exemptions at breakfast.		
Frozen desserts, ice cream, frozen yogurt, pudding or gelatin	***All Schools*** 4 oz.		
Beverages other than milk	6 fl. oz. Must not contain more than 30 grams total sugar per 6 fl. oz. Juice must be 100% fruit and/or vegetable juice. No limit on non-carbonated, unflavored water. Electrolyte replacement beverages are not allowed	12 fl. oz. Must not contain more than 30 grams of sugar per 8 fl. oz. No limit on non-carbonated, unflavored water.	12 fl. oz. Must not contain more than 30 grams of sugar per 8 fl. oz. No limit on non-carbonated, unflavored water.
Frozen fruit slushes (must contain at least 50% fruit juice)	6 fl. oz.	8 fl. oz.	12 fl. oz.
Contracts	***All schools*** Contracts, contract renewals and amendments must expressly comply with this policy.		
Age-Grade Groups • Establish age/grade groups: K-5, 6-8, 9-12	2012 - 13 implementation with the lunch program 2013 - 14 implementation with the breakfast program		
Offer vs. serve • Reimbursable meals must contain a fruit or vegetable (1/2 cup minimum)	2012 - 13, implementation with the lunch program 2014 - 15, implementation with the breakfast program		

Menu Planning • A single FBMP approach **Monitoring** • 3 year adminstrative review cycle • Conduct weighted nutrient analysis on 1 week of menus	• Beginning with 2012-13 school year for lunch • Beginning with 2013-14 school year for breakfast • Beginning in 2013 - 14 school year for both lunch and breakfast • Beginning with 2012 - 13 school year for lunch • Beginning with 2013 - 14 school year for breakfast	
Sodium Targets New standards for grades K-12	***School Breakfast program*** *Sodium reduction:* *Timeline and Amount* Current baseline: K-5 – 573 mg Current baseline: 6-8 – 629 mg Current baseline: 9-12 – 686 mg Target 1: School year 2014 - 15 K- 5: ≤ 540 mg 6-8: ≤ 600 mg 9-12: ≤ 640 mg Target 2: School year 2017 - 18 K-5: ≤ 485 mg 6-8: ≤ 535 mg 9-12: ≤ 570 mg Target 3: School year 2022 - 23 K-5: ≤ 430 mg 6-8: ≤ 470 mg 9-12: ≤ 500 mg	***School Lunch Program****:* *Sodium reduction* *Timeline and Amount* Current baseline: K-5 – 1,377 mg Current baseline: 6-8 –1,520 mg Current baseline: 9-12 –1,588 mg Target 1: School year 2014 - 15 K- 5: ≤ 1,230 mg 6-8: ≤ 1,360 mg 9-12: ≤ 1,420 mg Target 2: School year 2017 - 18 K-5: ≤ 935 mg 6-8: ≤ 1,035 mg 9-12: ≤ 1,080 mg Target 3: School year 2022 - 23 K-5: ≤ 640 mg 6-8: ≤ 710 mg 9-12: ≤ 740 mg
Calorie Ranges Only food-based menu planning allowed <10% of total calories is from saturated fat	***Breakfast Program*** Beginning School year 2012 - 13 K - 5: 350 - 500 calories Grades 6 - 8: 400 - 550 calories Grades 9 - 12: 450 – 600 calories	***Lunch Program*** Beginning School year 2012 - 13 K-5: 550 - 650 calories Grades 6 - 8: 600 -700 calories Grades 9 - 12: 750 - 850 calories

Measure and Evaluation

Wellness policy shall be reviewed annually by each of the (Arch) dioceses.

Yearly measurement of height and weight are recommended for students and recorded on the health card. Screening for Type II Diabetes is done according to guidelines set up by the Texas Mexico Border Health Office and recorded on the permanent health card. Negative/positive findings documented along with the results (outcome) from referral to the student's health care provider.

Committee Members – list

Approved by -

WEST NILE VIRUS

West Nile virus is a virus commonly found in Africa, West Asia, and the Middle East. It is not known how long it has been in the United States, but the Centers for Disease Control and Prevention (CDC) believe the virus probably has been in the eastern United States since early summer 1999. It is closely related to St. Louis encephalitis virus found in the United States. The virus can infect humans, birds, mosquitoes, horses, and some other animals.

Preventing mosquito bites is the best way to avoid becoming infected with the West Nile virus. Protect yourself from the West Nile virus with these four tips:

1. Use an approved insect repellent every time you go outside. Approved repellents are those that contain DEET, pericaridin or oil of lemon eucalyptus. Follow the instructions on the label.
2. Regularly drain standing water, including waster that collects in empty cans, ties, buckets, clogged rain gutters and saucers under potted plants. Mosquitoes breed in stagnant water.
3. Wear long sleeves and pants at dawn and dusk when mosquitos are most active.
4. Use air conditioning or make sure there are screens on all doors and windows to keep mosquitoes to keep mosquitoes from entering the home.

Symptoms

Most people infected with West Nile virus will not have any signs of illness. Twenty percent of people who become infected will have mild symptoms such as fever, headache, body aches, and occasionally a skin rash on the trunk of the body and swollen lymph glands.

The symptoms of severe infection (West Nile neuroinvasive disease) include high fever, neck stiffness, stupor, disorientation, coma, tremors, convulsions, muscle weakness, and paralysis. Only about one out of 150 people infected with West Nile virus will develop this more severe form of the disease.

The incubation period of West Nile virus in humans is three to 14 days. Symptoms of mild disease may last a few days. Symptoms of severe disease may last several weeks, although neurological effects may be permanent. Rarely, death can occur.

West Nile virus is **spread** by the bite of an infected mosquito and can infect people, horses, many types of birds, and some other animals. There is no evidence that West Nile virus can be spread from person to person or animal to person.

People older than 50 have the **highest risk** of severe disease, and people with weakened immune systems are at an increased risk for West Nile Virus.

There is no specific **treatment** for West Nile virus infection. In severe cases, intensive supportive therapies are indicated such as intravenous fluids and medicine to control fever or pain. Antibiotics may be given for any secondary bacterial infection.

Currently there is **no vaccine** for West Nile virus, but several companies are working toward developing a vaccine. Cases of West Nile neuroinvasive disease usually occur in the last summer or early fall. However, Texas has a variety of climates; when temperatures are mild, West Nile virus can be transmitted year round. It is best to try and protect yourself all year.

Fewer than 1 percent of those bitten by infected mosquitoes become severely ill. IF you have the symptoms mentioned in this fact sheet, contact your doctor immediately.

Information

Contact your local health department. West Nile Virus information can be found on the Texas Department of State Health Services website at www. dshs.state.tx.us and the CDC website at www.cdc.gov/ncidod/dvbid/westnile/.

Department of State Health Services
1100 W. 49th St.
Austin, Texas 78756
512-776-7400
Toll Free – 1-888-963-7111
TDD 1-800-735-2989

HEALTH PROMOTION CONTACTS, *updated 5/2013*

Asthma

- Asthma Awareness
  http://www.nhlbi.nih.gov/health/prof/lung/asthma/school/

- American Academy of Allergy Asthma and Immunology (AAAAI)
  www.aaaai.org/

Dental

- Colgate Bright Smiles, Bright Futures
  www.colgatebsbf.com/

- Crest (Proctor and Gamble) grade 1
  www.pgschoolprograms.com/

Food Allergy

- The Food Allergy & Anaphylaxis Network
  www.foodallergy.org

- http://www.epipen.com

- Allergyready.com

- FARE (www.foodallergy.org)

Handwashing/Germs

- Food Safety/Handwashing Education
  www.fightbac.org

- Healthy Kids, lesson plans
  www.purell.com/

- www.scrubclub.org

Head injury/concussion

- Texas Brain Injury Alliance
  http://www.texasbia.org/

- Texas Traumatic Brain Injury Advisory Council
  http://www.hhsc.state.tx.us/hhsc_projects/abj/Council.shtml

Head Lice

- The National Pediculosis Association
  http://www.headlice.org/

Nutrition

- http://www.choosemyplate.gov/

Poison Control

- http://www.poisoncontrol.org/

Puberty

- Always Changing! About you (Proctor and Gamble)
  www.pgschoolprograms.com/

Section 4. Forms

ACCIDENT AND ILLNESS LOG – STUDENT

Initial	Date	Time	Student's Name	Grade	Complaint	Treatment

ACCIDENT AND ILLNESS LOG – STAFF

Name of staff member	Date and time of accident or illness	Describe incident	Treatment	Notify principal	Time out

ACCOMMODATION PLAN, STUDENT p. 1

NAME _____ DOB _____

SCHOOL _____ DATE _____

1. Describe the nature of the concern

_____

_____

_____

2. Describe the basis for determination of handicap or disability (if any): _____

_____

_____

3. Describe how the handicap or disability affects a major life activity: _____

_____

_____

4. Describe the accommodations that are necessary: _____

_____

_____

5. Review/Reassessment Date: _____ (must be completed)

6. Participants (Name and Title)

_____ _____

_____ _____

_____ _____

cc: Student's Cumulative File

ACCOMMODATION PLAN, STUDENT, p. 2

Name _____ **Condition** _____

Preparation Date _____ **Review Date** _____

_____ / _____

Signature of Principal and date signed

Student Objectives	Interventions	Person Responsible	Evaluation	Date Met

FOOD ALLERGY ACTION PLAN

Name: _____Date of birth: _____

Allergy to: _____

Weight: _____lbs. Asthma: _____Yes (higher risk for a severe reaction) _____No

Extremely reactive to the following foods: _____

THEREFORE:
_____, if checked, give epinephrine for ANY symptoms if the allergen was *likely* eaten.

_____, if checked give epinephrine immediately if the allergen was *definitely* eaten, even if no symptoms noted.

Any severe symptoms after suspected or known ingestion:
One or more of the following:

Lung: Short of breath, wheeze, repetitive cough
Heart: Pale, blue, faint, weak pulse, dizzy, confused
Throat: Tight, hoarse, trouble breathing/swallowing
Mouth: Obstructive swelling (tongue and/or lips)
Skin: Many hives over body

Or *combination of symptoms* from different body areas:
Skin: Hives, itchy rashes, swelling (e.g., eyes, lips)
Gut: Vomiting, crampy pain

PLAN

1. **INJECT EPINEPHRINE IMMEDIATELY**
2. Call 911
3. Begin monitoring
4. Give additional medications: *
   - Antihistamine
   - Inhaler (bronchodilator) if asthmatic

   *Antihistamines & inhalers/brochodilators are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE

Mild symptoms only:

Mouth: Itchy mouth
Skin: A few hives around mouth/face, mild itch
GUT: Mild nausea/discomfort

PLAN

1. **GIVE ANTIHISTAMINE**
2. Stay with student: alert healthcare professionals and parent
3. IF symptoms progress (see above), USE EPINEPHRINE
4. Begin monitoring

Medications/Doses

Epinephrine (brand and dose): _____

Antihistamine (brand and dose): _____

Other (e.g., inhaler-bronchodilator if asthmatic): _____

Monitoring

Stay with the student; alert healthcare professionals and the parent. Tell rescue squad epinephrine was given; request an ambulance with epinephrine. Note time when epinephrine was administered. A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping student lying on back with legs raised. Treat student even if parents cannot be reached.

Parent /Guardian Signature _____ Date _____

Physician/Healthcare Provider Signature _____ Date _____

A food allergy response kit should contain at least two doses of epinephrine, other medications as noted by the student's physician, and a copy of this Food Allergy Action Plan.

A kit must accompany the student if he/she is off school grounds (i.e., field trip).

Contacts

Call 911

Physician: _____ Phone: _____

Parent/Guardian: _____ Phone: _____

Other emergency contacts

Name/relationship: _____ Phone: _____

Name /relationship: _____ Phone: _____

References: Allergyready.com
FARE (www.foodallergy.org)

SCHOOL ASTHMA ACTION PLAN
(Please print legibly)

(To be completed at the beginning of each school year and kept on file with the school nurse or office of the principal)

Student's name:_____ Grade: _____DOB: _____

Teachers' Name: _____School Year: _____

Parent/Guardian:_____Home phone:_____

Address: _____Work phone: _____

Emergency Contact: _____/ Relationship:_____

Phone Number (s): _____

Physician student sees for asthma:_____Phone: _____

Other physician: _____Phone: _____

Daily Treatment Plan
Please list any medication taken daily to manage asthma including nebulizer treatments, with specific instructions

	Name	Purpose	Dosage	When to use
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____

These medications are prescribe for the time period _____until _____

Medical Equipment

Please list any medical equipment this student will need to treat his/her asthma at school.
(i.e. spacer, nebulizer, oxygen, pulse oximeter etc.)

_____

_____

_____

_____

_____

_____

_____

ASTHMA ACTION PLAN, p. 2

EMERGENCY PLAN

Emergency Action is necessary when this student has symptoms such as:

1. _____ 2. _____

3. _____ 4. _____

Steps to take during an asthma episode:

1. Give emergency medications:

A. Bronchodilator (quick - relief medication)

Name: _____

Purpose: _____

Dosage: _____When to use: _____

Can be repeated for severe breathing difficulty_____ times _____minutes apart

Oxygen saturation with pulse oximeter (if available): Norms expected for student _____% to_____%

Call 911 or EMS if minimal or no improvement

B. Other medications:

Name: _____

Purpose: _____

Dosage: _____

When to use: _____

Additional instructions: _____

These medications are prescribed for the time period _____ until _____

2. Seek emergency care if this student experiences any of the following:

- No improvement 15-20 minutes after initial treatment with medication and a relative cannot be reached
- Oxygen saturation is at or below _____%.
- Student exhibits:

Chest and neck pulled in with breathing	Struggling to breathe	Stops playing and cannot start activity again
Hunched over while breathing	Trouble walking or talking	Lips of fingernails turn gray or blue

Comments and special instructions: _____

_____

_____ _____

Physician's Signature (stamp not accepted) Date

_____ _____

Parent/Guardian's Signature Date

PEDIATRIC CARDIAC RISK ASSESSMENT QUESTIONS FOR PARENTS, updated 10/11

Patient History Questions for parents: Yes or No, and discuss any "yes" answers with physician

- Has your child fainted or passed out DURING exercise, emotion or when startled?
- Has your child fainted or passed out AFTER exercise?
- Has your child had extreme fatigue associated with exercise (different from other children)?
- Has your child ever had unusual or extreme shortness of breath during exercise?
- Has your child ever had discomfort, pain or pressure in his chest during exercise?
- Has a doctor ever ordered a test for your child's heart?
- Has your child ever been diagnosed with an unexplained seizure disorder? Or exercise –induced asthma not well controlled with medication?

Family History Questions

- Are there any family members who had an unexpected, unexplained death before age 50? (include SIDS, car accident, drowning, others)
- Are there any family members who died of heart problems before age 50?
- Are there any family members who have had unexplained fainting or seizures?
- Are there any relatives with certain conditions, such as;
  - Enlarged Heart: Hypertrophic cardiomyopathy (HCM)
    Dilated cardiomyopathy (DCM)
  - Health Rhythm problems: Long QT syndrome (LQTS)
    Short QT syndrome
    Brugada syndrome
    Catecholaminergic ventricular tachycardia
    Arrhythmogenic right ventricular cardiomyopathy (ARVC)
  - Marfan syndrome (aortic rupture)
  - Heart attack, age 50 or younger
  - Pacemaker or implanted defibrillator
  - Deaf at birth (congenital deafness)

Reference: American Academy of Pediatrics
Project Adam, Laura Friend, Cook Children's Hospital, Fort Worth

SAMPLE DIABETIC CARE PLAN

American Diabetic Association (ADA) and the Disability Rights Education and Defense Fund, Inc. (DREDF)

Effective Dates: _____ to _____

To be completed by parents and the student's health care team. This document should be reviewed with necessary school staff and kept with the student's school records and where easily accessible by staff in emergencies.
Student's Name: _____ DOB _____

Homeroom Teacher/Grade: _____

CONTACT INFORMATION:

Parent/guardian #1:

Name: _____

Address: _____

Telephone: Home: _____ Work: _____ Cell: _____

Parent/guardian # 2:

Name: _____

Address: (if not the same) _____

Telephone: Home: _____ Work: _____ Cell: _____

Student's Doctor/Health Care Providers:

Doctor: _____

Address: _____

Telephone number: _____

Other Emergency Contacts:
Name: _____

Relationship: _____

Telephone: Home: _____ Work: _____ Cell: _____

Notify parent/guardian or emergency contact in the following situations: _____

_____

_____

BLOOD GLUCOSE MONITORING

Target range for blood glucose is _____ mg/dl to _____ mg/dl

Usual times to test blood glucose: _____
_____

Times to do extra blood glucose tests (check all that apply)
_____ before exercise
_____ after exercise
_____ when student exhibits symptoms of hyperglycemia
_____ when student exhibits symptoms of hypoglycemia
_____ other (explain): _____

Can student perform own blood glucose tests? Yes _____ No_____

Exceptions: _____

_____

Type of blood glucose meter student uses: _____

School personnel trained to monitor blood glucose level and dates of training:

_____

INSULIN

Types, times, and dosages of insulin injections to be given during school:
Time /Type(s) / Dosage

_____

_____

School personnel trained to assist with insulin injection and dates of training:

_____

_____

_____

Can student give own injections? Yes _____No_____

Can student determine correct amount of insulin? Yes_____ No_____

Can student draw correct dose of insulin? Yes_____ No_____

FOR STUDENTS WITH INSULIN PUMPS

Type of pump: _____Basal rates: _____

Insulin/carbohydrate ratio: _____Correction factor: _____

Is student competent regarding pump? Yes _____ No _____

Can student effectively troubleshoot problems (e.g., ketosis, pump malfunction)? Yes _____No _____

Comments: _____

_____

_____

MEALS AND SNACKS EATEN AT SCHOOL

The carbohydrate content of the food is important in maintaining a stable blood glucose level.

Meal/Snack Time Food content/amount
Breakfast _____

Lunch _____

Mid-afternoon snack _____

Snack before exercise? Yes _____No _____

Snack after exercise? Yes_____ No _____

Other times to give snacks and content/amount: _____

A source of glucose such as _____

and should be readily available at all times.

Preferred snack foods: _____

Foods to avoid, if any: _____

Instructions for when food is provided to the class, e.g., as part of a class party or food sampling:

_____

_____

EXERCISE AND SPORTS

A snack such as _____

should be available at the site of exercise or sports.

Restrictions on activity, if any: _____

_____

Student should not exercise if her blood glucose level is below _____mg/dl or above _____mg/dl.

HYPOGLYCEMIA (Low Blood Sugar)

Usual symptoms of hypoglycemia: _____

_____

Treatment of hypoglycemia: _____

_____

_____

School personnel trained to administer glucagon: _____

_____

Glucagon should be given if the student is unconscious, having a seizure (convulsion), or unable to swallow. If glucagon is required, it should be administered promptly. Then, call 911(or other emergency assistance) and notify the parents/guardians immediately.

HYPERGLYCEMIA (High Blood Sugar)

Usual symptoms of hyperglycemia: _____

_____

_____

Treatment of hyperglycemia: _____

_____

Circumstances when urine ketones should be tested: _____

Treatment for ketones: _____

School medical personnel trained to test for ketones: _____

_____

SUPPLIES AND PERSONNEL

Where are supplies for testing blood glucose levels kept? _____

Where are supplies for administering insulin kept? _____

_____

Where are supplies for testing ketones kept? _____

Where is glucagon kept? _____

_____

Where are supplies of snack foods kept? _____

_____

School personnel trained in the symptoms and treatment of high and low blood sugar and dates of training:

_____

_____

_____

_____

SIGNATURES

This Health Plan has been reviewed by:

_____ / _____

Student's Health Care Provider Date

Acknowledged and received by:

_____ / _____

Student's Parent(s) or Guardian(s) Date

Acknowledged and received by:

_____ / _____

School Representative / Date

DIABETES – SAMPLE WORKSHEET FOR INSULIN DEPENDENT DIABETICS ON INSULIN PUMP

Date and Time	Blood Sugar	Before Lunch	2 hours after eating?	Units of Insulin given	Additional Bolus?

DIABETES – SAMPLE WORKSHEET FOR INSULIN DEPENDENT DIABETICS

Date and Time	Blood Sugar	# Glucose tabs given or carbohydrates given	Carbs Consumed	# of Units and type of Insulin given after lunch	Additional # and type of insulin given

Lunch protocol:
Specifics as prescribed by physician

Insulin coverage for elevated blood sugar
As prescribed by physician

Parent information/phone numbers

EMERGENCY FORMS

ACCIDENT REPORT

To be completed at time of an accident by the person caring for an injured student who is referred to and seen by a Physician.

Report all accidents to the Principal promptly

STUDENT'S NAME_____PHONE #_____

ADDRESS_____AGE_____SEX_____

DATE_____TIME_____INSURANCE_____

GRADE/TEACHER_____SCHOOL_____

LOCATION OF ACCIDENT_____

PERSON IN ATTENDANCE_____

NATURE OF ACCIDENT

Abrasion	Head Injury
Bruise/Bump	Fracture
Burn	Laceration
Cut	Puncture
Convulsion	Shock
Dislocation	Sprain

Other_____

PART OF BODY INJURED

Abdomen	Eye*	Head
Ankle*	Face	Knee*
Arm*	Finger*	Leg*
Back	Foot*	Teeth
Chest	Hand*	Wrist*
Elbow*		

Other_____

*Left, Right, or Both

HOW DID IT HAPPEN?_____

_____

_____

WERE PARENTS NOTIFIED: YES_____NO_____BY WHOM?_____TIME_____

DID PARENT COME TO SCHOOL? YES_____NO_____TIME OF ARRIVAL _____

TREATMENT AND DISPOSITION:_____

_____

FOLLOW-UP:_____

AMOUNT OF TIME LOST FROM SCHOOL: _____

SIGNATURE_____

(Signature of person completing report)

ANIMAL BITE REPORT

Report all animal bites to Principal promptly

Date of Bite _____ Time of Bite _____

Name of person involved _____

Address _____

City, State, Zip _____

Telephone _____ Age _____ Sex _____

Breed/Type of Animal, with a general description _____

_____

Age of Animal _____ Sex of Animal _____ Weight of Animal _____

Date of Vaccinations _____ City/State _____

Description of Incident: (on school grounds? Animal confined? Leashed? Unleashed?) _____

_____

_____

_____

Area on person bitten _____

_____

_____

Owner of Animal _____

Address _____

City/State/Zip _____

Telephone _____

BITE REPORTED TO _____ /_____
(Local Animal Control Agency and name of individual you spoke with)

TIME &DATE REPORTED _____

Signature _____
(Signature of person completing report)

HEAD INJURY REPORT

Date _____

Dear Parent/Guardian,

Today _____received an injury to the

head caused by_____.

Your child was seen in the school office/clinic and has no problem at the time of the injury. But please watch for the following symptoms and contact your doctor or emergency room immediately if you notice any of these signs. Observation by the parent for the next 24 - 48 is the usual time frame following a bump on the head. If changes persist in attention, behavior and learning are observed following a head injury, please consult your physician.

- A constant headache that gets worse
- Slurred speech
- Dizziness that does not go away or happens repeatedly
- Extreme irritability or other abnormal behavior
- Nausea or vomiting
- Clumsiness or difficulty walking
- Oozing blood or other watery fluid from the nose or ears
- Difficulty waking up or excessive drowsiness
- Unequal size of the pupils (the dark center part) of the eyes
- Unusual paleness that lasts for more than an hour
- Convulsions (seizures)
- Blurred vision or double vision
- Stunned, dazed, confused or acting strangely

_____
Signature of person completing report

_____
School phone number

MEDICATION INCIDENT REPORT

Student's Name: _____

Address: _____

Date: _____ Time: _____ Insurance: _____

Grade:_____Teacher: _____ School: _____

Description of Incident
(Check applicable)

_____wrong medication
_____omitted dose
_____medication reaction
_____wrong route
_____wrong time
_____wrong person
_____wrong dose
_____other

Brief, descriptive account of Incident: (include names of key people, drugs, number of doses involved)

_____

_____

_____

Action Taken: (Check all that apply)

1. Parent/Guardian notified: yes_____ no _____

   By whom: _____ Time: _____a.m. p.m.

2. Physician notified: yes _____ no _____

   Name of Dr. _____ Time: _____ a.m. p.m.

3. Sent home: yes _____ no _____ Time: _____ a.m. p.m.

4. Other: _____

_____

Signature: _____
(Signature of person completing report)

STUDENT EXPOSURE INCIDENT FORM

Texas Catholic Conference Education Department

Student Name (Party 1) _____

Student Address _____

Involved Party # 2 Name _____

Involved Party # 2 Address _____

Exposure incident circumstances (describe what happened) _____

_____

_____

_____

Route of exposure (e.g. needlestick, splash, puncture wound, abraded skin) _____

_____

_____

Date and time of incident _____

_____
Signature

_____
Title

_____
Date

Note: Maintain this record until the student is age 18 plus 30 years.
Copy to Physician if applicable

STUDENT INFORMED REFUSAL OF POST-EXPOSURE MEDICAL EVALUATION

Texas Catholic Conference Education Department

I_____ a student at _____

School in the Diocese of _____have been provided by

the Principal _____information regarding the risk

of disease transmission and this exposure incident. On _____,said student

was involved in an exposure incident.

Describe incident: _____

_____

_____

My Principal has offered to provide follow-up medical evaluation for me (or my child in order to assure that I have full knowledge of whether I have been exposed to or contacted an infectious disease from this incident. However, I, of my own free will and volition, and despite my Principal's offer, have elected not to have a medical evaluation. I have personal reasons for making this decision

_____

_____

_____

(comments)

_____

Signature (parent/guardian, if minor, state relationship)

_____

Address City State Zip

_____ _____

Date Principal

EMPLOYEE EMERGENCY INFORMATION

EMPLOYEE EMERGENCY INFORMATION
(Please Print)

Employee Name: _____

Address: _____
(Street/Box #) (City/State) (Zip)

Home Telephone Number: _____

List Persons to Contact in Case of an Emergency and their relationship to you:

Contact Name	Telephone#	Relationship
	HM:	
	WK:	
	CELL:	
	HM:	
	WK:	
	CELL:	
	HM:	
	WK:	
	CELL:	

Physicians Name: _____ Phone: _____

Address: _____

Insurance: _____ Group/Policy # _____

Hospital of Choice: _____

If an emergency arises, I give permission to Dr. _____
to be wholly responsible for my care. If he is unavailable in the event of a major emergency, the administration is directed to seek emergency care at the medical or hospital facility indicated above. I will be responsible for the payment of all expenses incurred.

Employee Signature: _____ Date: _____

HEALTH SERVICES REVIEW - TCCED

The **Principal** is ultimately responsible for the implementation of health services in a school.
This responsibility may be designated to a responsible person who is accountable to the principal.

School Name:_____ Date:_____

Area Reviewed	Yes	No	Comments/Recommendations
License of School Nurse verified by the State of Texas to be in good standing			
Copy of State Certifications on file for: ▪ Vision Screener ▪ Hearing Screener ▪ Spinal Screener ▪ Acanthosis Nigricans Screener (By health region) (grades 1-3-5-7)			
Two fulltime personnel designated and certified to render First Aid and CPR			
Emergency cards are current and reflect required information			
Written procedure for emergency care kept in a central location			
A daily log is maintained on all students receiving first aid			
Adequate first aid supplies on hand			
Disposable latex gloves available			
Separate containers for blood contaminates materials designated, locked closet/cabinet			
Individual health cards are setup an maintained			
Health screenings for 4yr olds, grades K, 1, 3, 5, 7, 9 and all first entrants and out of state transfers conducted per state law in other grades			
Problems identified as result of health screening are referred			
Referrals are followed up and final disposition noted on health card			
Medication policy is written and followed			
All Medications are kept in locked drawer or cabinet, refrigerator (as indicated)			
Signed parental consent on file			
Daily medication log being maintained on all students administered medications during school hours			
All students have required immunizations			
Immunization dates recorded on health card show day, month and year of immunization			
Check eye wash station, cleanliness/working order			
Check monthly Fire Drill Records and Tornado Drill Plans			
T.D.H. documents on file: Annual Report of Immunization Status Annual Screening Reports • Vision, Hearing and Spinal • Acanthosis Nigricans (by health region) Immunization audit (if applicable) Environmental Health Studies (if applicable)			

Signature of person reviewing:_____

Signature of school employee responsible to the school health program:_____

IMMUNIZATION CHECKLIST 2013-2014 (revised 12/05/12)

Student Name: _____ Grade: _____ Date Due: _____

In order for every student to be protected from communicable disease and to be able to participate in the school programs, The Texas Department of State Health Services has established minimum immunization requirements.
All new students admitted to a Catholic School in the State of Texas are required to furnish a copy of their immunization record to the school office before they may enter school on the first day. Checked items on this list are missing from your child's records and must be furnished to the school office in order for your child to enter class.

Complete immunization record (day, month, and year) with physician validation _____

Copy of Birth Certificate is required for all students in PK 3, PK 4, K and 1st grade _____
(Copy of hospital certificate not acceptable)

Diphtheria/tetanus/pertussis containing vaccine, ages 3 and 4 years: 4 doses _____

Diphtheria/tetanus/pertussis containing vaccine, Kindergarten entry 5 doses required, one dose on or after 4th birthday unless the 4th dose was given on or after the 4th birthday _____

Entry, grades 7– are required to have one booster of tetanus/diphtheria/pertussis containing vaccine, if at least 5 years have passed since the last dose of a tetanus-containing vaccine or when the 5 year interval has lapsed (Tdap) _____

Entry, grades 8 – 12, one dose Tdap booster when 10 years have passed since the last dose, date due: _____

Hepatitis A, 2 doses, **1st dose** is to be given on or after age 1 for children in grades PK 3, PK 4, K, 1, 2, 3 & 4 _____

Hepatitis A, **2nd dose** is to be given a minimum of 6 months after the 1st dose, grades PK 3, PK 4, K, 1, 2, 3, & 4 _____

Hepatitis B, 3 doses required for all students grades PK 3, 4, and grades K – 12 _____

HibCV, minimum 1 dose required for students younger than 5 years after 15 months or a primary series with a booster on or after age 1 _____

Meningococcal, 1 dose for students for entry into grades 7, 8, 9, 10 and 11th _____

MMR (1 dose) is required for student's ages 3 and 4 years: 1st dose on or after age 1. _____

MMR – 2 doses for students in grades Kindergarten, 1, 2, 3 and 4 (1st dose on or after age 1) _____

MMR/M – 2 doses measles containing vaccine and 1 dose of rubella and mumps students in grades 5-12 _____

Pneumococcal - minimum 1 dose required for students 59 months and younger, given after age 2
(unless a primary series was received as an infant with a booster given after age 1) _____

Polio, students ages 3 and 4: 3 doses required _____

Polio, Kindergarten entry, 4 doses required, one dose on or after 4th birthday unless the 3rd dose was given on or after the 4th birthday. (Required for grades K-12) _____

Varicella vaccine, 1 dose required for students age 3 and 4 and grades 5 - 6, 12th (2 doses if given after age 13) _____

Varicella, 2 doses required for students in grades Kindergarten, 1, 2, 3, 4, 7, 8, 9, 10, 11 _____

Requested by: _____ Date: _____

IMMUNIZATION COMPLIANCE LETTER

Diocese of _____

Office of Catholic Schools

Name and Grade of Student: _____Date: _____

Dear _____,

In order to be in compliance with Texas Administrative Code: Title 25, Health Services 97.61-97.77, we must receive proof of the required immunizations for all of our students. If a student does not meet this requirement, we cannot allow the student to attend school in the Diocese of _____.

Your child will not be allowed to attend school until all the delinquent immunizations are documented.

If your child does not have the proper documentation on record at school by: _____ he/she will not be permitted to attend school until it is received. Please take the appropriate steps to have your child immunized or to send the documentation to the school nurse/office.

Refer to the attached health checklist to view the immunization(s) your child is required to have.

_____
School Nurse/Health Representative

_____
Principal

Please sign this form to verify that you are aware of the need for this immunization for your child and return this form to the school nurse/office. Thank you for your cooperation.

_____ _____
Student Name Date Immunization (s) Due

_____ Date: _____
Parent/Guardian Signature

Please return this form to the nurse/office by: _____

MEDICATION LOG, DAILY

STUDENT ____GRADE _______________

Medication ____/Expiration date __________
Dosage ________________________________
Time (s) ________________________________

Week of (dates):

Monday	Tuesday	Wednesday	Thursday	Friday

Medication ____/Expiration date __________
Dosage ________________________________
Time (s) ________________________________

Week of (dates):

Monday	Tuesday	Wednesday	Thursday	Friday

Medication ____/Expiration date __________
Dosage ________________________________
Time (s) ________________________________

Week of (dates):

Monday	Tuesday	Wednesday	Thursday	Friday

Medication ____/Expiration date __________
Dosage ________________________________
Time (s) ________________________________

Week of (dates):

Monday	Tuesday	Wednesday	Thursday	Friday

Medication ____/Expiration date __________
Dosage ________________________________
Time (s) ________________________________

Week of (dates):

Monday	Tuesday	Wednesday	Thursday	Friday

Name of person administering medication and time of administration must be entered in the appropriate dated space each time medication is administered. It is also acceptable to initial the time the dose of medication is given, providing your signature is also on this form.

MEDICATION LOG, ANNUAL

Student Name _____School year _____

Grade _____

Medication_____/expiration date_____

Time (s) _____

Aug																			
Sept																			
Oct																			
Nov																			
Dec																			
Jan																			
Feb																			
Mar																			
April																			
May																			
June																			

MEDICATION ADMINISTRATION APPOINTMENT

The School Principal shall appoint responsible persons to supervise the storing and dispensing of medication at school.

The designated persons below have been approved by the Principal to dispense and maintain the storage of the student's medication. This shall be done yearly, at the beginning of each school year.

Place this form in the front of the medication administration manual.

School year 2_____ to 2 _____

1. _____Title _____

2. _____Title _____

3._____Title _____

4._____Title _____

5._____Title _____

6._____Title _____

7. _____Title_____

8. _____Title _____

9. _____Title _____

10. _____Title _____

Signature of Principal _____Date_____

NOTIFICATION LETTERS TO PARENTS/GUARDIANS

These letters were prepared to give schools a guideline. Use the following letters by adjusting them to meet your school's needs. During a specific communicable disease outbreak, your local health department may intervene with specific health information and letters to be sent out to the families of your students. Please note that there is a separate letter for a child who has head lice and one for the classroom students**.**

An example when the local health department will intervene is when there is a confirmed case of bacterial meningitis involving a child or employee at a school. The local health department will provide all written materials for the school families, testing and prophylactic treatment if deemed necessary. That is the reason there is not a letter in this manual for this communicable disease, the local health department will make the decision.

Petussis has been on the rise in recent months in Texas and Texas Department of State Health Services, along with CDC and your local health departments have a wealth of information to share with you and your school families.

CHICKEN POX

School _____

Date _____

Dear Parent/Guardian,

A case of Chicken Pox has been reported at school. The following information is for your reference.

Chicken Pox is caused by a virus and is spread from person to person through direct contact with the chicken pox rash of an infected person, or by respiratory droplets expelled when an infected person breathes, coughs, or sneezes. It may take from 10 to 21 days after exposure to an infected person for the illness to appear. (commonly 14-17 days)

Fever and rash can appear first on head and then spread to body. Usually two or three crops of new blisters that heals, sometimes leaving scabs.

A person with Chicken Pox is considered contagious for 1 to 2 days prior to the onset of the rash and for about 5 days after the rash appears. When all the blisters have scabbed over, with no new lesions occurring, the child may return to school.

The treatment for Chicken Pox consists of measures to make the victim comfortable. Avoid overheating and sweating. Use cold compresses or tepid baths to reduce the itching. Acetaminophen may be given to reduce fever or relieve symptoms. **Avoid giving your child aspirin or products containing aspirin** as use of aspirin containing drugs during a viral episode has been linked to **Reyes Syndrome,** a potentially fatal illness.

A vaccine to prevent Chicken Pox is available and required for specific ages according to the Texas Department of State Health Services. Breakthrough cases of Chicken Pox disease have been documented in children who have had the immunization. Disease in vaccinated children can be mild or absent of fever with few lesions, which might not be blister-like. The vaccine is 95% effective in preventing moderate or severe disease. Exclusion from school is the same as previously discussed.

Consult your physician with any questions and concerns. And any pregnant woman who have been exposed should consult their physician.

If your child contracts Chicken Pox, please notify the school. Contact your physician immediately if your child has difficulty walking or shows mental changes during or following illness with Chicken Pox.

Sincerely,

References: 2013 Texas Department of State Health Services
American Academy of Pediatrics

FIFTH DISEASE

School _____

Date _____

Dear Parent/Guardian,

We have had a confirmed case of Fifth Disease at school. Fifth Disease is a viral infection, spread through respiratory droplets that causes a red rash to develop on the cheeks, giving the "slapped cheek" appearance. As those rash fades, a lacy or net-like rash appears on the arms, moving to the legs and trunk. This "under the skin" appearing rash can last for several weeks, increasing and decreasing in intensity.

The vast majority of children recover without problems, but Fifth Disease may cause complications in children who have blood abnormalities such as sickle cell disease.

Pregnant women who have been exposed should consult their physician.

By the time the rash appears, the contagious stage of the disease has passed, and the child may remain in school.

Please consult your physician if you have further questions or concerns.

Sincerely,

Reference: American Academy of Pediatrics
Texas Department of State Health Service, 2013

HAND, FOOT AND MOUTH DISEASE

School _____

Date _____

Dear Parent/Guardian,

There has been a reported case of Hand, Foot and Mouth Disease at school. The following information is for your reference.

Hand, Foot and Mouth Disease is an infection caused by the Cocksakie A virus. It has no relationship to hoof and mouth disease. The illness is most common in children under 10 years of age, and occurs most often in the summer and fall months.

The infection is spread through droplets expelled from the nose and mouth during coughing or sneezing. It can also be spread through contaminated hands and objects (such as toys) when improper hand washing techniques are used following bathroom use.

The disease may be prevented by thorough hand washing with soap and running water after using the bathroom, wiping the nose and mouth or handing soiled diapers. Additionally, toys and contaminated areas should be cleaned and disinfected and tissues and diapers should be disposed of properly.

Symptoms may include small ulcers in the mouth, a mildly painful mouth, small blisters or red spots on the palms, soles, buttocks, or between fingers or toes, and a low-grade fever lasting 1 to 2 days. Rash on the feet may last up to 10 days. The disease is contagious during the illness and possibly for several days afterward. The illness may take 3 to 6 days to appear after exposure to an infected person.

Treatment consists of measures to help the child feel more comfortable. Avoid citrus, spicy or salty foods and foods which require excessive chewing. Change to soft foods for a few days and encourage plenty of clear fluids. Have the child rinse the mouth with clear water after eating.

The child can return to school when fever free for 24 hours without use of fever reducing medication.

If your child contracts this disease, please notify the school. Thank you.

Sincerely,

References: Taber's Cyclopedic Medical Dictionary, Edition 18
Texas Department of State Health Services, 2013

HEAD LICE LETTER FOR PARENT/GUARDIAN WHOSE CHILD HAS HEAD LICE

School _____

Date _____

Dear Parent/Guardian.

The following is information for you about how to treat your child's head lice.

Head lice are not a sign of poor health habits or being dirty. It is spread by sharing combs, brushes, clothing, and hats and in bedding.

Head lice can happen to anyone. We realize there is a lot to do, but with vigilance, the head lice will not reoccur.

- To control the spread of head lice, your child may not return to school until his or her head is free of lice and nits (lice eggs.) There are many lice treatment shampoos on the market as well as other mechanical and manual methods of controlling the lice. Please check with your physician, health department, pharmacist or other health provider to determine what is best for your child. With whatever method of lice control you use, follow the directions carefully.

- Bedding, clothing, and hats should be laundered in very hot water (120 degrees) on the same day or evening your child is treated.

- Nits (lice eggs) are tiny, white, pearly eggs that attach themselves to the hair shaft close to the scalp. The nit can be removed manually by pinching between two fingernails and pulling it off the hair shaft, or by using a "nit comb", available in most pharmacies.

- All members of the household need to be checked when there is one case of head lice in your immediate family.

- Stuffed animals can be bagged in plastic for 2 weeks to rid them of lice.

- Vacuum the inside of the car and the car seats. Vacuum the sofa along with the carpets in your home.

- Hair color or a hair permanent is not a recommended.

- It has been found that after shampooing, combing the hair and "nits" out in the sunlight is helpful. Faithful combing of the "nits" is so important. Please continue to do so for 1-2 weeks after lice treatment shampoo.

When your child returns to school, please stop by the school office/clinic for the health representative to "check" your child's head before they are permitted to re-enter their class.

Sincerely,

References: National Pediculosis Association
Texas Department of State Health Services

HEAD LICE INFORMATION LETTER FOR PARENT/GUARDIAN OF CLASSMATES

School _____

Date _____

Dear Parent/Guardian,

There has been a case of reported head lice in your child's classroom. We have checked all the students in the classroom and at this time they appear lice free.

The following information is provided for you about head lice, even though your child is lice free at this time. Please keep this for reference.

- Even though they do not jump or fly, they can spread from one student to another by sharing combs, brushes, clothing, hats and in bedding. Head lice can happen to anyone. It is not a sign of poor health habits or being dirty.

- There are many lice treatment shampoos on the market as well as other mechanical and manual methods of controlling the lice.

- Bedding, clothing, and hats should be laundered in very hot water (120 degrees) on the same day or evening your child is treated.

- Nits (lice eggs) are tiny, white, pearly eggs that attach themselves to the hair shaft close to the scalp. The nit can be removed manually by pinching between two fingernails and pulling it off the hair shaft, or by using a "nit comb", available in most pharmacies.

- All members of the household need to be checked when there is one case of head lice in your immediate family.

- When the child that has been treated for head lice returns to school, his or her head should be checked by the school nurse or health representative to insure that it is free of lice and nits.

Thank you for your cooperation.

Sincerely,

References: National Pediculosis Association
Texas Department of State Health Services

IMPETIGO

School _____

Date _____

Dear Parent/Guardian,

There has been a case of impetigo reported at the school. The following information is for your reference.

Impetigo is a ***highly contagious*** skin infection caused by bacteria, which is normally found on the skin. When the bacteria get under the skin by way of a cut, scratch, insect bite or abrasion, it begins to multiply and grow. The wound becomes swollen and reddened, a small pus-filled blister forms, and when the blister breaks, it forms a distinctive honey-colored crust. The lesions are most commonly found on the face, arms or legs, but can occur anywhere on the body. If lesions are not treated, they will continue to grow as the bacteria spreads. The lesions are typically not painful, but may be tender to touch. People of any age may get impetigo, but it occurs most frequently in children 2 to 5 years of age.

Impetigo is spread through contact. Fingers, clothing or anything that touches the lesion can transfer the bacteria to other areas of skin and to other persons. Good hygiene and thorough hand washing can help prevent the spread of infection.

Impetigo requires treatment by a physician, usually with oral antibiotics or antibiotic ointment. Warm soaks to soften and loosen the crusts may help the child feel more comfortable and prevent picking at the crusts. Daily bathing and frequent changes of clothing and bedding are also important.

A student infected with impetigo may remain/return to school when the blisters and drainage can be contained and maintained in a clean, dry bandage.

If you have further questions or concerns, please consult your physician.

Sincerely,

Reference: Texas Department of State Health Services, 2013

INFECTIOUS MONONUCLEOSIS

School _____

Date _____

Dear Parent/Guardian:

A case of Infectious Mononucleosis has been reported at school. It is an infectious disease, but transmission to other students in considered unlikely. The following information is for your reference.

A virus causes Infectious Mononucleosis. The virus may affect anyone, but the infection most often occurs in people between the ages of 16 and 25 years old. It can occur as an epidemic or as a single case. It is believed to be spread by infectious saliva. The incubation period for the disease may be from 7 days to 50 days.

Symptoms of Infectious Mononucleosis may include fever, sore throat, and loss of appetite, fatigue, weakness, sore muscles, swollen lymph nodes and left-sided abdominal pain. Infectious Mononucleosis may become serious in rare cases when the spleen or other vital organ becomes affected. In most cases the symptoms disappear after 10 days, however, full recovery may take 2 to 3 months.

A physician should be consulted immediately in the presence of suspicious symptoms. Treatment is usually bed rest. Activities that require exertion (such as sports), may be restricted for several months. Increased fluid intake to help relieve fever and sore throat is usually recommended.

If you have further questions or concerns, please consult your physician.

Sincerely,

Reference: Red Book: American Academy of Pediatrics

MRSA

School _____

Date _____

Dear Parent/Guardian:

The following information is about Staph and MRSA (methycillin –resistant Staphylococcus aureus)

- *What is Staph?*

Staph is a type of bacteria. It may cause skin infections that look like pimples or boils. Skin infections caused by Staph may be red, swollen, and painful or have pus or other drainage.

- *Who gets Staph?*

Anyone can get a Staph infection. People are more likely to get a Staph infection if they have:

1. Skin-to-skin contact with someone who has a Staph infection.
2. Contact with items and surfaces that have Staph on them.
3. Openings in their skin, such as cuts or scrapes.
4. Poor hygiene.

- *How are Staph infections treated?*

Treatment for a Staph infection may include taking an antibiotic or having a physician drain the infection.

- *How do we keep Staph infections from spreading?*

We are encouraging the students and staff to practice good hand-washing techniques and to wash their hands often. Custodians/housekeeping are doing their part to keep our schools clean. Please follow up at home as well, so we can keep all of our students healthy and infection free.

Sincerely,

Reference: CDC

PINK EYE (conjunctivitis)

School _____

Date _____

Dear Parent/Guardian,

There has been a reported case of "Pink Eye" (Conjunctivitis) at school. The following information is for your reference.

"Pink Eye" is the common name for conjunctivitis, an inflammation of the tissues in the eye socket. An irritant, an allergy, bacteria or a virus may cause the inflammation. When bacteria or virus causes it, it is an infection and is **highly contagious**. It is spread through contact with the discharge from the eyes of an infected person. It can be prevented by avoiding contact with the eyes of an infected person and by thorough hand washing. The viral infection may take from 12 hours to 12 days to develop after exposure to an infected person. And the bacterial infection may take 1-3 days to develop following exposure

Signs and symptoms include red, itching eyes usually with some discharge or crusting around the eyes. Crusts are common upon awakening.

The treatment for pink eye infection is medication prescribed by a physician or clinic, usually a prescription antibiotic specific to the infection. The child must be excluded from school until the physician determines that the child may return, with a written release. This varies from overnight to any number of days.

If you have further questions or concerns, please consult your physician.

Sincerely,

Reference: Texas Department of State Health Services, 2013

PINWORMS

School _____

Date _____

Dear Parent/Guardian,

There has been a case of pinworms reported at school. The following information is for your reference.

Pinworms are the most prevalent intestinal parasite in the U.S. Pinworms occur most often in school age children, but are highly contagious and often spread to the entire household. Incubation commonly ranges from 4 – 6 weeks.

The human pinworm is a small roundworm with a white body and a pointed tail. A visual inspection during the hours of sleep will often confirm a suspected pinworm infestation, as the worms migrate out of the anus onto the surrounding skin. They lay their microscopic eggs on the skin and the movement cause swelling and severe itching.

Symptoms include Pruitis Ani (itching in the anal area), restless sleep, irritability, enuresis (bedwetting), and secondary infection due to excessive scratching.

Good hygiene will not eradicate pinworms, but can help prevent re-infection and transmission to other family members. The tiny, usually invisible eggs contaminate clothing, bed linens, and the hands; especially under the fingernails. If swallowed, the eggs reach the intestine where they become mature pinworms and re-infection usually follows. To help prevent re-infection you should:

1. Wash hands, especially under the fingernails, with soap before meals and after using the toilet.

2. Wash bed linens and bedclothes after treatment.

3. Check with your pharmacist for a recommended safe and effective over the counter product to treat pinworms. They are usually effective and require only a single dose.

Sincerely,

Reference: Pharmacist Magazine
Texas Department of State Health Services, 2013

RHEUMATIC FEVER

School _____

Date _____

Dear Parent/Guardian,

We have had a confirmed case of Rheumatic Fever at school. Rheumatic Fever is a rare disease today. It is a type of acquired heart disease caused by a particular sensitivity to the same germ that causes strep throat.

A physician must treat the underlying strep throat. The usual treatment is a course of antibiotics. The medication must be given for the full amount of time specified on the prescription. The child must be excluded from school until at least 24 hours after administration of the antibiotic has begun and the fever is below 100 degrees for 24 hours.

Covering the mouth when coughing or sneezing, practicing good hand washing and avoiding sharing food, beverages, eating utensils and drinking containers, may prevent the spread of the strep infection. Once antibiotic therapy has begun, a new toothbrush will help prevent recurrence of the strep throat.

Please consult your physician if you have any further questions or concerns.

Sincerely,

References: The New School Health Handbook, 3rd Edition.
American Academy of Pediatrics
Texas Department of State Health Services, Communicable Disease Division

RINGWORM

School _____

Date _____

Dear Parent:

There has been a confirmed case of tinia or "ringworm" at school. Tinea is a general name for a group of fungal skin infections. Skin on the body, feet, scalp or nails may be infected. As the fungus grows, it spreads out in a circle. A center of clear skin is surrounded by a reddish, scaly edge, looking like a ring, slightly raised. Ringworm may also cause bald patches. The area is often very itchy.

The fungus is found in soil or may be spread with the lesions of an animal or person that has the infection. No immunity develops and a person may be re-infected. Keeping skin clean, dry and intact may help prevent a fungal infection. Clothing should be kept clean and sharing of clothing, hats, combs, shoes and towels is strongly discouraged.

Tinea of the scalp or the body requires exclusion from school if the infected area cannot be completely covered by clothing or a bandage.

Tinea of the skin requires covering until medical treatment has been received for 24 hours. See your physician for appropriate treatment.

If you have a pet, check the animal for hair loss and infection. Treatment of the animal will aid in prevention of further infections.

Sincerely,

References: Texas Department of State Health Services, 2013

SCABIES

School _____

Date _____

Dear Parent/Guardian,

There has been a reported case of Scabies at school. The following information is for your reference. Scabies occurs worldwide and affects all socioeconomic groups. Transmission can occur as long as the infected person is untreated.

Scabies is a skin rash caused by a mite, a small insect in the spider family. The most common symptom is severe itching, which may be worse at night or after a hot bath. Small raised bumps or blisters form in the top layer of the skin, by the mites burrowing into the superficial layer. The burrows sometimes appear as short, wavy, darkened lines on the skin's surface. Sites commonly affected are wrists, webbing of fingers and thighs.

Transmission occurs by touching an infected person's skin, body fluid or a contaminated surface. Symptoms may appear several days or up to 6 weeks after exposure. Cleaning and covering any broken skin will help prevent bacterial infection of the sites.

If experiencing a persistent skin rash, identification by a physician and treatment is needed. Prescription creams will treat the infection, and relieve the intensity of the itching.

Diagnosis by a physician is based on the appearance of the rash, complaints of itching or visible scratch marks and the child can return to school once treatment has begun.

Incubation period is 2-6 weeks.

If you have any further questions or concerns, please consult your physician.

Sincerely,

References: Texas Department of State Health Services, 2013
The New School Health Handbook, 3rd edition

SCARLET FEVER

School _____

Date _____

Dear Parent/Guardian,

We have had a confirmed case of Scarlet Fever at school. With early antibiotic therapy prescribed by a physician the disease does not carry the stigma it once did.

Scarlet Fever is caused by a strain of streptococcal bacteria characterized by fever and sore throat. Often there are tender lymph nodes in the neck. With Scarlet fever, a fine red rash appears 1-3 days after the onset of the sore throat.

A physician must treat Scarlet Fever. The usual treatment is a course of antibiotics. The medication must be given for the full amount of time specified on the prescription. The student must be excluded from school until at least 24 hours after administration of the antibiotic has begun and until the fever is below 100^{o} for 24 hours without fever reducing medication.

Covering the mouth when coughing or sneezing, practicing good hand washing and avoiding sharing food, beverages, eating utensils and drinking containers, may prevent the spread of this infection. Once antibiotic therapy has begun, a new toothbrush will help prevent recurrence of the disease.

Please consult your physician if you have further questions or concerns.

Sincerely,

References: American Academy of Pediatrics
Texas Department of State Health Services, 2013

"STREP" THROAT

School _____

Date _____

Dear Parent/Guardian,

We have had multiple confirmed cases streptococcal sore throat at school.

Streptococcal sore throat ("Strep Throat") is a bacterial infection which causes a severe sore throat usually accompanied by a fever over 100^{o} degrees and a general feeling of fatigue and illness. There may be large, tender swollen glands in the neck. The throat may be red and swollen making swallowing painful. A fine red rash on the torso may precede the sore throat. The condition generally appears within 1 to 3 days after exposure to an infected person.

A physician must treat streptococcal sore throat. The usual treatment is a course of antibiotics. The medication ***must*** be given for the full amount of time specified on the prescription. The student with streptococcal sore throat must be excluded from school until at least 24 hours after administration of the antibiotic has begun and until the fever is below 100^{o} degrees for 24 hours without fever reducing medication.

Covering mouth when coughing or sneezing, practicing good hand washing, and avoiding sharing food, beverages and eating/drinking utensils may prevent the spread of streptococcal sore throat. Once antibiotic therapy has begun, a new toothbrush will help prevent recurrence of the disease.

Please consult your physician if you have further questions or concerns.

Sincerely,

Reference: American Academy of Pediatrics
Texas Department of State Health Services, 2013

Nurse Licensure Verification Form

For The State of Texas

Name: _____
First Middle Last

R.N. _____ L.V.N. _____ SS#: _____

License # _____ Expiration Date: _____

Verified by: _____
Name and Title/Employer

Phone verification: # 1/512/305-7400

On-line verification: www.bne.state.tx.us/olv/

Information required for verification both R.N. and L.V.N. license:

First Name: _____

Last Name: _____

License: # _____

Or Social Security # _____

It is recommended to print the online verification as proof of licensure for a RN or LVN who works or volunteers at a Catholic School.

This will provide confirmation of licensure.

PARENT VALIDATED HISTORY OF VARICELLA
(Chicken Pox)

This is to confirm that my child _____
has had Chicken Pox. (Print name of child)

_____

Date of Chicken Pox Illness

_____

Signature of Parent/Guardian

_____

Date

Return this form to the School Nurse / School Office

VARICELLA REPORTING FORM: Please note: Reporting is preferred to your local health office, the alternative Texas DSHS in Austin. (FAX) (512.458.7616)

Texas Department of State Health Services: (800).705.8868

VARICELLA (chickenpox) Reporting Form

Please use this form to report cases of varicella to your local or regional health office, or you can fax a copy of this document to the Texas Department of State Health Services in Austin at (512) 458-7616 at the end of every week.

ONSET DATE	VACCINATED AGAINST VARICELLA? Yes No Number of Doses Received? 1 2 Date(s) Varicella Vaccine Administered: ____/____/____ , ____/____/____			
LAST NAME	FIRST	DOB	AGE	SEX
ADDRESS	CITY		ZIP CODE	
PHONE	RACE		HISPANIC? Yes No	

ONSET DATE	VACCINATED AGAINST VARICELLA? Yes No Number of Doses Received? 1 2 Date(s) Varicella Vaccine Administered: ____/____/____ , ____/____/____			
LAST NAME	FIRST	DOB	AGE	SEX
ADDRESS	CITY		ZIP CODE	
PHONE	RACE		HISPANIC? Yes No	

ONSET DATE	VACCINATED AGAINST VARICELLA? Yes No Number of Doses Received? 1 2 Date(s) Varicella Vaccine Administered: ____/____/____ , ____/____/____			
LAST NAME	FIRST	DOB	AGE	SEX
ADDRESS	CITY		ZIP CODE	
PHONE	RACE		HISPANIC? Yes No	

Name of Person Reporting: ________________________ **Phone:** ____________

Agency/Organization Name: ____________________________________

Address: ____

City: ____________________ **Zip code:** ________**County:** _______________

Date Reported: ____________________

TEXAS DEPARTMENT OF STATE HEALTH SERVICES
Emerging and Acute Infectious Disease Branch

STOCK NO. F11-11046
REVISED 1/09