

New Mexico School Health Manual

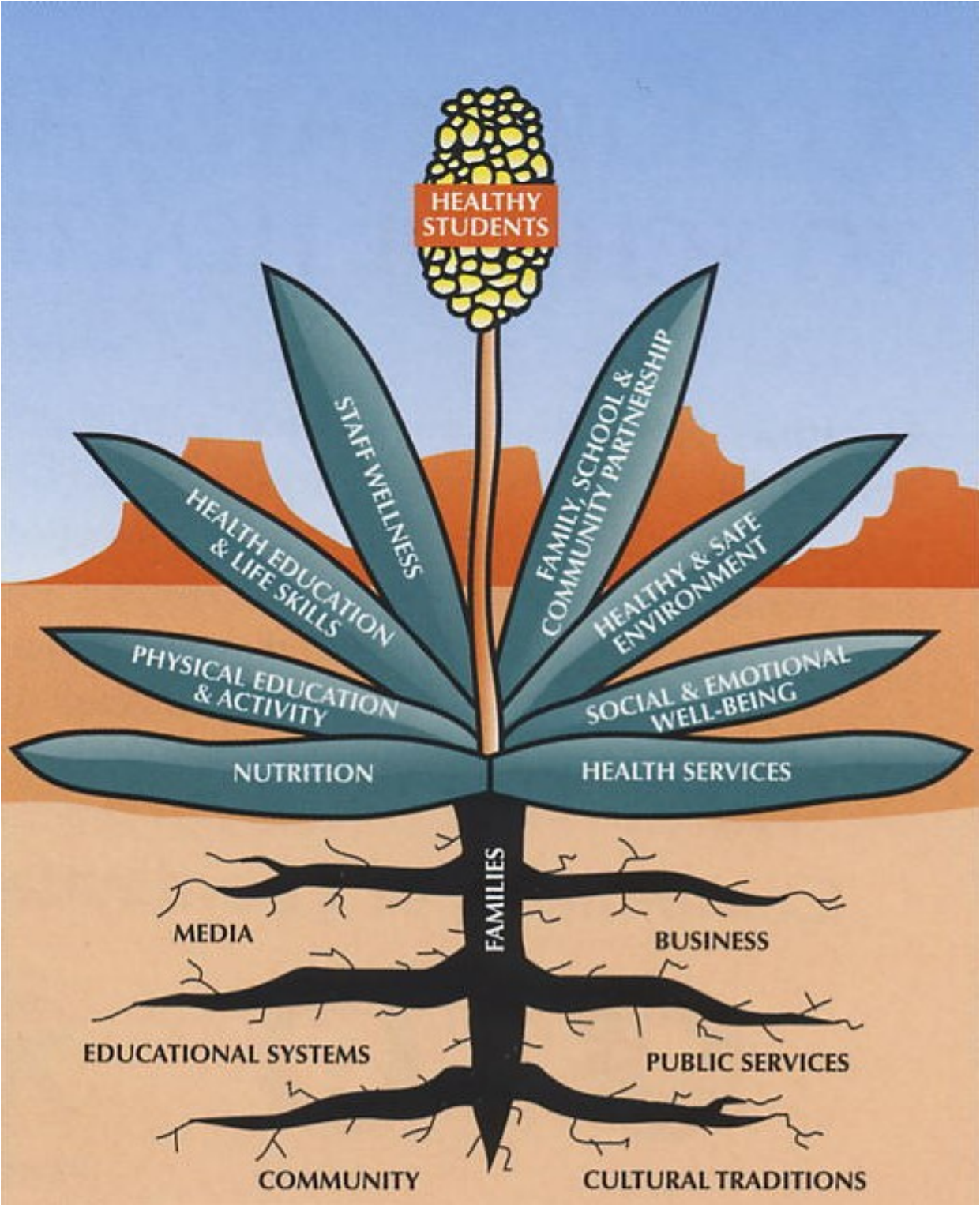


TABLE OF CONTENTS

CHAPTER ONE – COORDINATED SCHOOL HEALTH PROGRAM.....	7
Implementing the School Health Program.....	7
School Health Assistant.....	8
Licensed Practical Nurse.....	9
Teaching/Instructional Staff.....	9
Counseling Staff (Counselors, Social Workers, Psychologists).....	9
Food Services Personnel.....	9
School-Based Health Centers.....	9
Health Room Facility.....	10
Health Room Facility Recommendations and Requirements.....	10
Equipment Recommendations and Requirements.....	10
First-Aid Supplies Recommendations and Requirements.....	10
School Nursing Staff Medical Oversight.....	11
References and Resources.....	13
CHAPTER TWO – New Mexico Statutes, Administrative Codes, Policies and Regulations Relating to School Health.....	15
Introduction.....	15
Licensure and Competencies for School Health Professionals.....	15
New Mexico Nurse Practice Act.....	15
New Mexico School Health Program.....	17
Specific School Health Issues covered by NMAC.....	19
Health Records Retention.....	24
Confidentiality.....	25
Confidential Services for Minors.....	27
Documentation.....	29
Adverse Event Reporting.....	30
References and Resources.....	33
CHAPTER THREE – SCREENING ASSESSMENT AND SPECIAL EDUCATION.....	37
Introduction.....	37
Standards for Vision Screening in New Mexico Schools.....	37
Near Vision Acuity Screening Process.....	44
Hearing Screening.....	47
Height/Weight/BMI Screening.....	51
Scoliosis Screening.....	52
School Blood Pressure Screening.....	52
Special Health Related Assessments.....	53
Recommended School Nurse SAT or Special Education Screening Checklist.....	55
Resources and References.....	57
CHAPTER FOUR – STUDENTS WITH SPECIAL NEEDS.....	59
CHAPTER FIVE – INDIVIDUALIZED HEALTH CARE PLANS.....	61
CHAPTER SIX – MEDICATIONS IN THE SCHOOL.....	63
Introduction.....	63
Legal Definitions and Consideration for Medication Administration in the School Setting.....	63
Options for Medication Administration in the School Setting.....	65
Delegation of Medication Administration in the School Setting.....	68
Safety Considerations for Medication Administration in the School Setting.....	69
Emergency Medications in the School Setting.....	70
Students Rights - Asthma and Anaphylaxis Emergency Medications in the School Setting.....	72
Students Rights - Diabetes Self-Management in the School Setting.....	73
Guidelines for Over the Counter Medications in the School Setting.....	74
Guidelines for Controlled Substances in the School Setting.....	75
Guidelines for Complementary and Alternative Medications and Therapies in the School Setting.....	77
Guidelines for Medication Administration for Field Trips and School Sanctioned Events in the School Setting.....	80
Guidelines for Off Label, Research, and Investigational Medication Administration in the School Setting.....	81

Storage and Handling of Medications in the School Setting	82
Documentation and Record Keeping for Medication Administration in the School Setting	83
Disposal of Medications in the School Setting	84
References and Resources	84
CHAPTER SEVEN – PROCEDURE GUIDELINES	89
CHAPTER EIGHT – EMERGENCY SERVICES/FIRST AID	91
Guide to Providing Emergency Care	91
Automatic External Defibrillator (AED) Guidelines	92
Allergic Reaction	93
Asthma/Wheezing or Difficulty Breathing	95
Behavioral Emergencies	95
Bites Human & Animal	96
Bleeding	96
Blisters from Friction	97
Bruises	98
Burns	98
Child Abuse/Neglect	99
Chocking	99
Concussions	100
Cuts/Scratches/Scrapes	100
Diabetes	101
Diarrhea	102
Ears	102
Electric Shock	102
Eyes	103
Fainting	104
Fever	104
Fractures/Dislocations/Sprains/Strains	105
Frostbite	105
Headache	106
Head Injuries	106
Heat Stress	107
Hypothermia	108
Menstrual Difficulties	108
Mouth or Jaw Injuries	109
Neck/Back Injuries	109
Nose	110
Poisoning/Overdose	110
Pregnancy	111
Puncture Wounds	111
Rashes	112
Seizures	113
Splinters	114
Shock	114
Stings	115
Stomach Aches/Pain	115
Teeth	116
Unconsciousness	118
Vomiting	119
Student Emergency Medical Authorization Form	119
References and Resources	121
CHAPTER NINE – IMMUNIZATION	122
New Mexico Immunization Law	122
Immunization Assessment	122
New Mexico Administrative Codes	123
Exemptions From immunizations	123

School and Community Based Immunization Clinics	125
New Mexico Statewide Immunization Information System	126
Foreign Language Vaccine-Related Terms	128
References and Resources	128
CHAPTER TEN – COMMUNICABLE DISEASE CONTROL.....	131
Procedures for Control of Communicable Diseases	131
Diapering	133
Bloodborne Pathogen Exposure List	134
Animal or Human Bite.....	138
Bacterial Enteritis	140
Bed Bugs	142
Chlamydia, Gonorrhea.....	144
Conjunctivitis (Pink-eye).....	147
Cytomegalies Infection (CMV)	149
Diarrhea (Acute).....	150
Fifth Disease (Erythema Infections).....	152
Genital Warts.....	153
Giardiasis, Cryptosporidiosis.....	154
Haemophilus influenzae Invasive Disease.....	155
Hand, Foot and Mouth Syndrome.....	157
Hantavirus Pulmonary Syndrome (HPS).....	158
Hepatitis A (Acute).....	159
Hepatitis B and C (Acute).....	161
Herpes Simplex-Genital Infection	162
Herpes Simplex, Non-Genital Infections.....	164
HIV Infection/AIDS (Acquired Immunodeficiency Syndrome).....	165
Impetigo.....	167
Influenza	168
Meningitis (Bacterial).....	170
Meningitis (Viral or Aseptic).....	171
MRSA (Methicillin-Resistant Staphylococcus Aureus)	173
Mononucleosis (Infectious Mononucleosis, Mono).....	174
Mumps	175
Norovirus	177
Pediculosis (Head Lice).....	178
Pertussis (Whooping Cough).....	181
Plague	183
Rubella (German Measles, Three-Day Measles)	185
Rubeola (Measles)	186
Scabies	188
Streptococcal Infections (Strep throat)/Scarlet Fever.....	189
Tetanus	190
Tinea Capitis, Corporis, Cruris and Pedis.....	191
Tuberculosis (TB).....	192
Tularemia.....	194
Upper Respiratory Tract Infection, Acute Viral	195
Vaginitis	196
Varicella-Zoster Infections (Chicken Pox and Shingles).....	196
West Nile Disease.....	199
References and Resources	200
CHAPTER ELEVEN – SCHOOL SAFETY.....	202
CHAPTER TWELVE – SCHOOL WELLNESS POLICY	203
This chapter is Under Construction	203
CHAPTER THIRTEEN – DENTAL HEALTH.....	204
Oral Health Is Essential to General Health	204
Tooth Function	204

Oral Disease.....	204
Tooth Decay/Cavities	204
Periodontal Disease	205
Malocclusion	205
Oral Cancer.....	205
A Diet for Good Oral Health	205
Water Consumption	206
Brushing and Flossing	206
Tooth Brushing	206
Flossing.....	206
Fluoride.....	206
Systemic Fluorides	206
Topical Fluorides.....	207
Dental Sealants	207
Prevention of Oral Injury.....	207
Mouth Guards	207
Dental First Aid	208
References and Resources	208
CHAPTER FOURTEEN – MENTAL HEALTH.....	209
School’s Role.....	209
Developmental Stages	209
Prevention Activities	211
Common Mental Health Concerns	212
Depression	212
Bipolar Disorder (Previously called manic-depressive illness)	214
Disruptive Behavioral Disorders	215
Conduct Disorders	216
Oppositional Defiant Disorder (ODD)	217
Attention-Deficit / Hyperactivity Disorder.....	219
Eating Disorders	223
Post-Traumatic Stress Disorder (PTSD).....	226
Suicidal Ideation	231
Suicide Crisis Response.....	237
Non-Suicidal Self-Injury (NSSI)	238
Preventing Social Contagion	240
Somatic Complaints.....	241
Substance Abuse.....	242
Psychotropic Medication: Use with Children and Adolescents.....	243
Divorce	244
Grief and Loss	245
Child Abuse and Neglect.....	249
Human and Sex Trafficking Awareness	253
References Resources	255
CHAPTER FIFTEEN - STANDING ORDERS.....	261
Introduction	261
Standing Order for Administration of Naloxone by School Personnel.....	261
Guidelines for Administration of Vaccines by The School Nurse.....	263
Standing Order for Administration of Vaccines by The School Nurse.....	263
Standing Order Administer Influenza Vaccine for SKIIP Participants.....	263
Emergency Order for Vaccine Reactions	264
Guidelines for the School Nurse to Administer Oxygen	265
Standing Order for the School Nurse to Administer Oxygen	266
Standing order for the School Nurse to Provide Head Lice (Pediculosis) Treatment.....	267
Guidelines for Pregnancy Testing by the School Nurse	269
References and Resources	270
CHAPTER SIXTEEN – ANNUAL SCHOOL SERVICE REPORT.....	271

Definitions and Clarifications.....	271
Nursing Staff Data	271
Assistive Personnel Data	272
Students with Medical Diagnoses.....	274
Students Requiring Medically Complex Procedures	277
Students with Prescription Medications at School.....	278
Student Deaths Occurring During the School Year	279
Student Visits to Health Office.....	279
Emergency Medication Administered	282
Disposition of Students Visiting Health Office	282
Student Screenings	283
Miscellaneous School Nursing Functions.....	284
• The staff immunization count is the number who received immunizations, not the number of vaccines administered.	284
• Referrals for additional medical care for any condition should be captured in this section under the referral category.	284
• Any encounter that is not for immunizations nor results in a referral for additional medical care should be included in “Other Medical Encounters” e.g. emergencies, medication issues, injuries, individual advice/education, counseling, monitoring health conditions such as hypertension and diabetes.	284
• Any health education presentation/training provided specifically for the school staff should entered in that category.	284
References and Resources	285
CHAPTER SEVENTEEN – BLOODBORNE PATHOGENS –EXPOSURE AND CONTROL	286
New Mexico Regulation on Bloodborne Pathogens	286
Guidelines.....	286
Hepatitis B Vaccination and Post-Exposure Follow-Up.....	287
Exposure Classifications.....	289
Sample Bloodborne Pathogens Exposure Control Plan.....	290
Definitions	290
Exposure Determination	292
Methods of Compliance.....	292
Engineering and Work Practice Controls	292
Personal Protective Equipment (PPE)	293
Housekeeping	294
Regulated Waste	294
Handling Sharps	294
References and Resources	295
CHAPTER EIGHTEEN – DELEGATION.....	296
This chapter is Under Construction	296

CHAPTER ONE – COORDINATED SCHOOL HEALTH PROGRAM

Implementing the School Health Program

To be successful, a coordinated school health program requires collaboration among staff within the school district and community members representing the various components. The New Mexico Coordinated School Health Model, includes the following eight components: Nutrition, Physical Education and Activity, Family, School and Community Partnerships, Health Education, and Life Skills, Healthy and Safe Environment, Social and Emotional Well-Being, School Health Services, and Staff Wellness. Important team members in this collaboration include the school board members, administrators, school nurses, school health assistants, teachers, counselors, food services staff, and school-based health centers staff.

The New Mexico Public Education Department (NMPED) requires licensure for various levels of school health staff, as well as teaching staff. School Nurses, must be licensed by the New Mexico Board of Nursing as well as NMPED. Health Assistants must attend a one-time training by the New Mexico Department of Health (NMDOH) prior to being licensed by the NMPED.

[Application for Initial New Mexico Licensure](#)

School Health Advisory Councils (SHAC)

A coordinated approach to school health improves the health of young people and enhances their capacity to learn through the support of families, schools, and communities working together. Coordinated School Health is about keeping students healthy over time, reinforcing positive healthy behaviors throughout the school day, and making it clear that good health and learning go hand in hand. The School Health Advisory Council (SHAC) is a district advisory council that works on insuring that health and wellness are at the core of learning. The SHAC is made up of a broad cross-section of parents, business and community leaders, and school personnel. A SHAC facilitates communication and problem solving about health-related issues of children and youth. SHACs can assist schools in carrying out responsibilities for promoting and protecting the health of students and employees. An active (SHAC) is an excellent means to enlist parent and community involvement in the schools. The SHAC can provide a way for the schools to utilize valuable professional resources in their programs. A SHAC works with the district to help school communities support wellness and academic achievement.

Every public-school district or public charter school in New Mexico are required to have a SHAC and are an essential part of a comprehensive school district wellness policy. Both promote academic success and lifelong well-being of students in New Mexico. The NMPED has developed a school district wellness policy guidance document which is intended to assist school districts in developing and implementing a comprehensive school district wellness policy. The wellness policy also addresses school staff wellness. The overall health of has profound effect on the academic success and well-being of all

New Mexico students. The guidance document is intended to assist school districts in developing and implementing wellness policies to create a learning environment that helps students meet their academic potential and enjoy lifelong health. Developing and maintaining a Wellness Policy enables each district to meet NMPED [Wellness Policy Code](#). Other documents essential to a complete wellness policy are found on the NM PED website under [School District Wellness Policy: Guidance Document Wellness Policy](#)

School Board

The local School Board for the school district assumes responsibility for overall health policies as well as budget, facilities, planning and personnel. The School Board is an asset to the implementation of school health programs, including a SHAC. One recommendation is to have a school board member on the SHAC.

School Administrator

The School Administrator provides leadership for all phases of the school health program including the development and maintenance of policies. He/she works closely with the school nurse, in the planning and implementation of the school health program. The School Administrator is responsible for seeing that all students and employees under his/her authority comply with state laws and regulations relating to health and safety issues. It is the Administrator's responsibility to operate the school in accordance with all federal and state laws in addition to NMPED regulations.

School Nurse

The PED-licensed School Nurse's responsibilities include, but are not limited to, the following activities [Licensure for School Nurses, Grades Pre-K-12](#)

- Participating in planning, implementation, and evaluation of the school health program.
- Acting as an advocate for the health needs and rights of students.
- Delivering health services to students using nursing processes to assess needs, plan interventions and evaluate outcomes.
- Providing and/or assisting with access to health counseling and guidance for students on an individual basis or within a group setting.
- Participating in health education program activities for students, school personnel and the community.
- Facilitating communication between the student, family, medical provider, and the community.

The National Association of School Nurses (NASN) has adopted a [Framework for 21st Century School Nursing Practice](#) which outlines the structure and concepts of the complex clinical specialty practice of school nursing.

School Health Assistant

The School Health Assistant is a paraprofessional employed to assist and support the School Nurse so the school nurse may have more time and opportunities to utilize professional nursing skills in the school health program. The School Health Assistant,

supervised by the school nurse, provides health-related services as assigned by the school nurse. Completion of a NM Department of Health and NM Public Education Department approved training is a requirement for [School Health Assistant](#) licensure.

Licensed Practical Nurse

The principle role of the school [Licensed Practical Nurse \(LPN\)](#) is to assist the licensed school nurse with the implementation of the school health program by providing practical nursing care for students in the health room and by meeting the complex needs of medically fragile/severely disabled students. The LPN must be supervised by the RN school nurse.

Teaching/Instructional Staff

The instructional staff involvement in the school health program include the following responsibilities.

- Making informal observations regarding the health status of students and reporting concerns to the school nurse.
- Incorporating and coordinating health education as directed by the school district's K-12 health curriculum.
- Ensuring that students receive adequate first aid services.
- Encouraging students to evaluate their own health and health behaviors and to take responsibility for seeking improvement.
- Setting a good example as a role model regarding desirable health habits, attitudes, and practices.
- Accommodating all students' health needs in the classroom.

Counseling Staff (Counselors, Social Workers, Psychologists)

The counseling staff's involvement with the school's health program is essential for a successful program and might include the following responsibilities.

- Providing individual and group opportunities to promote emotional and social health, personal growth, and self-understanding, as well as teaching problem-solving and decision-making skills.
- Identifying students who demonstrate emotional and/or behavior disturbances and cooperates with staff and supporting personnel in assessing those students and assisting their families to seek help through school and community resources.
- Serving as resource personnel to other school staff for the planning of in-services, the development of applicable curricula, and the identification of available alternatives to serve students.
- Assisting the teacher, administrator, nurse, parent, and any other appropriate person(s) to help meet the needs of students engaged in counseling.

Food Services Personnel

The food services personnel assist the administrator in the organization of the school meal programs and assumes responsibility to provide nutritious meals to students in accordance with state and federal laws. In addition, local school districts must consider individual accommodation for students with special nutritional needs.

School-Based Health Centers

School-Based Health Centers (SBHCs) provide comprehensive health services, so that students can avoid health-related absences and get support to succeed in school. SBHCs are a cost-effective and accessible way to provide age-appropriate primary care, behavioral health, and dental services for students in schools (<http://www.nmasbhc.org/index.html>).

SBHC services are complementary to, and supportive of, the services provided by school nurses and other health professionals in the school setting. The National Association of School Nurses issued a fact sheet in 2016 highlighting this intersection called [School Nursing and School Based Health Centers](#)

Health Room Facility

The health room is designed to meet the needs of the school population it serves. It is to be accessible to all students, parents & staff. and meets [American Disabilities Administration \(ADA\)](#) requirements. Within the health office, the school nurse’s office must ensure privacy and to be as soundproof as possible to facilitate confidentiality. The health room must have enough locked storage space to accommodate supplies and equipment and be equipped with a restroom with hot and cold running water and toilet facilities which meet ADA requirements.

Health Room Facility Recommendations and Requirements

- Sink with hot and cold running water
- Adequate counter space
- Adequate storage
- Lockable cabinet specifically for medication storage
- Bathroom meeting ADA standards
- Adequate area (minimum 10 feet) for vision screening
- Two separate rooms - one for school nurse’s office and one for the health room
- Adequate ventilation system
- Lockable entry door
- [CDC Guidelines](#) on spacing of cots is 3 feet apart to prevent communicable disease

Equipment Recommendations and Requirements

- | | | |
|-------------------------|------------------------------|--|
| ▪ Wheelchair | ▪ Soap Dispenser | ▪ Chairs |
| ▪ Audiometer | ▪ Paper Cup Dispenser | ▪ Filing Cabinet |
| ▪ Blackboard | ▪ Stethoscope | ▪ Fireproof Locking Cabinet for Student Files |
| ▪ Bulletin Board | ▪ Cot | ▪ Otoscope |
| ▪ Refrigerator | ▪ Ice maker | ▪ Blood Pressure Cuffs (infant, child, adult, obese) |
| ▪ Computer | ▪ Phone (private) | ▪ Plastic Lined Trash Cans |
| ▪ Printer | ▪ Clock | ▪ Sharps Container |
| ▪ Paper Towel Dispenser | ▪ Lockable Desk | |
| ▪ Scales | ▪ Vision Screening Equipment | |
| ▪ CPR Mask | | |

First-Aid Supplies Recommendations and Requirements

- | | | |
|------------------------|---------------------------|--------------------------|
| ▪ Cotton Balls | ▪ Mild Liquid Soap | ▪ Hot Pack(s) |
| ▪ Eye Glass Repair Kit | ▪ Spray Bottle | ▪ Portable Emergency Kit |
| ▪ Plastic Bags | ▪ Sanitary Napkins | ▪ Vision Charts |
| ▪ Eye Wash | ▪ Ice/Cold Pack(s) | ▪ Washable Blankets |
| ▪ Masking Tape | ▪ Large Wash Basin | ▪ Splints |
| ▪ Flashlight | ▪ Disposable Linens | ▪ Table Salt |
| ▪ Thermometer/Covers | ▪ Adhesive Tape | ▪ Paper Towels |
| ▪ Kleenex | ▪ Non-medicated Band aids | ▪ Tongue Blades |

- Tweezers
- Cotton Applicators
- Triangle Bandages - (37" x 37")
- Vaseline
- Paper Cups
- Chlorine Bleach
- Antiviral Solution
- Sterile Gauze Squares
- Roller Bandages – (1", 2", 3" – 2 each)
- Safety Pins
- Scissors
- Disposable Latex-free Gloves
- Alcohol

School Nursing Staff Medical Oversight

NM PED license New Mexico school nurses; however, it is NMDOH who provides the medical oversight of all school nurses per the New Mexico State Statute 24-1-4(B) of the Public Health Act. The NM [Public Health Act](#), of 2016 states “a regional health officer shall provide medical oversight to school nurses in the regional health officer’s region. A school nurse shall make reports relating to public health as the regional health officer in the school nurse’s region requires.” Regional School Health Advocates assist the regional health officers and the school districts in their regions in compliance with this statute.

School Nurse Evaluation Tools

The NM PED licensing Bureau implemented a system for school nurse licensure levels along with revised school nurse competencies in 1997. The purpose of the licensure regulations and competencies are to allow school district administrators flexibility in hiring and assigning staff to meet the complex and diverse health needs of students. In addition, the licensure system establishes roles and responsibilities of school nurses and designates supervision at each level “[School Nursing : Scope and Standards of Practice](#)”.

Representatives of the NM School Nurse Advisory Committee (SNAC) developed supervision and evaluation tools for the different levels of school nursing using the NM school nurse competencies and National Association of School Nurses position statement on school nurse supervision and evaluation.

Evaluation Tools for Non-Medical Supervisor Use

Two nurse evaluation tools are available for use in those schools where a non-medical person evaluates the performance of the school nurse. For the non-medical evaluation of school nurses, there is a tool for the building principal or on-site evaluator and another for the superintendent or other evaluator outside of the school building. With the increasing complexity of the health and social needs of students, leadership for the school nurse is critical in coordinating various health services. Use of these evaluation tools, can assist in defining the role of the school nurse and assessing her/his skills to meet the health-related goals of the school and/or school district, [Nurse Evaluation Tool Non-Medical Administrator](#); [Nurse Evaluation Tool Non-Medical Site Administrator](#)

Evaluation Tools for Medical Supervisor Use

The tools developed for the professional licensed school nurse are aligned with PED competencies for school nurses and are for use by the supervisor evaluating the clinical performance of the school nurse. It is recommended that they be used in conjunction with the non-medical tools for evaluation of the school nurse's performance. For school nurses who do not have medical supervision, these tools can be used as support to address this issue with school administration and to discuss who might assume that role.

[Nurse Evaluation Tool – Medical Supervisor – Supervisory Nurse;](#)

[Nurse Evaluation Tool – Medical Supervisor – Professional Nurse;](#)

[Nurse Evaluation Tool – Medical Supervisor – Associate Nurse;](#)

[Nurse Evaluation Tool – Medical Supervisor – LPN;](#)

[Nurse Evaluation Tool - Medical Supervisor – Health Assistant.](#)

References and Resources

[CDC, Guidelines](#) for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings. Updated October 2017

National Association of School Nurses. (2016). [Framework for 21st Century School Nursing Practice](#). NASN School Nurse, 31(1), 45-53.

National Association of School Nurses. (2016). [School Nursing and School Based Health Centers: Working Together for Student Success](#).

National Association of School Nurses. (2017). [School Nursing: Scope and Standards of Practice](#) 3rd Edition

New Mexico Alliance for School-Based Health Care, <http://www.nmasbhc.org/index.html>

New Mexico Public Education Department, [Application for Initial New Mexico Licensure](#).

New Mexico Public Education Department, [Wellness Policy](#)

New Mexico Public Education Department,
[School District Wellness Policy: Guidance Document](#)

New Mexico Administrative Code, (NMAC), Title 6. Primary and Secondary Education,
Chapter 2. Public School Administration – Health and Safety, Part 6. School District
[Wellness Policy Code](#).

[New Mexico Administrative Code, Title 6.6.63, Primary and Secondary Education, School Personnel-Licensure Requirements for Ancillary and Support Personnel-](#)

[Licensure for School Nurses, Grades Pre-K-12](#)

[New Mexico Administrative Code, Title 6.63.16, Primary and Secondary Education, School](#)

[Personnel-Licensure Requirements for Ancillary and Support Personnel-
Licensed Practical Nurse \(LPN\)](#)

[New Mexico Administrative Code, Title 6.63.15, Primary and Secondary Education, School
Personnel – Licensure Requirements for Ancillary and Support Personnel –
School Health Assistant](#)

School Nurse Advisory Committee, Scopes, and Standards for School Nursing,

[Nurse Evaluation Tool Non-Medical Administrator;](#)

[Nurse Evaluation Tool Non-Medical Site Administrator;](#)

[Nurse Evaluation Tool – Medical Supervisor – Supervisory Nurse;](#)

[Nurse Evaluation Tool – Medical Supervisor – Professional Nurse;](#)

[Nurse Evaluation Tool – Medical Supervisor – Associate Nurse;](#)

[Nurse Evaluation Tool – Medical Supervisor – LPN](#)

[Nurse Evaluation Tool - Medical Supervisor – Health Assistant.](#)

United States Department of Justice, Civil Rights Division.

[American Disabilities Administration \(ADA\) requirements](#)

CHAPTER TWO – New Mexico Statutes, Administrative Codes, Policies and Regulations Relating to School Health

Introduction

There are many state and federal regulations, statutes, and administrative codes which govern schools in the USA. Many of these regulations effect only schools who receive federal funding. However, some regulations and rules affect all public, charter, private and even home schools.

Licensure and Competencies for School Health Professionals

In New Mexico (NM) Public and Charter Schools are regulated by NM Public Education Department (PED). Licensure issued by NMPED is required for all individuals working in public schools and public charter schools. This state statute was established in the 1960s to protect and standardize requirements for school staff. Licensure is determined by educational background and the position applied for. All PED licensure now requires a background check which is the responsibility of the applicant.

NM State Statutes – School Personnel

§Chapter 22-10A-5, Public Schools, [School Personnel Act](#)

NM Administrative Codes are rules written (promulgated) after a statute has passed both the State Senate, the House of Representatives and has been signed by the governor. The rule outlines how the statute will be carried out. Usually the division of government responsible for overseeing the statute, writes, and updates the rules also known as New Mexico Administrative Code (NMAC). The process of rulemaking is difficult and highly regulated. Here is a link to the process [New Mexico Rulemaking Process Overview. Listed below are rules that affect school personnel and school services.](#)

New Mexico Nurse Practice Act

Nursing Practice

§61-3-1-31

[Nursing](#)

NM Nursing Licensure

Title 16

Occupational and Professional Licensing

Chapter 12 Nursing and Health Care Related Providers

Part 2 [Nurse Licensure](#)

NM PED Nursing licensure for Schools

Title 6 Primary and Secondary Education

Chapter 63 School Personnel - Licensure Requirements for Ancillary and & Support

Part 2 Personnel – [Licensure for School Nurses, Grades Pre-K-12](#)

The current NMAC (August 2017) for school nursing establishes the requirement for three types of school nurse licenses. An associate school nurse license is issued to the school nurse who has an associate degree in nursing from a regionally accredited college, university or diploma program accredited by the National League of Nursing. A professional nurse level two licensure is issued to a nurse with a bachelor's degree in nursing or related health field, from a regionally accredited college, university or institution accredited by the National League of Nursing. A supervisory school nurse level three licensure is issued to a nurse with a master's degree in nursing or health related field, from a regionally accredited college, university or institution accredited by the National League of Nursing. [Licensure for School Nurses, Grades Pre-K-12.](#)

[NM PED Licensed Practical Nurse Licensure for Schools](#)

[Title 6 Primary and Secondary Education](#)

[Chapter 63 School Personnel – Licensure Requirements for Ancillary and Support](#)

[Part 16 Personnel - Licensure for School Licensed Practical Nurses,](#)

[Grades Pre-K-12](#)

[NM PED Health Assistant Licensure for Schools](#)

[Title 6 Primary and Secondary Education](#)

[Chapter 63 School Personnel – Licensure Requirements for Ancillary and Support](#)

[Part 15 Personnel – Licensure for School Health Assistants, Grades Pre-K - 12](#)

NM PED Denial, Suspension, and Revocation of License

Title 6 Primary and Secondary Education

Chapter 68 School Personnel – Denial, Suspension, and Revocation of License

This PED rule governs the application process for initial issuance or continuing licensure of all types of licenses and certificates issued by the PED, as well as the denial of such applications. Applicants must also meet all requirements prescribed in PED rules governing each type and level of license or certificate sought. [Denial of Application for Licenses for School Personnel.](#)

School Nurse Evaluation Tools

School Nurse Evaluation Tools are required to be used to evaluate School Nurses. These tools are in Chapter one of this Manual. (See Chapter 1 this Manual.)

New Mexico School Health Program

School Health Services

Title 6 Primary and Secondary Education

Chapter 29 Standards for Excellence

Part 1 General Provisions

“E. [School Health](#). School health programs provide opportunities for all students to develop healthy behaviors. Districts and charter schools shall provide or make provisions for school health programs that address the health needs of students and staff. Districts and charter schools shall provide the following programs: health education, physical education, health services and school counseling. Additional programs may include: nutrition, staff wellness, family-school-community partnerships, healthy environment and psychological services. These programs shall:

- (1) be in accordance with Section 22-10A-34 and Section 24-5-1 through 24-5-6 NMSA 1978; provide education and skill development program offerings;
- (2) provide community partnerships which help to achieve the goal of healthy students and staff;
- (3) be assessed as part of the EPSS process; and
- (4) support the local curriculum and EPSS.”

Health Screening Process

New Mexico Statute and Rules require some school health screenings. These include immunizations, vision, and requests from Special Education or Student Assistant Teams.

Most school nurses choose to do general screening for vision, hearing. The school nurse schedule and the size of the school district may determine how many grades are screened and what they are screened for. However, for Vision Screening Kindergarten, 1st and 3rd grades are required and immunization requirements are for all grades.

Immunizations

Title 6	Primary and Secondary Education (PED)
Chapter 12	Public School, Administration -health and safety
Part 2	Health services
8.A	Immunizations of School Children
<u>9.A</u>	Student's Right to Self-Administer Certain Medications
<u>10.A</u>	Human Immunodeficiency Virus (HIV)

Title 7	Health (DOH)
Chapter 5	Vaccinations and Immunizations
Part 2	Immunization Requirements

Title 7	Health (DOH)
Chapter 5	Vaccinations and Immunizations.
Part 3	Exemption for school, childcare, and pre-school immunization

For more in-depth information regarding immunization and the school requirements please see Chapter nine, Immunizations, and New Mexico Statewide Immunization Information System (NMSIIS) of this manual. Requirements and Exemptions are discussed. Also available are resources regarding training and the use of NMSIIS.

Vision Screening

Title 7	Health (DOH)
Chapter 30	Family and Children Health Care Services
Part 11	Vision Screening Test Standards for Students

Title 7	Health (DOH)
Chapter 30	Family and Children Health Care Services
Part 10	Award of Funds from Save Our Children's Sight Fund

For in-depth information regarding screenings in schools please refer to Chapter three, Screening, Assessment, and Special Education. In Chapter three, state requirements are discussed as well as options for assistance. Also included are template forms for use if the school district does not have them.

Specific School Health Issues covered by NMAC

Acquired Immune Deficiency Syndrome

Title 6	Primary and Secondary Education (PED)
Chapter 12	Public School Administration – Health and Safety
Part 2	Health Services

Diabetes Self-Management by Students in the School Setting

Title 6	Primary and Secondary Education (PED)
Chapter 12	Public School, Administration – Health and Safety
Part 8	Diabetes Management for Students in the School Setting

(See Chapter 4 of this Manual for Diabetes Care Management & Training Resources)

Students Rights to Self-Administer Certain Medications

Title 6	Primary and Secondary Education (PED)
Chapter 12	Public School Administration – Health and Safety
Part 2	Health Services
Subpart 9	Student's Rights to Self-Administer Certain Medications

Tobacco Free School Districts

Title 6	Primary and Secondary Education (PED)
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Chapter 12 Public School Administration – Health and Safety

Part 4 [Tobacco Free School Districts](#)

Pregnant or Parenting Student

Title 6 Primary and Secondary Education (PED)

Chapter 10 Public School Administration – Procedural Requirements

Part 8 [Compulsory School Attendance](#)

This NMAC:

“provides excused absences for pregnant and parenting students as follows:

(a) provides at least ten days of excused absences for a student who provides documentation of the birth of the student's child and allows the student a time period to make up the work that the student missed that equals the number of days the student was absent for the birth of a child;

(b) provides excused absences for any additional days missed by a pregnant or parenting student for which a longer period of absence is deemed medically necessary by the student's physician and allows the student a time period to make up the work that the student missed that equals the number of days the student was absent.....for a student who provides appropriate documentation of pregnancy or that the student is the parent of a child under the age of thirteen needing care and allows the student a time period to make up the work that the student missed that equals the number of days the student was absent;

Child Abuse and Neglect

[NM State § 32A-4-3 \(2016\)](#) EVERYONE has the duty to report child abuse and child neglect; responsibility to investigate child abuse or neglect; penalty.

(2005)

“A. Every person, including a licensed physician; a resident or an intern examining, attending or treating a child; a law enforcement officer; a judge presiding during a proceeding; a registered nurse; a visiting nurse; a schoolteacher; a school official; a social worker acting in an official capacity; or a member of the clergy who has information that is not privileged as a matter of law, who knows or has a reasonable suspicion that a child is an abused or a neglected child shall report the matter immediately to:

- (1) a local law enforcement agency;
- (2) the department; or

(3) a tribal law enforcement or social services agency for any Indian child residing in Indian country.” [NM State § 32A-4-3 \(2016\)](#)

Recognizing and Reporting Child Abuse and Neglect Training

E-learning web based training for schools by New Mexico State University, Extension Family and Consumer Sciences. [Recognizing & Reporting Child Abuse & Neglect](#)

School Health Support Services

Title 6 Primary and Secondary Education (PED)

Chapter 29 Standards for Excellence

Part 1.11 General Provisions

“H. School Health [Support services](#). Districts and charter schools shall provide support service programs which strengthen the instructional program. Required support service programs are: library media, school counseling and health services. Support services shall:

- (1) have a written, delivered and assessed program, K-12;
- (2) provide licensed staff to develop and supervise the program;
- (3) be assessed as part of the EPSS process; and
- (4) support the local curriculum and EPSS.”

Special Education

Title 6 Primary and Secondary Education (PED)

CHAPTER 31 Special Education

Part 2 [Children with Disabilities/Gifted Children](#)

In New Mexico, the definition of Tier 3 is special education and related services for students with identified disabilities under the federal Individuals with Disabilities Education Act (IDEA) and the state’s criteria for gifted. Students formally referred to Tier 3 first receive (with written parental consent) a multidisciplinary evaluation to determine their need for services at this level. In making the eligibility determination for Tier 3, the educational diagnostician and the group of qualified professionals who makes the eligibility determination will consider data from the student’s response to interventions which have been tried and documented from Tiers 1 and 2.

Tier 3 Referral and the Multidisciplinary Evaluation Process

When an individual student is referred to the SAT because a concern is raised, the team members are responsible for collecting information about the student and forming a hypothesis about the possible factors contributing to the student's difficulties academically and/or behaviorally. IEP and Section 504 may or may not include nursing services. If the IEP includes nursing services, these are usually services which may be billed for under Medicaid in the Schools. A student cannot have both a Section 504 and an IEP. If the SAT process decides the student is Tier 3 then that student gets all the supports and services needed must be provided as related services attached to the IEP. [Difference Between A Section 504 and an IEP](#)

ADA, IDEA, Section 504 and IEP

There are three main Federal Laws that affect students with disabilities and/or health conditions in schools:

- (1) Americans with Disabilities Act (ADA)
- (2) Section 504 of the Rehabilitation Act
- (3) Individuals with Disabilities Education Act (IDEA)

[Difference Between A Section 504 and an IEP](#)

- Section 504 is a broad federal civil rights law that protects all individuals with a handicap.
- IDEA (the Individuals with Disabilities Education Improvement Act) only applies to students who require special education because they have one of the specified types of disabilities.
- Students who qualify under section 504 must have a 504 plan that outlines the services to be provided. Some students will also qualify under the more stringent IDEA. These students will have an IEP (Individualized Educational Plan) rather than a 504 plan.

Section 504 and Accommodation Plan

Section 504 is federal civil rights law under the Rehabilitation Act of 1973. The U.S. Department of Education's Office for Civil Rights (OCR) administers Section 504—not the State. Section 504 is the other service option available to students with disabilities, but who are not eligible and/or are receiving special education services under the eligibility requirements of the IDEA. It is designed to provide equal access and fairness in general education to students with disabilities, thereby leveling the playing field for them. Under New Mexico's three-tier model of student intervention, a Section 504 Plan is a Tier 2 service and/or support.

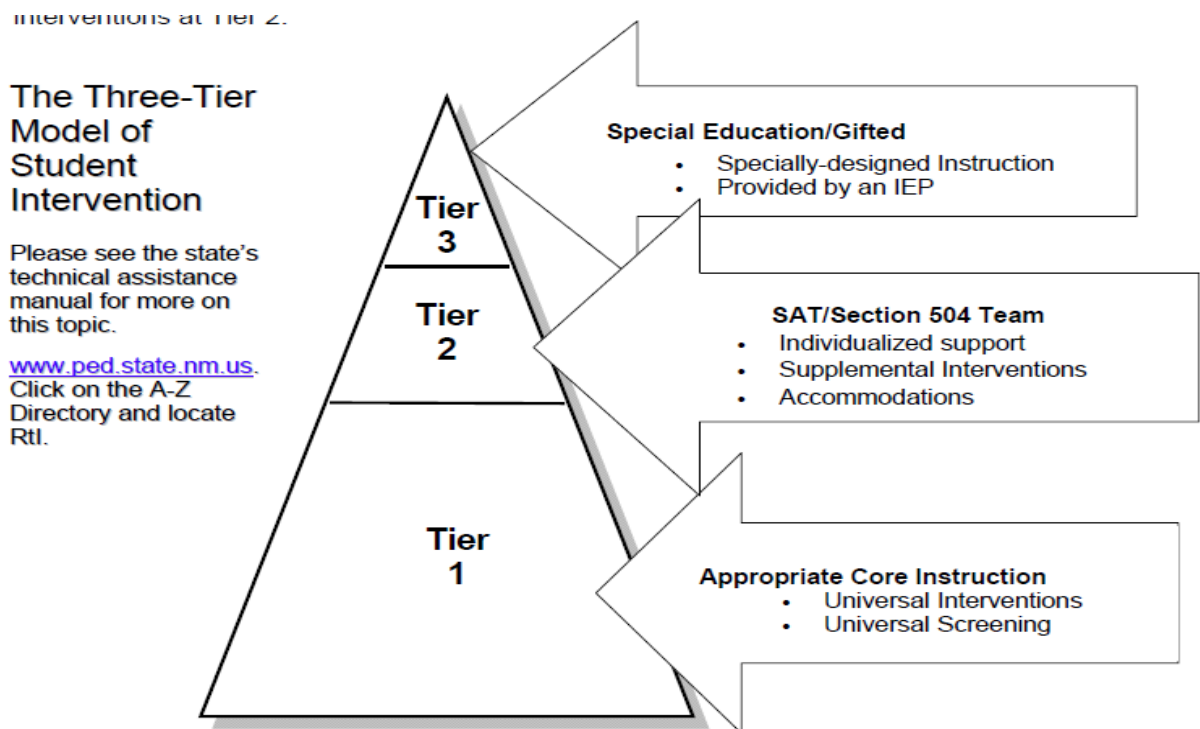
Under this federal law, the school is responsible for managing and funding this program/service. A student is eligible and entitled to a Section 504 Accommodation Plan if an evaluation shows that the individual has a mental or physical impairment that substantially limits one or more major life activities *and* substantially affects the student's overall performance in school.

All schools receiving federal funds and public agencies must comply with the following seven requirements:

1. Provide written assurances of nondiscrimination when applying for federal funds.
2. Take steps to eliminate discrimination against individuals with disabilities.
3. Appoint a 504/ADA Coordinator for local educational agencies with 15 or more employees to coordinate efforts to comply with this law.
4. Develop an ongoing process to locate and identify children who are not receiving services.
5. Provide public notice regarding nondiscrimination and responsibilities.
6. Develop a grievance procedure.
7. Conduct a self-evaluation of their programs and activities to ensure facilities are accessible and discriminatory practices are eliminated.

Three Required Elements of Section 504

1. The identification process for 504 is not the first step in determining the needs of students. The first step begins with the school's Student Assistance Team (SAT) process who determines if the student has a need that warrants evaluation. Nurses are encouraged to be part of the SAT process.
 2. The determination of impairment must limit a major life activity.
3. Limitation on the major overall life activity must be substantial, not mild or moderate



New Mexico Public Education Department: Section 504 Guide

The Three-Tier Model of Student Intervention pg. 10

[Guidelines for Educators and Administrators for Implementing Section 504 of the Rehabilitation Act of 1973-Subpart D](#)

Example of a 504 Plan for a student with Special Health Care Needs: ASTHMA

EXAMPLE: A student has been diagnosed as having asthma. The disability limits the major life activity of breathing.

Possible Accommodations

- Develop health care and emergency plan.
- Modify activity level for recess, physical education, etc.
- Use air purifier or inhalants.
- Provide inhalant therapy assistance.
- Administer medication as prescribed.
- Provide homebound instruction.
- Remove allergens—e.g., hairspray, lotions, perfumes, pine trees, carpet.
- Make field trips non-mandatory and supplement with videos, audios, movies, etc.
- Accommodate medical absence; arrange transportation to home/clinic.
- Provide education to peers/teachers/others (bus drivers, cooks, etc.).
- Provide access to water, gum, etc.
- Provide curriculum considerations (science class, physical education, etc.)
- Provide alternatives, if individual misses an excessive amount of school.
- Have peers available to carry materials to and from classes (e.g., lunch tray, books).
- Provide rest periods.
- Make school health care needs known to appropriate staff.
- Modify field trip experiences.
- Provide indoor space for before and after school.
- Arrange for access to wheelchair for transition purposes.
- Have a locker location that is centralized and free of atmosphere changes.
- Reimburse parent for transportation costs or provide alternate transportation to and from school.
- Modify attendance policies.
- Modify certain learning activities.

[Guidelines for Educators and Administrators for Implementing Section 504 of the Rehabilitation Act of 1973-Subpart D](#)

Health Records Retention

All student health records should be retained, regardless of media, for the period required by the agency's records retention program for any legal, user, historical or other purpose. Electronic files are subject to the same retention rules as hard-copy files. A new record

retention and disposition schedule was promulgated October 2015 which covers all public records.

Title 1 General Government Administration

Chapter 21 Functional Records Retention and Disposition Schedules (FRRDS)

Part 2 Retention and Disposition of Public Records

Subpart 181-189 [Student Records](#)

Confidentiality

"Confidentiality is an abstract concept that is inextricably intertwined with the individual's 'right to privacy' and with communication and record-keeping practices in health care settings and schools....With respect to minors in school settings, these challenges can be confounding" (Schwab & Gelman, 2001 p. 261) The issues for school nurses surrounding confidentiality include what constitutes student health information, who has a need to know, and why they need to know unless potential disclosure is discussed.

FERPA and HIPAA

The [Federal Educational Rights and Privacy Act](#) (FERPA) of 1974 established confidentiality standards and access rights to student records.

- Parents or eligible students have the right to inspect and review the student's education records
- Parents or eligible students have the right to request that a school correct records which they believe to be inaccurate or misleading.
- Generally, schools must have written permission from the parent or eligible student in order to release any information from a student's education record. However, FERPA allows schools to disclose those records, without consent, to the following parties or under the following conditions (34 CFR § 99.31):
 - School officials with legitimate educational interest;
 - Other schools to which a student is transferring;
 - Specified officials for audit or evaluation purposes;
 - Appropriate parties in connection with financial aid to a student;
 - Organizations conducting certain studies for or on behalf of the school;
 - Accrediting organizations;
 - To comply with a judicial order or lawfully issued subpoena;
 - Appropriate officials in cases of health and safety emergencies; and
 - State and local authorities, within a juvenile justice system, pursuant to specific State law.

Schools may disclose, without consent, "directory" information such as a student's name, address, telephone number, date and place of birth, honors and awards, and dates of attendance. However, schools must tell parents and eligible students about directory information and allow parents and eligible students a reasonable amount of time to request that the school not disclose directory information about them. Schools must notify parents and eligible students annually of their rights under FERPA. The actual means of notification (special letter, inclusion in a PTA bulletin, student handbook, or newspaper article) is left to the discretion of each school. (US Department of Education, 2015)

Congress enacted the Health Insurance Portability and Accountability Act (HIPAA) in 1996 to address the problem of health insurance confidentiality in the era of electronic information. Under HIPAA any identifiable personal health information is protected, and specific authorization is required for transfer of that information. However, in New Mexico school nurses have been granted [Public Health Authority](#) in the exchange of immunization information and, therefore, can obtain this information without parental authorization.

It is advisable that the school nurse obtain appropriate consent from parents before sharing protected health information outside of the school if there is any question regarding the need for consent. School nurses are encouraged to be knowledgeable of both HIPAA and FERPA regulations and be proactive in assisting school districts with establishing policy for sharing student medical information that is compliant with both. [Health Information Privacy](#)

Confidentiality in School Health Services

In the health care setting, there are situations when confidentiality might not be maintained. At any time if information a student has shared indicates the student is at imminent risk of endangering him/herself or others, that information must be shared with those who need to intervene to protect the student or others. Therefore, a statement from the school nurse in the nurse/student discussion should disclose to the student that any information will be kept confidential unless the nurse chooses to share it to protect the student or others from what she/he perceives to be harm.

In the school setting, the issue of “need to know” arises when other school personnel need to know confidential information to provide appropriate educational services beneficial to the student. However, care must be given as to how the information is shared and to what extent to maintain the student’s privacy.

Information provided teachers of students who may require accommodations or have the potential for life-threatening emergencies should be related to signs and symptoms, not necessarily a medical diagnosis. It is recommended that school nurses utilize nursing diagnoses when teaching staff about any student’s health problem. For example, two students might be labeled with asthma. While one of them rarely uses an inhaler, the other might be at high risk for respiratory distress and require frequent (on demand) inhaler use. It is more important to meet specific needs rather than treat the diagnosed condition generically. School staff members need to know how to recognize a health problem and what to do if that problem occurs.

School administrators should be given sufficient information about the health and safety needs of students to plan appropriate programs, ensure a safe environment, and provide adequate staff training. The school administrator should also be able to access emergency care plans for students in his/her buildings of responsibility.

Written Informed Consent

A parent/guardian of a minor may give written informed consent for personal health information to be shared with identified school personnel. The consent should specify what information will be shared and with whom. The expected outcomes and potential ramifications associated with written informed consent should also be discussed with the individual(s) giving consent. School districts may choose to define members of the health team and obtain a blanket written informed consent from the parent/guardian to allow disclosure of information on a "need to know" basis for these members. Many times, this blanket consent is on the ["Emergency Health Authorization Form"](#)

"If, for any reason, NEITHER I NOR THE ABOVE LISTED MEDICAL CARE PROVIDERS OR HOSPITAL CANNOT BE REACHED, I understand that appropriate transport and medical care of my child will be arranged to ANY appropriate medical care provider, hospital or medical facility. This authorization does not cover major surgery unless one other doctor/dentist concurs to the need. Nothing in this section shall be construed to impose liability on any school official or school employee, who in good faith, attempts to comply with this section. It is understood that I will be financially responsible for all emergency care. I authorize the school health office staff to contact my child's providers listed above regarding medical management of my child. I understand information on this card will be shared with appropriate personnel on an as-needed basis only. I, also, understand health screenings (including vision, hearing, height, weight, blood pressure, and BMI) may be done by school health personnel unless I provide the school health office with written notification requesting exclusion from these screenings."

Confidential Services for Minors

Sexually Transmitted Disease

§ 24-1-9 NMSA 1978 ... Sexually transmitted disease

Any person regardless of age has the capacity to consent to an examination and treatment by a licensed physician for any sexually transmitted disease. *Test results for sexually transmitted diseases may be released to the subject's legally authorized representative, guardian or legal custodian upon request (NMSA § 24-1-9.4), but it is not required.*

Pregnancy

§ 24-1-13.1 NMSA 1978 ... Pregnancy

A health care provider shall have the authority, within the limits of his license, to provide prenatal, delivery and postnatal care to a female minor. A minor is presumed to have the capacity to consent to prenatal, delivery and postnatal care by a licensed health care provider.

Contraception

§ 24-8-5 NMSA 1978 ... Contraception

Neither the state... nor any health facility furnishing family planning services shall subject any person to any standard or requirement as a prerequisite for receipt of any requested family planning service... [exceptions do not address age of client].

Emergency Conditions

§24-10-2 NMSA 1978 ... Emergency Conditions

... in cases of emergency in which a minor needs immediate hospitalization, medical attention or surgery and the parents of the minor cannot be located for consenting...after reasonable efforts have been made..., consent can be given by any person standing in locus parentis to the minor. But see also §24-7A-6.2 NMSA 1978 below

Homeless Youth

§24-7A-6.2 NMSA 1978 ... Consent for Certain Minors Fourteen Years or Older (homeless youth or parent of a child)

An unemancipated minor fourteen years of age or older has the right to consent to and receive medically necessary health care - clinical and rehabilitative, physical, mental, or behavioral health services that are essential to prevent, diagnose or treat medical conditions. The minor must be living apart from the minor's parents/ legal guardian, or the parent of child. The healthcare must be provided within professionally accepted standards of practice and national guidelines.

Mental Health

§32A-6A-14, 15 NMSA 1978 ... Mental Health (including substance abuse) [Rev. 2007] A child under the age of fourteen years may consent to initial assessment and early intervention services, limited to verbal therapy, not to exceed a two-week period. After the initial period, parental consent is required.

A child fourteen year of age or older has the right to consent to and receive individual psychotherapy, group psychotherapy, guidance counseling or other forms of verbal therapy and information regarding such counseling is confidential. A child fourteen year of age or older has the right to consent to psychotropic medication with notice to the parent/legal

guardian. A child fourteen year of age or older has the exclusive right to consent to disclosure of their mental health records. [Minors' Consent for Services NM](#)

Documentation

“Documentation is critical to the development and maintenance of school health service programs. It is essential to the practice of nursing and a fundamental component of the nursing process...Among other things documentation...:” (Schwab & Gelman 2005, p. 157).

- Validates the Nursing process was used;
- Provides a basis for evaluation;
- Demonstrates the Standard of care was followed;
- Facilitates communication with other nurses, providers, and school staff, and
- Provides data which generates funding initiatives (Schwab & Gelman ,2005).

Student Health Record

In general, each student health record should contain the following pieces of documentation and information.

- Health history
- Health screening results---hearing/vision/immunizations
- Chronic conditions/diagnoses/problem list
- Emergency information/contact/health care provider list
- Progress notes
- Appropriate Individual Health Plan/Individual Emergency Management Plan (IHP/EMP)

Health Room Visit Documentation

A description of each health room visit should be reflected in the student health record. The following inclusions in the documentation will help guide the school nurse toward completion of an adequate report of the visit.

- Document frequency and length of visits.
- Document re-assessment each time it occurs. With recurrent visits, document symptoms to demonstrate a pattern. Document gut-level feelings.
- Use the concept of "FACT" when documenting.

Factual

Accurate

Complete and comprehensive

Timely

- Complete documentation on the day of occurrence.
- Do not provide care or discontinue assessment if, in one’s professional opinion, needed medical information is lacking to arrive at a diagnosis.
- Show that a health history was taken before care was provided.
- Assure that the plan of care reflects appropriate health history and health screen(s).
- Document the method used to notify parent/guardian of the student’s health office visit e.g., by phone (emergency or need to pick up) or in writing (routine visit).
- Document what information is sent home with the student for exchange with the parent/guardian; however, the school is not responsible for assuring that information exchange occurs between the student and parent/guardian as requested.
- Failure to document delivery of nursing services violates the nurse practice act.

Consistency in Documentation

The health record is an information management document for the student throughout his/her school career. Consistency is the key to organization, continuity and accuracy. Likewise, all forms and documentation should have a signature and/or initials of the care giver and the name of the student. Any medication log sheets should contain a space for physician order, date, prescription changes as well as a comment section. The same health record forms should be used in the same manner for the same purpose in all schools within a school district.

Sign-in/Documentation Logs

Unless maintained without known patient identifiers, sign-in logs and patient activity logs may infringe upon patient confidentiality rights. Computerized logs may be acceptable if access is limited to identified individuals with a need to know.

Documentation Tools (See Resources at the end of the Chapter)

- Health Records
- Sick Child Memo – English
- Sick Child Memo – Spanish
- Injured Child Memo – English
- Injured Child Memo – Spanish
- Vision Screening
- Hearing Screening

Adverse Event Reporting

In New Mexico, the Department of Health (DOH) Regional Health Officers (RHO) are charged by state statute with oversight responsibilities of all school nurses. During the Legislative session of 2017 the Public Health Act was amended to read.

Public Health Medical Oversight

New Mexico school nurses are licensed by NMPED; however, it is the Department of Health (DOH) that provides medical oversight of all school nurses. New Mexico State Statute 24-1-4(B) of the [Public Health Act](#) states “a regional health officer shall provide medical oversight to school nurses in the regional health officer’s region. A school nurse shall make reports relating to public health as the regional health officer in the school nurse’s region requires.” Regional School Health Advocates assist the regional health officers and the school districts in their regions in compliance with this statute.

Protocol for Reporting an Adverse Event

Should a school nurse have knowledge of any of the below listed adverse events occurring in the school/school district in which he/she provides services, that nurse or the school nurse

leader/supervisor of the school district is required to report the event(s) to the local RHO through School Health Advocate (SHA) by phone, fax, or email. An Adverse Event Report should be completed as soon as possible following that notification phone call to alert the SHA of the outstanding report. If there is a question regarding whether a situation should be reported the nurse should contact the Regional SHA.

Adverse Events Reporting Form

In these instances, an Adverse Event Form should be initiated...

1. Any death of a student or staff member that occurs during school hours or on school grounds.
2. Any known suicide attempt (including completed or suspected) of a student, including those occurring after hours or during school vacation.
3. Any delivery of an infant on school grounds.
4. Any medication error as the result of a school nurse or other school staff action that requires an ambulance to be called or requires the student to be transported to an emergency room or urgent care facility.
5. Any error involving vaccine administration
6. Any untoward event with the potential of impacting physical or mental health of the school community.
7. Administration of emergency medication resulting in activation of EMS:
 ___prescribed or ___stock Specify medication:

The Adverse Events Form is now a fillable PDF form. It should be filled out electronically, saved to the school computer with the school name and date of the occurrence, then emailed to the Regional SHA. If the school response is not known at the time a follow-up amendment can be made to the original form. This information is collected and provides for data for follow-up action such as training.

Notification Timeframe

Reporting of adverse events should occur within:

1. 24 hours in the event of (1) or (2) above and
2. 72 hours of the occurrence in the event of (3) (4) (5) (6) or (7). If the required Reporting information is inconclusive within this timeframe, the event should still be reported with additional information to follow later.

References and Resources

[Adverse Event Reporting](#)

[Advocacy: The Case for School Nursing](#)

[Emergency Health Authorization Form](#)

FERPA, Family Policy Compliance Office, U.S. Department of Education

400 Maryland Avenue, SW, Washington, D.C. 20202-8520 www.ed.gov/offices/OM/fpco,
<http://www.ed.gov/policy/gen/guid/fpco/ferpa/safeschools/index.html>

[New Mexico Administrative Code, New Rule Process.](#)

[New Mexico Rulemaking Process Overview](#)

[New Mexico Administrative Code, Title 1.21.2. \(181-189\), General Government](#)

[Administration. Functional Records Retention and Disposition Schedules \(FRRDS\), Retention and Disposition of Public Records, Student Records](#)

[New Mexico Administrative Code, Title 6.10.8, Primary and Secondary Education Primary and](#)

[Secondary Education, Public School Administration – Procedural](#)

[Requirements, Compulsory School Attendance](#)

[New Mexico Administrative Code, Title 6.12.2., Primary and Secondary Education.](#)

[Health Services– Immunizations of School Children](#)

[Student’s Rights to Self-Administer Certain Medications](#)

[New Mexico Administrative Code, Title 6.12.4, Primary and Secondary Education, Public](#)

[School Administration – Health and Safety,](#)

[Tobacco Free School Districts](#)

New Mexico Administrative Code, Title 6.29.1, Primary and Secondary Education, Standards for Excellence, General Provisions, [School Health](#)

[New Mexico Administrative Code, Title 6.29.6, Primary and Secondary Education-Standards for Excellence, Health Education](#)

[New Mexico Administrative Code, Title 6.31.2, Primary and Secondary Education, Special Education, Children with Disabilities/Gifted Children](#)

[New Mexico Administrative Code, Title 6.6.63, Primary and Secondary Education, School Personnel-Licensure Requirements for Ancillary and Support Personnel- Licensure for School Nurses, Grades Pre-K-12](#)

[New Mexico Administrative Code, Title 6.63.15, Primary and Secondary Education, School Personnel – Licensure Requirements for Ancillary and Support Personnel Licensure for School Health Assistants, Grades Pre-K - 12](#)

[New Mexico Administrative Code, Title 6.63.16, Primary and Secondary Education, School Personnel – Licensure Requirements for Ancillary and Support Personnel Licensure for School Licensed Practical Nurses,](#)

[Grades Pre-K-12](#)

[New Mexico Administrative Code, Title 16.12.2, Occupational and Professional Licensing, Nursing and health Care Related Providers. Nurse Licensure](#)

New Mexico Administrative Code, Title 7.5.3., Health, Vaccinations, and Immunizations. [Exemption for school, childcare, and pre-school immunization](#)

New Mexico Administrative Code, Title 7.5.2., Health, Vaccinations, and Immunizations.

[Immunization Requirements](#)

New Mexico Administrative Code, Title 7.30.10, Health, Family and Children Health Care Services, [Award of Funds from Save Our Children's Sight Fund](#)

New Mexico Administrative Code, Title 7.30.11, Health, Family and Children Health Care Services, [Vision Screening Test Standards for Students](#)

[New Mexico State University, E-Learning, Recognizing & Reporting Child Abuse & Neglect](#)

[Minors' Consent for Services NM](#)

[2016 Public Health and School Nurse](#)

[Public Health Authority Letter](#)

[2017 School Nurses in the Nations](#)

Schwab, Nadine C. and Gelfman, Mary H. B. (2005) *Legal Issues in School Health Services*. North Branch, MN: Sunrise River Press, pp. 156-163.

Schwab, N., Panettieri, M.J., & Bergren, M. (1998). *Guidelines for school nursing documentation: Standards, issues, and models* (2nd ed.). Scarborough, ME: National Association of School Nurses.

[2016 Social Determinants](#)

Statutes, New Mexico, Child Abuse and Neglect, [NM State § 32A-4-3 \(2016\)](#)

[Statutes, New Mexico, Minors' Consent for Health Services in NM, §24-1-9, §24-1-13.1, §24-8-5, §24-10-2, §24-7A-6.2, §32A-6A-14,15, Minors' Consent for Services NM](#), New Mexico Public Access Law .

Statutes, New Mexico, [Public Health Act](#), §24-1-4 (pgs. 15-16)

Statutes, New Mexico, School Personnel §Chapter 22-10A-5, Public Schools,
[School Personnel Act](#)

US Office for Civil Rights, Health Information Privacy, www.hhs.gov/ocr/hipaa

[White Paper Absenteeism](#)

[Whole School, Whole Community, Whole Child Implications for 21st Century School Nurses](#)

CHAPTER THREE – SCREENING ASSESSMENT AND SPECIAL EDUCATION

Introduction

One of the important functions of a school health program is to promote student health through early identification and detection of health problems that may result in disability and/or interfere with learning. When performed in a context of individual health assessments and continuing care, carefully planned and implemented screening programs are appropriate components of the school health program. Screening results help complete the total health assessment of the individual student. When developing and implementing screening programs refer to the below recommendations:

- Determine cost to benefit ratio by determining if the disease/condition is significant enough to justify the cost and or the time spent in the mass screening effort.
- Evaluate whether the disease/condition has a significant effect of the quality of life and or learning process.
- Develop systems for the early identification and intervention prior to the onset of symptoms to promote beneficial outcomes for the student population.
- All methods of treatment to be used are to be assessable and available.

Teacher Observation -Component of Screening and Assessment

Teachers play an important role in noticing changes in appearance and behavior that may be related to a student's health status. Their day-to-day contact with their students gives them an opportunity to detect differences in the health of individual students which might go unnoticed by others, even the student's family members. As a guide to the teacher and other school personnel, the following conditions may indicate a need for referral to the school nurse:

- Frequent absences
- Persistent fatigue
- Attention deficits observed in the classroom
- Fidgeting (noted as new behavior)
- Skin eruptions or rash
- Frequent nosebleeds
- Deficiency in motor skills
- Emotional disturbances
- Obvious abnormal weight or height changes
- Shortness of breath

Standards for Vision Screening in New Mexico Schools

NM School Vision Screening Program

Legislation was passed in New Mexico in 2007 requiring all public schools to have a vision screening program and created the Save Our Children's Sight Fund to help with students that

meet program criteria and do not have insurance to obtain comprehensive eye examinations, lenses and frames for eye glasses. The Save Our Children Sight Fund contributions are furnished by New Mexico automobile owners who have the option to donate either \$1.00 or \$5.00 to the Save Our Children's Sight Fund at the time of vehicle registration. This fund is managed by the NM DOH Office of School and Adolescent Health (NM DOH OSAH) and the current contractor of this fund is New Mexico Lions Operation KidSight, Inc., NM Lions Club (NMLOK NM)

The target population for mass vision screening is defined in Section 22-13-30 NMSA and NMAC 7.30.11 [Vision Screening Test Standards for Students](#) requires public district and public charter schools to conduct vision screening for the following:

- Pre-Kindergarten students
- Kindergarten students
- First grade students
- Third grade students
- Transfer student in the above grades without a current school year vision screening

Parents may decline any visual screening; therefore, public schools are to provide advance notification of mass vision screening. The declaration of a mass vision screening program has been included in the NM [Emergency Health Authorization Form](#) in which all public NM schools are encouraged to use the current year's form.

Acceptable vision screeners for a mass vision screening program are school nurses or the school nurse's designee, a primary care health provider or a lay eye screener per NMAC 7.30.11 [Vision Screening Test Standards for Students](#).

Standards for Vision Screening at School

The Standards for Vision Screening in New Mexico School were developed to standardize and provide direction for vision screening in NM public schools. New Mexico Vision Advisory Committee appointed by the New Mexico Secretary of Health wrote an advisory document for schools. The [School Vision Screening Advisory Report](#) addresses target population for mass vision screening, parental notification, vision screeners. The NM standards for vision screening allow three vision screening methods to be used by New Mexico public schools. These three screening methods are:

- Traditional screening which is for most school students with the eye chart method
- Photoscreening using a machine with an automated technique that uses red reflex of the eye to screen for eye problems. Photoscreening is for students in pre-kindergarten, kindergarten, and first grade.
- Alternative screening used for students who cannot adhere to instructions for traditional or photoscreening methods.

The NMDOH Office of School and Adolescent Health recommends a school nurse oversee the general vision program to ensure appropriate training of all vision screeners,

assessment of needs, referral, and follow up and to follow the following best practice recommendations below:

- School nurse to oversee general vision program to include all vision screeners are appropriately trained and for the school to supervise all vision screeners
- All non-school nurse vision screeners to conduct only the first screening and all re-screening performed be conducted by the school nurse
- For schools without a school nurse the vision screener is to provide one vision screening and for any failed vision screening to document and notify the student's parent/guardian of the failed vision screening.
- For schools with a school nurse, the school nurse to provide assessment and re-screen student within 2 weeks from the first vision screening date before parent notification is made, if appropriate. This is to reduce the incidence of unnecessary referral to eye providers that saves family time and money.
- School nurse to make referral to appropriate eye care provider for a comprehensive eye examination.
- School nurse to provide appropriate follow up and case management for students referred for eye examinations.

General Vision Screening Program

A general vision screening program is a process that allows the vision screener to screen large numbers of students in a short period of time using a traditional vision screening method. The general vision screening program is to be defined in school policy and procedure which is to address which staff member oversees the school general vision program, designated vision screeners, vision screening training, and vision screening process which meet minimum standards defined in NMAC 7.30.11 [Vision Screening Test Standards for Students](#).

All students are to undergo a prescreening observation before undergoing vision screening and use the following referral criteria for the clinical observation. All educational staff are to be trained to be familiar with these pre-screening guidelines and the schools process for vision screening request:

Pre-Screening Observation All grades	
Clinical Observation	Referral Criteria
Eye Appearance	Refer for any of the following: <ul style="list-style-type: none"> • Cloudy or milky appearance • Keyhole pupil • Sustained eye turn inward or outward • Droopy eyelids • Absence of eyes moving together • Abnormal pupil constriction or dilation • Difference in size, shape, etc. of eyes

	<ul style="list-style-type: none"> • Excessive tearing • Jerky eye movements (nystagmus)
Visual Behaviors	<p>Refer for any of the following:</p> <ul style="list-style-type: none"> • Inconsistent visual behavior • Visually inattentive or uninterested • Difficulty sustaining eye contact • Holds objects close to face • Bending close to view objects • Tilts head • Stares at lights and ceiling fans • High sensitivity to room light or sunlight • Appears to look beside, under or above an object • Bumping into things • Tripping over objects

Traditional Vision Screening

Traditional vision screening is one of three screening methods (see charts below) considered appropriate for vision screening in New Mexico schools.

Traditional Vision Screening Method Ages 3 years and older		
Required Test	Results/Referral Criteria	Suggested Testing Tools
Distance Visual Acuity	3 through 5 years of age:	Snellen Letter Charts
	<ul style="list-style-type: none"> • Passing test line is 20/40. • Refer if either eye tests 20/50 or above. • Refer if more than 1 test line difference between the eyes. 	
	6 years and older:	HOTV- linear or Crowding bar
	<ul style="list-style-type: none"> • Passing test line is 20/30. • Refer if either eye tests 20/40 or above. 	Lea Symbol Chart linear or crowding bar

	<ul style="list-style-type: none"> Refer if more than 1 test line difference between the eyes. 	
<p>Ocular Alignment</p> <p>These tests required only once in any of the target population grades.</p>	<p>Passing is identification of test object</p> <p>Refer for failure to identify test object</p>	<p>Random Dot E (preferred)</p> <p>Stereo Fly or Butterfly</p> <p>Randot Preschool Stereoacuity</p>
<p>Color Vision</p> <p>These tests required only once in any of the target population grades.</p>	<p>Notify parent/guardian with failure to pass any standard color vision test. Consider referral to eye care provider for anticipatory guidance.</p>	<p>Standard Color Vision Chart</p>

Photoscreening Vision Screening

Vision screening using the Photoscreening method is endorsed by the NM DOH. The screening is done using a machine with an automated technique that uses red reflex of the eye to screen for eye problems

Photoscreening Method		
Pre-kindergarten, Kindergarten, First Grade		
Required Test	Results/Referral Criteria	Currently Approved Photoscreeners
Photoscreen	For passing criteria refer to recommendations of the American Association for vision screen committee Pediatric Ophthalmology and Strabismus (AAPOS)	<p>Welch Allyn Suresight</p> <p>iScreen</p> <p>PlusOptix</p> <p>The Photoscreener</p>

	Alternatively, may refer to the manufacturer's manual for the specific photoscreener used.	
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Alternative Vision Screening Method

An alternative vision screening method is a process whereby specific student are referred by teachers, Student Assistance Teams, Special Education staff, Child Find specialist, parents or others for screening as part of an extended evaluation. These may be symptomatic students or students who are being evaluated for Special Education in which a vision screening to include a near vision acuity evaluation is required for any student who is referred for special education services.

Alternative Vision Screening Method† Ages 3 years and older		
Required Test	Results/Referral Criteria	Suggested Testing Tools
Visual Acuity	For passing/referral criteria refer to the manufacturer's criteria for the testing tool.	Bailey Hall Cereal Test Colenbrander Lea Symbols Low Vision Chart Teller Acuity Cards McDowell Kit
Ocular Alignment This method of testing to be performed by school nurses, teachers of visually impaired or other professionals with training in alternative vision screening. This test required only once in any of the target population grades.	Passing is equal corneal light reflex in each eye.	Hirschberg Test

Vision Screening Procedures for Distance Visual Acuity

- Screen in a quiet, well-lighted area free of glare and distractions.

- Distance visual acuity wall charts to be measured 10 or 20 feet as specified by chart instruction from the student
- The wall chart is to be at eye level of the student being screened and on a wall free of other visual stimuli.
- Identify students to be screened and provide any classroom pre-screening education that is needed.
- Students who wear glasses should wear glasses for general screening.
- Students being tested in individual screening should be tested with and without glasses.
- Instruct student to place heels marker or be seated with the back of the chair directly over the marker.
- Instruct student to keep both eyes open when being tested.
- Instruct student to cover left eye with occluder first to help screener remember sequence.
- Begin with the line which is normal vision for the student being screened.
- Point to symbol and ask student to identify symbol indicated.
- Move up or down on chart as necessary until student can identify majority (one more than half) of symbols on any horizontal line
- Repeat Steps 5-7 with right eye occluded.
- Record findings in student medical record

Results/Referral Criteria

Students with results of more than one-line difference between eyes should be referred to an eye care specialist. Those with normal acuity in one eye and abnormal vision in the other eye are to be referred. Follow-up on referrals is the responsibility of the school nurse

Recording Results

Visual acuity is usually expressed in terms of a 20-foot testing distance. Charts or cards that are designed for use at 10 feet or other testing distance have been adapted to be equivalent to the 20-foot testing distance. Visual acuity is recorded as a fraction (20/20). The top number (numerator) represents the 20-foot distance measured from the chart to the floor marker. The bottom number (denominator) represents the line on the chart the student can see. A result of 20/20 means that a student can see at 20 feet what should normally be seen at 20 feet. When visual acuity is abnormal, the bottom number will be higher, i.e. 20/50. Results are recorded for each eye separately. Always record data for right eye first. Record date of the screening test.

Process for Ocular Alignment Screening

This test is required only once in any of the target population grades to be determined by school and outlined in policy

- Identify a quiet, well-lighted area free of glare and distractions.
- Follow manufactures directions per ocular alignment screening tool being used

Results/Referral Criteria

Any student who fails to identify the test tool object should be referred for a comprehensive

eye examination.

Reporting Results

Results are recorded as pass or fail.

Color vision screening process:

This test is required only once in any of the target population grades to be determined by school and outlined in policy. Utilize the manufacturer's instructions for the selected testing tool for the correct use of the tool and screener procedures and to be screened with both eyes open

- Identify a quiet, well-lighted area free of glare and distractions
- Identify students to be screened and provide classroom pre-screening education as needed.

Results/Referral Criteria

Criteria for passing the screening will be dependent on the testing tool used. Parents should be notified if the student fails to pass color vision screening. In consultation with the parent, referral to an eye care provider might be considered for anticipatory guidance and development of coping strategies for this abnormality.

Reporting Results

Results are recorded as positive or negative for color vision.

Near Vision Acuity Screening Process

Near vision screening is only recommended for a Student Assessment Team (SAT) meeting or Special Education referral or re-evaluation.

- Identify a quiet, well-lighted area free of glare and distractions.
- Identify students to be screened and provide classroom pre-screening education as needed.
- Students who wear glasses to be screened with and without glasses.
- Display screening cards at 14 inches (or recommended distance indicated for testing cards) from student's eyes.
- Place card on table top or hold at test distance.
- Instruct student to identify symbol(s) to which the screener point and begin with symbol line which is normal acuity for age of student being screened.
- Screen with both eyes open.

Results/Referral Criteria

Refer to testing device criteria information. Near vision acuity testing is done with both eyes open. Students must identify 80% of letters/symbols on the critical line of 20/30.

Near vision tests are not completely accurate for use in testing children under age 10

because of the accommodative power of the eye in this age group. Near vision cards may identify students with astigmatism because symbols will be blurred.

Recording Results

Results for near vision are recorded as pass/fail in reading the critical line of 20/30 binocular visual acuity or written as 20/____.

Vision Related [Definitions](#)

O.D.

Right eye, oculus dexter

O.S.

Left eye, oculus sinister

O.U.

Each eye, oculus untrique or both eyes - oculi unitas

Blind

Unable to see; without useful sight.

Legally Blind

Usually acuity of 20/200 or worse with best possible correction. Federal guidelines indicating eligibility for services available for persons with severe, non-correctable vision defects and visual acuity.

Cortically Blind

In a Cortically blind neurologically-based vision defect the visual system is intact but the individual has sustained brain damage that prevents the brain from properly processing and interpreting the visual image and information taken in by the eye. The individual may have some useable or functional vision, including light perception and blink reflex.

Amblyopia or Lazy Eye Amblyopia

Stereopsis testing and distance vision tests identify amblyopia. It is a condition that if not discovered and treated before the age of six or seven usually leads to permanent reduction of vision in the affected eye. An eye with amblyopia has dimness of vision without any apparent disease of the eye. It is often caused when one eye turns in or out while the other sees straight (strabismus) so that a double image is sent to the brain. It may also be associated with a marked difference in the refractive error of each eye (anisometropia) resulting in two images. The brain solves this confusion by ignoring the message from one eye that gradually weakens through disuse. The usual treatment is patching the good eye in order to force the use of the weaker one. Sometimes this is combined with glasses, surgery (for strabismus), medication, or eye exercises.

Anisometropia

Unequal refraction of the two eyes. Anisometropia eyes may have myopia or hyperopia but of different degrees, or one may be myopic and the other hyperopic. Marked anisometropia is a common cause of amblyopia because the eye with the greater refractive error is ignored

Astigmatism

is an eye refractive error problem resulting in blurred vision because of the irregular or defective curvature of the cornea or the lens causing a distorted image because light rays cannot focus on a single point of the retina. If the astigmatic person looks at a figure consisting of straight lines radiating out from a center, the lines pointing in only one direction may be seen clearly while the lines radiating out in another direction are blurred. Astigmatism affects the vision at all distances. It may be associated with myopia or hyperopia. Most cases of astigmatism can be corrected with glasses or contact lenses.

Color Deficiency

Inherited vision defect. Color deficiency is not a disease; it is characterized by the inability to recognize certain colors—primarily red or green, but rarely blue or yellow. Deficiency in this visual function is not correctable. It is important for students, parents, and teachers to be aware of this condition to help the student develop appropriate coping mechanisms. An estimated 5% of the population has defective color vision; 8% males and 0.5% of the females.

Hyperopia

Farsightedness identified by near vision tests, hyperopia is a refractive error in which the light rays focus behind the retina, either because the eyeball is too short or the lens is too thin and flat and does not bend the light rays enough. The result is that students who are farsighted see better at a distance than close-up. This condition can be corrected with glasses or contact lenses.

Myopia

Nearsightedness Identified by distance vision tests, myopia is a refractive error in which the light rays are bent and focused in the front of the retina, either because the eyeball is too long or because the lens is too thick and curved so that it bends the rays too much. As a result, students who are nearsighted see better close-up than at distances. Myopia is usually first seen in children 6-8 years of age. It can be corrected with glasses or contact lenses.

Strabismus

Squinting Identified by ocular alignment and stereopsis testing, strabismus is the term used to describe eyes that are not straight or properly aligned due to a muscle imbalance. One eye, or sometimes both, may turn in or turn out. The various forms of strabismus are spoken of as tropias. Their direction is indicated by the appropriate prefix cyclotropia, desotropia, exotropia, hypertropia, hypotropia. Sometimes more than one of these conditions is present. The deviation may be constant or it may come and go. It may be present at birth or it may become apparent at a later age spontaneously. It might occur after an illness or accident. Strabismus may be due to birth injuries, heredity, faulty muscle attachments, excessive farsightedness, and illness with fever. It cannot be outgrown nor will it improve by itself. An eye deviation that persists without treatment may result in permanent visual impairment because the vision in one eye is suppressed causing amblyopia. Treatment directed toward straightening the eyes can involve glasses, patches, eye drops, surgery, eye exercise.

Hearing Screening

The purpose of a general hearing screening program is to identify students who have hearing impairments that interfere with or have the potential for interfering with communication and learning processes. Authorities generally agree that early detection of medically remediable hearing loss helps to prevent related problems in speech, social and educational development.

There are no mandatory hearing screening requirements under the NM Administrative Code like vision screening. It is recommended by the NM DOH OSAH that schools provide general and individual hearing screenings based upon the following:

- School to define hearing screening program in policy and procedure defining hearing program manager or coordinator, hearing screeners, hearing screeners' training.
- Utilize American Speech, Language and Hearing Association Guidelines for Manual Pure-Tone Threshold Audiometry and the National Association's recommendations and hearing screening standards.
- School nurse to provide oversight of hearing screening and follow-up in the schools
- The identification of hearing problems is accomplished by using individual pure-tone air conduction testing.
- Acoustic immittance screening might also be considered if trained staff are available.

A well-balanced program will include screening and rescreening threshold audiometry as well as referrals for audiological or medical evaluations. Students identified with hearing abnormalities should be followed on a regular basis to ensure that their communication, educational and medical needs are met. Education and habilitation planning and counseling for parents and teachers should be implemented. The target population for hearing screening is a recommendation and not a mandate. The following target population is recommended for pure tone hearing screening:

- Pre-school
- Kindergarten
- First
- Third
- Eighth
- High risk students
- New students with no documented evidence of prior hearing screening at the designated grade levels
- All students being referred for special education evaluation

Pure Tone Conduction

[A pure tone audiometer](#), calibrated to published audiometric standards is required for reliable pure tone conduction testing. Audiometers are delicate electronic devices and can easily be damaged. The audiometer needs routine maintenance and accuracy checks by qualified technicians. All audiometers should be electro acoustically checked and serviced (returned to the factory if necessary) at least once a year and more often if a malfunction is suspected. Pure tones are described in terms of pitch or frequency.

- Hertz (Hz) equals units that define frequency.
- Loudness is measured in decibels (db.).

Screening Method

The Sweep Test is the preferred pure tone conduction hearing screening. It is a screening measure whereby preselected frequencies are presented at predetermined levels, and the student is asked to give a response each time the tone is heard. The series of frequencies are presented first in the right ear and then in the left. Each student is tested individually. Time intervals between the presentation of each tone must vary for the screening results to be reliable.

The audiometric equipment should be checked before testing to verify that it is working properly. The test environment should be as quiet as possible.

The recommended frequencies for sweep testing include 1000, 2000 and 4000 Hz presented at 20 db., using the following steps as procedural guidelines.

- Set (intensity) hearing level dial at 20 db.
- Set audiometer on "reverse" or "tone off" so that the sound goes through the earphone only when the tester pushes the "tone switch"
- Student should be positioned so that the tester's hand and eye movements cannot be observed
- Instruct student to raise hand when tone is heard; lower hand when tone disappears.
- Keep instructions simple. The student unable to raise a hand can respond by dropping a small object, such as a block, into a container. An oral response, "yes", is also acceptable.
- Earphones should be placed on the student by the tester to assure proper fitting so that the earphone is centered over the ear canal. Care should be taken to prevent obstructing the ear canal or folding the ear.
- Provide a sample tone of loud intensity, such as 200 Hz at 40 db. **to ensure that student understands what is meant by the word "tone".**
- Provide student opportunity to ask questions.

The suggested order of presenting tones is: 1000, 2000 and 4000 Hz.

The student fails the sweep test if one of the tested frequencies cannot be heard in one ear at the recommended decibel level. At this point an otoscope exam should be performed. Signs of abnormalities, such as otitis media, tympanic perforation or cerumen impaction, warrant a medical referral. However, the student without any abnormalities on otoscope

exam should be scheduled for a repeat test at a later time; allow three weeks between screening tests. A second failure at pure tone conduction hearing screening warrants a medical referral.

Immittance Screening

[Impedance audiometry](#) (tympanometry and acoustic immittance) provides information about the middle ear. It is a valuable diagnostic tool but not usually included in hearing screening. This measure is optional in school screening programs, but should not be substituted for the pure tone audiometric testing. It may be used for the very young and difficult to screen students.

Rescreening and Referral Criteria

Audiometry screening results should be properly documented as pass/fail for each ear separately. Observational factors such as frequent earaches, draining ears, excessive cerumen, mouth breathing and decreased responsiveness in the classroom should all be considered when making a medical referral. The referral process should be initiated ideally by the school nurse and a referral form to be sent home to the parents. The referral form is to have any observations of school personnel in addition to screening results.

The form should be accompanied by at least one audiogram showing abnormality, along with observations, history and explanation for referral. Any referral should be accompanied with a request that the school nurse receive a follow-up report. The school nurse should plan anticipatory guidance efforts with parents and school staff that might be appropriate.

Audiological Assessment

The evaluation report on a student who has been referred by the school nurse and tested by the audiologist will contain valuable information about the individual's ability to hear speech. Under controlled conditions, the student is tested on the ability to hear spoken words that are repeated to the audiologist.

Signs and Symptoms of Hearing Problems

The classroom teacher plays an important role in recognizing and reporting students who show symptoms of possible hearing loss. The student who presents the following may have trouble in hearing and should be referred to the school nurse for further evaluation.

- Draining ears
- Ears filled dried wax or crust from draining ears
- Inflammation in or around the ear
- Mouth breathing
- Upper respiratory allergies
- Cleft palate
- Chronic colds
- Chronic ear infections
- Mastoiditis and meningitis
- Neonatal history (low birth weight, prematurity, perinatal infections)
- Pain in or around ear

- Ears “stopped up”
- Ringing or buzzing in ears
- Asks speaker to repeat
- Turns head to side when listening
- Leans forward when listening
- Stares intently at speaker
- Appears confused or bewildered when listening to speaker
- Hears better when directly in front of speaker
- Interrupts conversation (not aware that others are talking)
- Has trouble with oral directions
- Performs better on written work than oral work
- Has poor diction and/or articulation
- Withdraws from group activities when hearing is required
- Doesn't pay attention - Some students may develop a habit of inattention even when hearing is normal; however, presence of inattention should not be dismissed, and the student should be given a hearing test.

Classroom Considerations for the Hearing-Impaired Student

It is essential that the teacher understand a student's hearing problem and important to establish a feeling of acceptance for the hearing-impaired student. It is also important that the teacher be alert for signs of improvement or deterioration in hearing and be willing to discuss these observations with the school nurse and/or parents.

Significance of Hearing Loss

The degree of difficulty the student experiences will depend upon the amount and type of hearing loss. Students who have trouble hearing speech sounds may be unable to follow directions. It is likely that they will make mistakes in spelling and will have difficulty producing some of the speech sounds correctly. Students with severe hearing loss often have trouble listening. If the student has a hearing loss in only high tones, some of the sounds may be heard well and others poorly. Often high tone loss results in failure to hear the following speech sounds: Sh, Ch, Th, S, F, V and J.

Unilateral Hearing Loss

Hearing loss in one ear will create difficulty locating the direction from which the sound originated, particularly when there is loud background noise. Classroom noise may keep the student from hearing directions correctly. It is also important that the student with unilateral hearing loss be reminded to take care when walking or playing in traffic areas or on the playground.

Hearing Aid Users

Hearing aid wearers may be distracted by environmental noise creating difficulty in following conversations in a group. In a classroom with a student wearing a hearing aid the teacher should understand the mechanics of the hearing device to ensure it is being effectively utilized and assist in trouble shooting with any problems.

Seating Considerations

For bilateral hearing loss, seat the student directly in front of the teacher and for unilateral hearing loss, seat the student close to the instructor with the normal ear toward the source of instruction. Affected ear should be away from the instructor.

Speaker Awareness

It is important to patiently restate and rephrase when the student does not understand and do not stand in a glare, such as a window. Face the student when speaking and when using a writing board, face the class when providing explanations. Speak slowly and distinctly, speaking naturally and do not exaggerate lip movements. Speaking too loudly may be especially disturbing to the hearing aid wearer. Use FM voice projection equipment if available and lapel microphones as appropriate if available.

Tips on Giving Directions

Acquaint the student with any new vocabulary when a new topic is introduced and get the student's attention before giving directions. Ensure that the student understands the directions and encourage the student to request that directions be repeated if necessary. Provide opportunity for student to repeat directions. Use written directions if student has continued difficulty understanding.

Special Considerations

Fatigue may be a factor because hearing impairment requires extra concentration to receive information. Language development may be challenging because many words and ideas have no meaning if the student is unable to hear the words. Encouraging the hearing impaired to do extra reading, spelling, creative writing, etc. may help compensate, but it is not uncommon for these students to exhibit delays in language development.

Height/Weight/BMI Screening

The New Mexico Administrative Code does not require New Mexico schools to do weight/weight/BMI screening of students. The NM DOH Medical Oversight Committee [position statement](#) does not endorse school personnel to engage in mass screening of students for height/weight/BMI measurements. Screening requires medical follow-up and nutritional referrals.

The NM DOH conducts height/weight/BMI surveillance programming with schools under specialized programming to understand and develop interventions related to childhood obesity. These surveillance programs assess the weight status of a specific population (e.g., students in an individual school, school district,) to identify the percentage of students potentially at risk for weight-related health problems. Data collected from surveillance are typically anonymous and may be used to identify population trends as well as monitor outcomes of interventions to help them take appropriate action. School-based BMI screening programs, like height-weight screening programs, have not been proven to be effective nor have they been proven to be cost-effective.

Scoliosis Screening

Because of literature review on recommendations for scoliosis screening and assessing priorities for the evolving role of school nurses, the following recommendations were issued by memorandum by the DOH Chief Medical Officer in 1995 and is the current recommendation of the NM DOH. The recommendation is that mass scoliosis screening should not be done in schools and Scoliosis evaluation is best performed by a medical provider when examination for other reasons takes place. Schools who choose to conduct scoliosis screening based on special concerns of parents, school and community, are to be properly trained and establish a follow-up referral system for students with positive and/or suspicious findings.

School Blood Pressure Screening

The New Mexico Administrative Code does not require New Mexico schools to conduct mass blood pressure screenings for students and the NM DOH Office of School and Adolescent Health does not recommend mass screening of blood pressure. A blood pressure measurement is to be taken by a school nurse or delegated to a health assistant due to symptoms that could be associated with a blood pressure issue. The need for a blood pressure reading is to be based upon a nursing assessment and or medical orders that are student specific.

Current [Blood Pressure Percentiles](#) tables for systolic blood pressure and diastolic blood pressure according to height, sex, and age. The 50th percentile provides the BP level at the midpoint of the normal range. The 95th percentile provides a BP level that defines hypertension; any student who consistently has BP that falls in this range should be referred for medical evaluation.

General Guidelines for Blood Pressure Measurement

It is important for the healthcare provider to measure blood pressure accurately, using the correct equipment and technique.

- Have student sit in a quiet environment for a few before taking a blood pressure reading
- Student to be seated with back and feet in a supported position.
- It may be necessary to measure the BP a few times (several minutes apart) to get the most accurate reading
- Take BP reading only if the student is not upset and crying or unable to cooperate to avoid an inaccurate reading
- Use the appropriate size cuff
- Measure BP in the right arm unless contraindicated
- Stimulants such as cigarettes and caffeine are to be avoided for several hours before BP is measured

Defining Hypertension in Children and Adolescents

The proper management of childhood hypertension depends on prompt recognition and treatment. Inadequate awareness of pediatric blood pressure (BP) norms, poor technique resulting in inaccurate measurements, or failure to obtain blood pressure measurements can prevent or delay recognition of this clinical condition.

Special Health Related Assessments

Response to Intervention (RTI) Process

In New Mexico the RTI framework is set forth in state rule at [Subsection D of 6.29.1.9 NMAC](#) for all public district and charter schools, and is known as the three-tier model of student intervention in which the intensity of instruction and assessment increases as students are served in the next higher tier. Students who struggle academically may also exhibit behavior problems and vice versa. For that reason, both academic and behavioral systems are addressed in a concerted effort in all three tiers:

- Tier 1: Universal Screening, Appropriate Core Instruction with Universal Intervention – 80% of students needing assistance in general education and will need vision/hearing screening and general health screening or comprehensive health assessment by RN school nurse.
- Tier 2: Student Assistance Team (SAT) process which will be target individualized interventions determined by the SAT team for referred students that may need a 504-accommodation plan
- Tier 3: Special Education/Gifted Education targeted for few students requiring intensive and specially designed instruction and services for students who qualify for Special Educational Services under a Individualized Education Plan

Students referred to a SAT will need at a minimum a health screening to include a vision/hearing screening or health assessment before the SAT team convenes for the referred student to determine vision or other health related needs are not the reason for the student's inability to succeed in the classroom. Only a RN school nurse may conduct a comprehensive health assessment, however, health assistant or designated trained personnel may participate in a student's health by conducting the initial vision or hearing screening for students being evaluated or re-evaluated for Special Education. Develop a process for managing these referrals with Special Education.

Development of Comprehensive Health Assessment

The initial step in developing a comprehensive Health Assessment is to conduct a thorough health history by the school nurse. The student health history provided by the parent/guardian of each student should include the following information: Medical diagnosis and medications.

Initial Health History/Nurse Assessment guidelines

To obtain a complete medical history of the student, it is recommended that the Initial Student Health History Form be completed either by the parent/guardian or by the school nurse either by telephone or in-person interview. If this is not possible, the Initial Student

Health History form may be sent home with instructions to complete and return it so that screening may proceed.

- Document any unsuccessful attempts to obtain health history information in the student's medical record.
- Develop student specific Individualized Health Plans or Emergency Care Plans and forward confidentially to any designated Special Education staff with a need to know
- Do not delay the educational testing process to be impeded by the inability to obtain health assessment.
- All findings, recommendations and comments can be documented on the Nurse Screening
- Student Health Assessment forms and Initial Health History forms should always be a part of the student health file.

Nursing Assessment for Special Education Students

The NM DOH Office of School and Adolescent recommends only the NM PED licensed school nurse be responsible for health assessments and screenings for any students being evaluated or re-evaluated for Special Education. When nursing services are required for the student to benefit from special education services, nursing services are considered a related service like occupational therapy, speech therapy, or physical therapy.

Developing a district level or school process for the school nurse to be able to identify students referred for Special Education services that might have health related conditions or needs that may potentially influence special education is important staff to prevent missed opportunities to intervene and will allow the evaluation to flow in a timely fashion for all parties involved and for the process to begin at the beginning of each school year and occur at least 10 school days prior to diagnostic evaluation or re-evaluation for special education service. Using a tracking form will help keep the referral process organized and on time in addition to having teachers and diagnosticians log in requests and submit referral forms appropriately to prevent confusion.

The following general guidelines are intended to assist the school nurse in organizing her/his role in the process:

- school nurse to be notified in a timely fashion of students who are being referred to special education with potential health related needs for a comprehensive nursing assessment for any student being evaluated or reevaluation for Special Education services.
- The school nurse to obtain parental consent to perform screenings and complete a comprehensive nursing assessment and student health history interview for each referral.
- The school to complete a student health history and conduct a comprehensive student health assessment after parental/guardian consent which includes vision and hearing screening results and a general health assessment be completed within 10 school days after receiving the referral and parent/guardian consent.

- When completing the Student Health Assessment form, it is appropriate to utilize vision and hearing screening results that have been completed within the current school year rather than repeating. At the discretion of the school nurse and based on student complaints or symptoms, a physical assessment may be performed and/or referral made to a medical provider for the assessment. Any school nurse concerns should be shared with parent/guardian with a request for follow up with a medical provider if appropriate.

Health Assistants cannot be delegated to conduct a comprehensive health assessment since assessment and care plan development is an exclusive function of a RN under the NM Nurse Practice Act but may assist the school nurse in collection of information to complete portions of the assessments when appropriately trained and when requested to participate.

Individual Educational Plans (IEP) and Adding Services

An IEP meeting is always necessary to request an evaluation for related services (nursing services) for a student already in Special Education. If the student qualifies for related services and an IEP meeting is scheduled, and nursing services may be needed, the school nurse may need to attend if it is not an annual IEP. If the related services are not nursing services and an evaluation for Physical Therapy (PT), Occupational Therapy (OT), APE, Assistive Technology, or any related service other the nursing services or speech and language pathology (SLP), the school nurse need not be involved, and no additional assessments or health history is to be provided by the school nurse.

When a student is referred for an evaluation by SLP, the school nurse should review the student's health record and perform a hearing screening if one has not been done within the current school year. Failure to pass the hearing screening should result in a referral for Audiology evaluation with results being documented in the student health record and shared with the school speech and language pathologist.

To change or delete health services on an IEP an addendum may be added to the existing IEP and does not require a full formal IEP meeting with all staff. It is acceptable for the school nurse, Special Education representative and the parent to meet, discuss and make changes to the IEP regarding school health services.

Recommended School Nurse SAT or Special Education Screening Checklist

For an Initial Evaluation Referral

- Student Health Assessment Form
- Initial Student Health History Form
- Special Education Nurse Screening Assessment Summary Form

3-year Special Education Student Re-evaluation

- Student Health Assessment Form
- Initial Student Health History Form
- Special Education Nurse Screening Assessment Summary Form

Gifted Re-evaluation Referral

- **Student Health Assessment Form, if warranted**
- **Conduct a health history review**
- **Special Education Nurse Screening Assessment Summary Form**

Speech & Language Referral

- **Related Student Health History**
- **Hearing Screening Results for Current School Year**
- **Audiology Report (if applicable)**

Health Record

The school health record is to contain the health history and any additional health information to assist with a nursing assessment of the health of each student. It is important that school personnel understand the confidential nature of this school health record. Schools are to have written policies that govern who may have access to the records and storage and retention of health records.

Information from the health record should not be released to outside agencies or individuals without written consent of the student's parents, except for immunization records. The administrator responsible for health services is to determine how records are to be used and who is responsible for recording data and keeping records up to date. The school nurse is usually responsible for maintaining the health records.

Resources and References

American Association for Pediatric Ophthalmology and Strabismus,
[Pediatric Ophthalmology and Strabismus \(AAPOS\)](#)

[Blood Pressure Percentiles](#)

Campbell, K., Meyers, A., Medscape, *Impedance Audiometry* (February 22, 2017)
<https://emedicine.medscape.com/article/1831254-overview>

[Familiar Sounds Audiogram](#)

[Hearing Screening](#)

[Initial Student Health History](#)

Kutz, J., Meyers, A., Medscape., *Audiology Pure-tone Testing* (April 7, 2016)
<https://emedicine.medscape.com/article/1822962-overview>

NM Lions Kidsight Program Referral form

http://nmlionskidsight.com/uploads/3/2/7/9/3279891/socsf_provider_referral_nofication_form_4-15.pdf

New Mexico Administrative Code 7.30.11 [Vision Screening Test Standards for Students](#)

New Mexico Department of Health [School Vision Screening Advisory Report](#)

[New Mexico Medical Oversight Committee BMI Position Statement](#)

[Parental Permission to Obtain Information - English](#)

[Parental Permission to Obtain Information - Spanish](#) Permiso Parental para Obtener Información

[Referral Form - General](#)

[Release of Medical Information](#)

[Release of Medical Information \(Publicación de Información Médica Padre\)](#)

[Save Our Children's Sight Brochure](#)

[Save Our Children's Sight Presentation](#)

[Save Our Children's Sight Screening Day Protocol](#)

[Save Our Children's Sight Vision Referral Form](#)

[Save Our Children's Sight Vision Referral Letter](#)

[Save Our Children's Sight Voucher Form](#)

[Save Our Children's Sight Voucher Procedure](#)

[Special Education Nurse Screening Summary Form](#)

[Student Health Assessment](#)

The Free Medical Dictionary <http://medical-dictionary.thefreedictionary.com/>

CHAPTER FOUR – STUDENTS WITH SPECIAL NEEDS

This chapter is Under Construction



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CHAPTER FIVE – INDIVIDUALIZED HEALTH CARE PLANS

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CHAPTER SIX – MEDICATIONS IN THE SCHOOL

Introduction

Many school aged children and adolescents can attend school due to advances in medical treatments and medications. Subsequently, there has been a dramatic increase in the range of medications used in schools, making the medication administration process more complex (McCarthy, Kelly, Johnson, Roman, & Zimmerman, 2006).

Schools are accountable to provide safe, legal, and appropriate care for students. This includes the administration of medications necessary during the school day for the student to attend school and take full advantage of his or her educational program. Educational performance, attendance, student safety, health maintenance and student wellbeing can be impacted by medications being administered correctly and effectively.

Whenever possible, it is recommended that medications to be given at home. If medication is required to be given at school or school sanctioned events, all schools are to have current medication administration policies, procedures, and protocols. It is the position of the National Association of School Nurses (NASN) that school nurses be responsible for medication administration in the school setting and lead the development of medication administration policies and procedures, (National Association of School Nurses, 2017).

School nurses are a valuable resource and should be utilized in the development of school district policies/procedures and consult on the creation of legislative policies relating to medication administration in the school setting (Canham, Bauer, Concepcion, Luong, Peters, & Wilde, 2007).

Medication policies and procedures are to address the delegation of medication administration, student confidentiality, training, medical authorization, proper labeling, storage and handling, documentation and record keeping, medication errors, self-carry and self-administration of medications, over-the-counter medications, homeopathic/herbal medications, essential oils and aromatherapy, field trips/school sanctioned events, and off label medication administration, and non U.S. Food and Drug Agency (FDA) approved investigational medications and samples, (National Association of School Nurses, 2017).

This section of the NM School Health Manual provides guidance to schools which is based upon national standards of care, state, and federal statute, regulations, and industry best practices. The information contained in the New Mexico School Health Manual regarding medication administration in a school setting is intended to serve as guidance to assist in developing and revising policies and procedures and is not intended for legal guidance.

Legal Definitions and Consideration for Medication Administration in the School Setting

Federal and state laws, regulations, and rules exist regarding the administration, prescribing, and the dispensing of medication. It is imperative for school personnel to understand the legal definitions of each. Even though prescribing, dispensing, and

medication administration are specific functions, each work in concert to support medication safety and efficacy.

The school environment is education focused. Health care delivery poses special challenges for medication administration. School staff and school nurses must be knowledgeable of laws affecting school medication administration and be diligent to practice within professional scope of practice and the law.

To protect the school districts and staff from liability and to insure student safety, schools must provide for the safe medication administration. Medication Administration to students must follow strict guidelines that do not conflict with state and federal laws, standards of medical, pharmacy, and nursing practice. Schools are to have sufficient staff and staff training to decrease school liability and risk to students.

Legal Terms for Medication Administration Medication

The Federal Food and Drug Administration defines medications as "articles intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease" and "articles (other than food) intended to affect the structure or any function of the body of man or other animals" [FD&C Act, sec. 201(g)(1)].

Medication Administration

As defined under the New Mexico Nurse Practice Act "a process whereby a prescribed drug or biological agent is given to a patient/client by a person licensed or certified by the board to administer medications". Medication administration falls under the auspices of nursing practice. Administering medication in schools without a nursing license or that has not been delegated by a registered nurse could be construed as practicing nursing without a license and may be subject to criminal and civil penalty as define in the [NM Nurse Practice Act](#)

Prescribing

The [New Mexico Medical Practice Act](#) governs the prescribing of medication. The term "prescribe" means to issue an order individually for the person for whom prescribed, either directly from the prescriber to the pharmacist or indirectly by means of a written order signed by the prescriber, bearing the name and address of the prescriber, license classification, the name and address of the patient, the name of the drug prescribed, direction for use and the date of issue.

The New Mexico Department of Health issues non-patient specific orders under the medical authorization of Regional Health Officers and are utilized by public health nurses and school registered nurses. Non-patient specific medical orders are commonly referred to as standing orders and authority to grant standing orders belongs to medical officers within the New Mexico Department of Health. It is prohibited in New Mexico for schools to have private medical directors who issue non-patient specific medical orders or standing orders per the New Mexico Medical Practice Act. Schools may have advising private physicians or other practitioners to help develop policy and procedures or to advise on health service programing but may not issue non-patient specific orders for schools to use.

Medication Dispensing

The [New Mexico Board of Pharmacy \(NMBOP\)](#) governs the dispensing of medications, and only those authorized under the New Mexico Board of Pharmacy may dispense medications which are pharmacists, advanced practice nurses, physician assistants and physicians. It is not within the scope of practice for any school nurse to dispense a medication. Schools or school nurses technically dispense medications and fall outside of appropriate practice parameters when they transfer medications into alternative containers, do not use accurate language in policy and procedures and purchase stock over the counter medications. The term “dispense” per the [New Mexico Pharmacy Act](#) means to deliver a drug directly to a patient and includes the compounding, labeling and repackaging of a drug from a bulk or original container.

School nurses and educational staff inadvertently dispense medication during preparation for field trips by the medication being transferred to another container or bottle in which the process of transfer into another container is considered “repackaging” of the medication. It is recommended that doses for school sanctioned events be dispensed by a pharmacist or sent by the parent in an appropriately labeled prepackaged container to avoid the school or school nurse from practicing outside scope of practice. Many pharmacists will dispense extra doses in a separate container for this type of circumstance.

Additionally, schools use the term dispense medications in lieu of administering medications in policies and procedures. To avoid misinterpretation and to avoid functioning outside scope of practice it is recommended schools use the correct term. When addressing medication, administration is the proper term to use in policy and procedures.

The direct purchase of stock Over the Counter (OTC) medication by a school or school district could be construed as dispensing and distributing medications and would be a potential violation of the NM Board of Pharmacy. Standing orders for stock OTCs are not extended to NM schools through the Regional Health Officers within the Public Health Division of the NM Department of Health. Therefore, it is recommended that any OTC be provided by the parent or legal guardian and be accompanied by a written student specific medical authorization/order signed by the provider and parent/legal guardian.

Options for Medication Administration in the School Setting

New Mexico schools are diverse, ranging from private and parochial schools to public charter and schools within local school districts. Each of these school types have unique differences and varying resources to support medication administration and have different models of nursing service delivery which affect medication administration in the school setting. Many schools in NM do not have nurses or have limited nursing service for only several hours per week and may require school nurses to cover multiple schools with large geographical distances between the schools.

It is imperative the school participate in the development of clear medication administration policies and procedures. The school nurse has the education and experience to ensure medical orders are appropriate and provide clear medical information to ensure student safety. The RN school nurse is the only school professional with the license and standard of

practice that can develop the individualized medication administration plans for each student with medication needs. Schools or school districts who receive federal money must provide [Free and Appropriate Public Education \(FAPE\)](#) and may find it necessary to contract or hire a school nurse to oversee and delegate medication administration and must be available for assessment and consultation during the school day or school sanctioned event.

School Nurse Medication Administration

Optimally, all student medications should be administered at home, or administered by a school nurse. The school nurse has the educational background, knowledge, and licensure that provide the qualifications to administer or direct the administration of medications in the school setting (NCCMERP, 2015). School nurses identify and address issues that may affect management of acute and chronic health conditions, such as environmental factors and socio-economic challenges, including obstacles to obtaining medications and delivery of medication to the school (Blaakman, Cohen, Fagnano, & Halterman, 2014). Evidence indicates that school nurses provide culturally appropriate, sensitive information for students and families regarding management of health issues, including proper use of medications (McNaughton, Cowell & Fogg, 2014).

Delegation to Unlicensed Assistive Personnel

Medication administration in schools has been a school nurse responsibility. Due to budget reductions, it is common for students to receive medication from non-nursing school employees who have no medical training. This trend has caused an alarming increase in the number of medication errors made by unlicensed assistive personnel, also known as UAP (Institute for Safe Medication Practices [ISMP], 2012).

The NM Board of Nursing practice act allows nurses to assign or delegate to licensed and unlicensed persons only those nursing tasks which that person is prepared, qualified, licensed or certified to perform. However, the nurse may not delegate the specific functions of nursing assessment, evaluation, and nursing judgment to non-licensed persons. Based on his/her nursing assessment & judgment, the school nurse and only the school nurse may assign the task of medication administration to a licensed practical nurse or delegate the task to UAPs per the [New Mexico Nurse Practice Act](#).

Medication Administration Without a School Nurse

Schools who are unable to contract or employ school nurses may have difficulty in the implementation of a safe and effective medication administration policy. Schools without a school nurse should consider having a policy which prohibits the school from administering any medication unless delegated under nursing authority and trained in medication administration policies, procedures, and best practices to reduce student risk. If there is not a school nurse to delegate medication administration the best practice is to have a parent/guardian administer the medication to reduce potential risk to the student and school district. This alternative is found to be impractical and may not be an option if the parent/guardian is not able, capable, or is unwilling.

Self-Medication Administration Under School Staff Observation/Supervision

This option should only be used by the school when a school nurse cannot be employed, or services contracted. With this option, the student will self-administer under direct observation by assigned school staff. It is highly recommended all school personnel take the NMDOH sponsored Health Assistant Training to enhance knowledge of medication administration, medication storage and safety, medication disposal, applicable laws and regulations, and best practices in medication administration. Schools should have a backup plan and have adequate staff trained to assume this role in case of staff absence.

Student Independent in Self-Administration

New Mexico law allows for certain emergency medications to be self-carried or self-administered by a student. Regarding non-emergency medications, there is not clear guidance for schools outlined in statute. NMDOH recommends schools develop clear policies indicating whether the self-carry and self-administration of non-emergency medications is allowed. NMDOH does not endorse students to self-carry and self-administer non-emergency medications and recommends all non-emergency medications that are not defined in statute be stored in a secure area. If the student self-administers medication, it should be with observation by an educational staff member trained in medication administration safe practices.

If schools choose to allow students to self-carry or self-administer non-emergency medications defined under statute, it is recommended that only a one-day supply of medication be carried by a student at any given time, and only allowed in secondary school environments with written approval by parent/guardian and health care provider. Any controlled substance medication must be stored securely per the U.S. Drug Enforcement Agency (DEA) guidelines and is not to be self-carried by any student in a school. Self-administration instructions are to be provided by the parent/guardian or health care provider, and if a school nurse is employed by the school, the school nurse is to conduct and provide a written assessment to evaluate the student's ability to perform safe and accurate self-administration. Below are considerations when school policy allows for self-administration of medication:

- Is the medication a controlled substance? Prohibit if medication is a controlled substance due to high dependence index, high street value, and need for higher level of accounting and higher security for storage and handling.
- Has the student demonstrated his/her capability for self-administration and an understanding that medication is not to be shared?
- Is there a medication order stating that the student is qualified and/or able to self-administer the medication?
- Is there written parental consent for self-administration?
- What medication will the student be allowed to carry and administer?
- Does the medication require refrigeration or security?
- Is there a need for notification of appropriate team members (such as teachers, principals, support persons) of all self-testing or self-administration of medication?

- Is there a need for staff to be appropriately prepared for working with the student?
- Should there be recognition that self-administration of medication is a privilege which can be taken away if medication policies are abused or ignored?

Delegation of Medication Administration in the School Setting

One of the most complex nursing skills is delegation. It requires sophisticated clinical judgment and final accountability for student care. Effective delegation is based on the nurse practice act in each state and understanding of the concepts of responsibility, authority, and accountability. Nursing delegation is to take into account student care complexity, skill and knowledge for the delegated nursing task, acuity of care, and consistency in effective delegated task assignments. (Weydt, 2010)

Medication administration is defined in the [New Mexico Nurse Practice Act](#) (NMNPA) to be under the auspices of nursing practice. Therefore, the decision to delegate medication administration to unlicensed assistive personnel (UAP) rest solely with the registered nurse providing services to the student. In doing so, the school nurse must be competent in the process of delegation and medication administration, Medication administration is one of the most common nursing task delegated in a school setting.

The school administrator may select the UAP for consideration by the school nurse to delegate medication administration; however, if in the opinion of the school nurse, the UAP is not competent or willing to carry out the task of administering medication. the school nurse is not required to delegate to the UAP the task of medication administration when the school nurse believes the unlicensed staff is not competent to carry out this task.

The [NMNPA](#) allows registered nurses to assign or delegate to licensed and unlicensed persons only those nursing actions which that person is prepared, qualified, licensed or certified to perform. The nurse may not delegate the specific functions of nursing assessment, evaluation and nursing judgment to non-licensed persons. Based on his/her nursing assessment & judgment, the school nurse may assign the task of medication administration to a licensed practical nurse or delegate the task to a health assistant, or other qualified unlicensed person.

The [NMNPA](#) authorizes unlicensed personnel to administer medications under the delegation and on-going supervision of the school's registered nurse if the school nurse assesses the student, environment, trained school staff member, and medication to be administered to be appropriate for delegation and meet the below criteria:

- Administration of the medication must be within the area of the RN's responsibility
- The medication to be administered must be within the knowledge, skills, and ability of the RN
- The medication to be administered must be a routine and repetitive nature with predictable outcome regarding response

- The unlicensed assistive person must have individualized training for the medication to be administered and return competency by the unlicensed individual
- The medication to be administered must not require exercising nursing judgment, evaluation, or assessment
- Delegation of the medication administration must not be transferred to another unlicensed individual without going through the appropriate delegation process
- Delegation of medication administration must be documented, supervised, and periodically evaluated

The school nurse must be available to the UAP during the school day and during a school sanctioned school event to provide on-going supervision of the delegated medication(s). This is of special consideration when part-time or contract school nurses are hired. It is recommended that schools and school districts develop backup plans that list other UAPs that may administer delegated medications to students in the absence of the primary UAP. This practice will enhance safety and promote that delegation of medications meet the school nurse's responsibility in adhering to standards of practice related to delegation.

Safety Considerations for Medication Administration in the School Setting

In any given week, 56% of children younger than 18 years of age take at least one medication, 27% take two or more medication and 21% use at least one prescription drug. The American school system delivers medications to more students than large hospital or nursing home systems. Approximately 6% of school-aged children (nearly 13 million) receive medications while in school, and 80% of school-related medication errors reported were missed doses. (Gaunt, 2015)

To ensure that students are medicated at school under maximum protection, the following guidelines should be followed and addressed in the school or school district's policy, procedures, and student handbook:

- Schools and school districts are to have approved school board policy and procedures for medication administration which are reviewed annually and updated as needed.
- Medications Administration policies are best developed, supervised and guided by a school nurse.
- Administer medications only if there is a current school year medication administration authorization form signed by the student's primary health care provider and parent/guardian. This form is to be updated as needed by the primary care provider as medications change, and each school year.
- The signed medication authorization form should be reviewed and approved by the school nurse prior to any medication administration or is delegated.
- The medication label should not be used to determine or verify route, dose or frequency. Use the most current provider medical authorization/order.
- Changes in the dosage of the medication require a written provider authorization/order.
- Unused medication should be disposed of or returned according to the school board

approved policy and procedure for medication administration

- It is recommended that the first dose of a newly prescribed medication be given at home.

All medications are to be provided by a parent/guardian as follows:

- Prescription medication must be in a container with a current prescription label that matches the medical provider's written order.
- All medications administered at school should be made available to the school nurse in a pharmacy-labeled container that provides the following information:
 - Name of student
 - Name of medication
 - Drug strength and prescribed dosage
 - Route of administration
 - Time schedule of administration
 - Name of prescribing health care provider

Over the counter medication should not be purchased by schools or school districts to avoid the appearance of dispensing medications, unless the school or school district has a class C pharmacy license and purchases only single dose packaged over the counter medications. If the over the counter medication must be taken for more than five consecutive school days, a physician's authorization must be obtained.

The over the counter medication administration form is to include the following:

- Student's name
- Age of the student
- Name of the over the counter medication
- Amount of medication to be taken
- Time to be taken and frequency

The goal of these targeted medication safety best practices for schools is to prevent harmful medication administration errors

Emergency Medications in the School Setting

Students with diabetes, seizures, life-threatening allergies and asthma need immediate access to emergency medications (e.g. auto-injectable epinephrine, albuterol, rectal diazepam, intranasal valium, and glucagon) in the school setting. While schools are not expected to function as emergency care centers, there are students with life-threatening medical conditions who require prescribed emergency medications at school.

Experts agree the school nurse should be the key coordinator and if possible, the primary administrator of emergency medications. Potential legalities involved in not responding with emergency medication (if available), and intervention by a trained unlicensed individual in the absence of a licensed school nurse, should be considered when establishing school district policy. School nurses should coordinate the training of an adequate number of

school personnel to ensure that if the school nurse is not present, there is at least one adult present who is trained to administer emergency medications in a timely manner.

Keeping any emergency medication on school premises involves certain legal/ethical issues and may create even more complex issues around emergency medication administration. An example would be a situation in which a student is discovered in anaphylaxis and the only treatment readily available is epinephrine designated for a different student. Administration of the available epinephrine by any trained individual could be a life-saving step; failure of the individual to receive treatment could result in death for the victim and legal action against the trained licensed or unlicensed individual who does not respond. If there is a need, schools are recommended to consider employing a Stock Emergency Medications in the Schools and Narcan in Schools program to enhance safety.

Below are some guidelines to consider when developing local policy, procedure, and emergency crisis plans:

- The most common emergency medications required in the school setting are epinephrine, albuterol, glucagon, seizure medications, and oxygen. All staff are to be trained in the identification of emergent symptoms necessitating the need for the emergency medications, deployment of school emergency call system, location of emergency medications, evacuation and transportation plans.
- These guidelines along with other emergency interventions that include mobilization of emergency services should be included in the student's individualized emergency care plan and signed by the parent/guardian. This plan should be developed in collaboration with the student, parents, primary care provider, and appropriate school staff, and with the student's safety and the school's capability in mind.
- Schools may need to identify unlicensed personnel to be trained to assist with emergency medications in the absence of a school nurse. The [New Mexico Nurse Practice Act](#) allows RN school nurses to "assign/delegate to licensed and unlicensed persons only those nursing actions which that person is prepared, qualified, or licensed or certified to perform. When any medication is delegated, the school nurse is to assess and document the return demonstration of the emergency medication administered by unlicensed personnel or self-administered and document assessment.
- Federal laws including the Individuals with Disabilities Education Act (IDEA) of 1975 (20 U.S.C. §§1400 et seq, and 34 C.F.R. pt. 300), Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act (ADA) of 1990 require that health services for complex student health needs be provided so that students can access their education. Immediate access to emergency medications is critical and vital to the effectiveness of these life-saving interventions.

Depending upon the availability of 911 emergency services and the proximity to the school, 911 response might be the most appropriate solution for emergency response needs in the absence of a licensed health care provider to administer care. It is recommended that discussion between school district administration, school health

personnel and the local 911 responders take place to determine the feasibility of this option as policy

- Emergency response to students/staff for students/staff who do not have documented medical risk or an emergency medication at school are to be considered in the school emergency plan.
- The student's health care provider is responsible for writing medication orders and for providing clear guidelines regarding the circumstances under which emergency medications should be administered.
- The Individualized Health Plan (IHP) and Emergency Care Plan (ECP) are to delineate acceptable and safe emergency intervention procedures and parameters. Such plans require parental signature as well as signature of responsible school staff. *Loco parentis* designation may be considered in such an IHP, specifically as it relates to mobilizing emergency response service.

Students Rights - Asthma and Anaphylaxis Emergency Medications in the School Setting

New Mexico Administrative Code requires all schools, whether public or private to have school policies to allow any student in grades K-12 to carry and self-administer provider prescribed asthma and anaphylaxis emergency medication during school day, school sponsored activity, before and after school care if on school property, in transit to and from school or school sponsored events.

School policy is to disclose and address the following information:

- Maintenance of student confidentiality,
- That no school employee who in good faith who reports any known or suspected violation of the school discipline policy or in good faith attempts to enforce the policy shall be held liable for any civil damages.
- Requirement of a written plan of care signed by an appropriate healthcare provider authorizing and acknowledging that appropriate student instruction in the correct and responsible use of the medication and associated devices has been done.
- Requirement of a written and health care provider treatment plan be submitted and signed by the parent/guardian and be renewed by the parent or guardian each subsequent school year.
- Address procedure for any back-up medication, if provided by a student's parent or guardian, be kept at the student's school at a location easily accessible to the student in event of an emergency.

- The student has demonstrated to the health care provider, school nurse, or other school official the skill level necessary to use the medication and any device that is necessary to administer the medication as prescribed. The school is to document and maintain records of such;

Students Rights - Diabetes Self-Management in the School Setting

New Mexico Statute requires all schools, whether public or private to have school policies to allow any student in grades K-12 to carry and self-administer provider prescribed diabetes management medications, supplies, and equipment during school day, school sponsored activity, before and after school care if on school property, in transit to and from school or school sponsored events.

School policy is to disclose and address the following information:

- Maintenance of student confidentiality,
- That no school employee who in good faith who reports any known or suspected violation of the school discipline policy or in good faith attempts to enforce the policy shall be held liable for any civil damages.
- Requirement of a written plan of care signed by an appropriate healthcare provider authorizing and acknowledging that appropriate student instruction in the correct and responsible use of the medication and associated devices has been done.
- Requirement of a written and health care provider treatment plan be submitted and signed by the parent/guardian and be renewed by the parent or guardian each subsequent school year.
- Address procedure for any back-up medication, if provided by a student's parent or guardian, be kept at the student's school at a location easily accessible to the student in event of an emergency.
- The student has demonstrated to the health care provider, school nurse, or other school official the skill level necessary to use the medication and any device that is necessary to administer the medication as prescribed. The school is to document and maintain records of such
- All school staff are to be adequately trained in diabetes awareness, signs and symptoms of hypoglycemia and hyperglycemia and the associated emergency response.

The [Guide to Helping the Student with DM Succeed](#) provides the necessary resources and tools to assist schools in managing diabetes in the school setting. There are three levels of school staff training. Level One training is for all school staff and provides an overview of

diabetes, signs and symptoms of hypoglycemia and hyperglycemia, and emergency response. It is designed for all staff members that do not have direct care management responsibilities. Level two training provides more in-depth training than level one and is designed for any school staff member that may be assisting the student in the day to day management of diabetes. Level Three training is designed for a staff member that will be directly providing direct diabetes care in the school setting.

Guidelines for Over the Counter Medications in the School Setting

In 2009 the American Academy of Pediatrics (AAP) issued a policy statement: [Guidelines for the Administration of Medication in School](#) was reaffirmed in 2013. Guidance related to providing over-the-counter (OTC) medications in this chapter has been acquired from the AAP policy statement. These guidelines were designed to give guidance to school districts that choose to allow the administration of OTC medications to promote appropriate safeguards for optimal health and safety of students. When addressing whether to use OTC medications in schools, there are multiple factors to consider in relation to the risk to benefit of OTCs. The benefits of having OTC medication(s) include keeping students in school, reducing parental work absence and, providing symptom relief.

The potential risks include side effects from the OTC medications; for example, cold and cough OTC medicines have not been shown to be effective in children younger than 6 years and are not appropriate for use at school without a physician order. OTCs may influence cognitive functions and impact the ability to learn under the influence of the medication. They also can mask underlying health conditions. Additional factors to consider are whether there is a school nurse employed or under contract to conduct an assessment to determine appropriateness of using an OTC. Safety and security of the medications must be considered as well. If medications are not safely stored in the school health office the sharing of medications between students may heighten.

Schools that allow and permit the use of OTCs may permit the OTC medications to be given on a short-term basis and to use the below guidelines:

- Schools are to use a risk to benefit analysis when deciding to permit the use of OTC medications under school policy.
- Schools that permit OTC use must determine which specific conditions will be indicated for use, e.g., mild fever, mild headache, symptoms of seasonal allergies.
- OTC medications must be supplied by the parents/guardians and are to be brought to the school by an adult in the unopened and manufacture's labeled container.
- The labeling is to also include the student name, date of birth.
- All OTC medications are to be stored in a secure location with limited access by school personnel and students.
- Students presenting with symptoms of minor illness, the use of comfort measures e.g., rest, ice, elevation, warm/cold compress will be used before proceeding to the use of an OTC.
- Schools are to require written parental/guardian consent and it is recommended the school obtain provider authorization for OTCs to prevent potential risk.

- School policies should permit the use of an OTC for no more than 3 consecutive days unless a medical authorization is obtained from a primary care provider (MD, DO, CNP, PA).
- An assessment conducted by an LPN must have school nurse RN review the assessment since a LPN cannot conduct the initial assessment under New Mexico Nurse Practice Act.
- School policies are to state that all OTCs administered will follow manufacturer's label directions for dose, indication for use, and age and weight guidelines unless medical authorization is obtained.
- Schools to require all medication administration to be documented in the student health record and Medication administration record (MAR).
- Of special note, it is unlawful for unlicensed assistive personnel (UAP) to make an assessment or determination to offer OTC medications. A trained UAP can collect information or data and report the information to the school nurse RN so that the RN can make an assessment as to the appropriateness to give the medication to a specific student.

Guidelines for Controlled Substances in the School Setting

The Controlled Substance Act (CSA) defines controlled medications as any drug or therapeutic agent with a potential for abuse or addiction and which is held under strict governmental control. These drugs and other substances under the CSA are divided into five schedules (U.S. Department of Justice, 2011). Substances are placed in their respective schedules based on whether they have current acceptable medical use in the United States, their relative potential for abuse, and their likelihood of causing dependence when abused. Schedule II controlled medications routinely administered at school include Adderall, Concerta, Focalin, and Vyvanese,

For the purposes of ensuring the secure storage, handling, and disposal of controlled medications, schools are to provide effective controls and procedures to guard against theft and misuse of controlled substances. Below are suggested best practices and recommendations to be in school policy and procedures,

- Parent/guardians are to deliver medication(s) to the school in the original prescription bottle
- All controlled substances must be inventoried by counting the medication(s), amount documented, dose count verified and documented by two adults, with ongoing monitoring and accounting of the remaining doses
- A signed and written medical authorization must be on file with the school before administration of the medication occurs
- All controlled medications are to be stored in a double lock system where the medication is stored in a substantially constructed cabinet.
- Any accounting irregularity, loss, or suspected theft must be immediately reported to parent/guardian and school administration with incident report to be made per school policy.

- Contact to be made within one business day of loss or theft discovery with the local Drug Enforcement Agency Office to ascertain further guidance regarding reporting obligations for the school.

Regarding the disposal of controlled drugs, the American Nurses Association (ANA) supports disposal of pharmaceutical waste in a manner that will minimize and ultimately stop the diversion and misuse of pharmaceuticals that are expired, unused or no longer needed; and the direct or incidental release of pharmaceuticals into the environment. American Nurses Association. (2010). Position statement: Pharmaceutical waste.

Schools remain organizations that have not been defined under the CSA and are not subject to requirements for organizations that must register with the U.S. Drug Enforcement Agency for the disposal of controlled drugs. Schools are acting “*In loco Parentis*” and subject to disposal of controlled medications as a “ultimate user”. The CSA refers to an “ultimate user” as a person who has lawfully obtained, and who possesses, a controlled substance for his own use or for the use of a member of his household or for an animal owned by him or by a member of his household and are not required to register with the DEA because the controlled substances in their possession “are no longer part of the closed system of distribution and are no longer subject to DEA’s system of corresponding accountability. (Yeh, December 13, 2012)

The American Nurses Association recommends the following for process for disposal of a controlled substance for nurses, 2010; USDHHS, 2014

- Parental notification for pick up and disposal of medication by sending three notifications reminders to parent/guardian that medication not claimed at the end of the treatment, and the end of the school year. Inform parents all medications will be destroyed:
- Medication count: two school nurses or a school nurse and an administrator prior to actual disposal and recorded on a controlled medication disposal log and records retrained per state statute.
- Disposal includes: a. emptying medication from original container; placing medication into a coffee can, sealable bag, or other container; c. mixing the medication with used coffee grinds or kitty litter and adding water to the mix; sealing the container; and disposing with regular trash.
- Remove labels from the student’s empty medication bottles prior to discarding original prescription containers.
- CFC inhalers are being replaced by environmentally friendly inhalers that may be disposed of in the regular trash.

Consumer guidance for disposal of controlled medications was developed in collaboration between the DEA and the U.S. Food and Drug Administration (FDA) to deter illegal drug abuse, reduce the danger of unintentional use of controlled medications and provided these recommendations for consumers:

- Find a Pill Take Back or DEA Authorized Collector which are located your local area. Sometimes there are various events set up in communities where the DEA will come to collect all unused or expired medications for disposal.
- Locate a registered DEA waste management service for pick up and disposal of controlled medications.
- Consider flushing only medications on the approved FDA's list recommended for flushing if the quantity is small and frequency is occasional. To evaluate appropriateness for flushing look up the medication on the FDA's website.

Guidelines for Complementary and Alternative Medications and Therapies in the School Setting

A wide range of complementary health approaches and products are being used for children and adolescents. Parents are frequently requesting these products to be administered in the school setting. These complementary and alternative health approaches include herbs, dietary supplements, massage therapy, mind-body energy alignment, acupuncture, chiropractic care, aromatherapy, essential oils.

[The National Center for Complementary and Alternative Medicine \(NCCAM\)](#) is part of the National Institutes of Health (NIH) and conducts research on the efficacy of complementary medicine and is a resource clearinghouse for CAM therapies and products. NCCAM defines Complementary Alternative Medicine (CAM) as a group of diverse medical and health care systems, practices, and products that are not presently considered to be part of conventional Western medicine. CAM is also known as integrative or alternative therapies.

In 2012 the [National Health Interview Survey \(NHIS\)](#) reported a rise of in use of herbal products and essential oils is of specific consideration within CAM environment. Herbal products and essential oils are not evaluated and approved by the [U.S. Food and Drug Administration \(FDA\)](#) and can be marketed without proven safety, purity, of effectiveness of the product and are not required to report any data on adverse events from these products to the FDA. Dietary supplements are regulated but not approved as drugs by the FDA as covered in [Health and Education Act of 1994 \(DSHEA\)](#)

Under DSHEA, a dietary supplement is defined as a product intended to supplement the diet. The supplement bears or contains one or more of the following ingredients: a vitamin, a mineral, an herb or other botanical, or an amino acid and is intended to be ingested in pill, capsule, tablet, or liquid form. The product cannot be used as a conventional food or as the sole item of a meal or diet; and must be labeled as a dietary supplement.

The classification of dietary supplements is specifically separate from food or drug categories and, as such, lies outside the jurisdiction of many of the safety and regulatory rules that cover food and drugs and by law the manufacturer is responsible for ensuring that its dietary supplement products are safe before they are marketed. Unlike drug products that must be proven safe and effective for their intended use before marketing, there are no provisions in the law for FDA to approve dietary supplements for safety or effectiveness before they reach the consumer.

In New Mexico limited prescriptive privileges have been granted to the following health care providers for integrative therapies and are expected to meet the same standards when prescribing medication for administration in the school setting as in any other situation:

- Nurse Practitioners (CNP)
- Nurse Midwives (CNM)
- Physician Assistants (PA)
- Rural Anesthetists (CNA)
- Nurse Specialists (CNS)
- Doctors of Oriental Medicine (DOM)
- Chiropractors (DC).

The New Mexico school nurse may administer medications prescribed by any of these licensed health practitioners if within the scope of the nurse's training, knowledge, and experience per the [NM Nursing Practice Act](#) (NMNPA). School nurses are accountable for knowing therapeutic effects, safe dosage, contraindications, and potential side effects of products or medications administered. In addition, the school nurse must administer integrative therapies with same best practices and standards of care; e.g. pharmacy-labeled containers or in the original provider-issued container, labeled with the same information routinely included on pharmacy labels, and should be transported, stored, tracked, documented, and disposed according to the same guidelines of other medications.

It is important to respect for the needs of all students and wishes of their parents/guardians. School nurses should provide culturally sensitive care and communicate concerns if issues arise in providing safe and competent care within nursing standards of practice. The administration of any integrative therapy or medication administration is to take place only if permitted by local school district policy, NMDOH guidelines in the New Mexico School Health Manual, in compliance with NMNPA and NM State Law.

Of special note, there are federal or state statutes which address whether a parent or legal guardian can or cannot administer integrative or CAM products in the school setting. Therefore, it is incumbent on the school or district to develop the school policy which addresses the parameters under which this activity may take place. School nurses may always consult their School Health Advocate if unsure of federal and or state laws.

To guide schools in policy development for CAM, the following statements were extracted from *Legal Issues in School Health Services* by Schwab and Gelfman (2001).

- School nurses are expected to know and practice within the laws of their respective **states.**
- When the law does not sufficiently address an issue or ethical issues arise for the school nurse, a written opinion should be obtained from the local Board of Nursing.
- Collaboration with other Boards of Nursing, Medical and Pharmacy Boards, and the **state departments of health and education are encouraged when appropriate.**
- To explore and advise on issues, consideration should be given to convening a

committee on ethics with appropriate representation and expertise from the school and community.

- School district policies should be developed to meet professional standards of practice and should be followed consistently throughout the district.
- School policy should address students carrying and personnel administering any **substance that could be identified as a medication (including natural remedies, a aromatherapy, herbs and nutritional supplements). Such policy should include requirements for an explicit order from an authorized provider in the state, parent authorization, verification that a product is safe to administer in the prescribed dosage, and information regarding therapeutic and untoward effects.**

The NMDOH Office of School and Adolescent Health recommends the following for schools to follow:

- School district policies and procedures should meet professional standards of practice for safe medication administration and are to be followed consistently and school not require nurses to administer CAM.
- School nurses are to cautiously approach the decision to administer a dietary supplement and use of a decision-making model that ensures compliance to the NM Nurse Practice Act and the American Nurses Association scope and standards of practice and code of ethics.
- The NM Nurse Practice Act and Standards of Professional Nursing Practice require the school nurse to know the rationale for and the effects of medications to correctly administer the medication. New Mexico school nurses are not to administer herbal supplements, and essential oils orally, topically, or diffused. These substances do not have consistent and reliable [United States Pharmacopeia](#) (USP) formulation to ensure dose purity and consistency, are not regulated by the FDA, and a predictable dose calculation for herbal products has not been established in pediatrics.
- School policy should prohibit any school personnel from administering an herbal supplement or essential oil topically, orally, or diffused. These substances do not have consistent (USP) formulation and are not regulated by the FDA. Non-licensed school personnel may not be aware of the potential for reacting with other medications and associated contraindications. Any essential oils used in a diffuser must be prohibited since the diffused essential oils can increase the risk of asthma exacerbations and anaphylaxis due to the inability to contain the essential oil to the point of contact.
- School policy should prohibit students from carry herbal products and essential oils on their person. For student self-administration, a predetermined place of storage is to be defined in school policy, and school procedures to outline who will retrieve the product from the storage area for self-use, require written medical provider and

parent/guardian authorization, and the direction for administration to be provided from the medical provider and or parent/guardian directly to the student.

- The health care provider should provide verification that the product is safe to administer to children in the prescribed dose, is therapeutic and has no untoward effects. Supplements that are often given to children may interact with many conventional medications such as St. John's wort has been shown to interact antidepressants, birth control pills, seizure control drugs, and certain drugs used to treat cancer. Melatonin may alter the levels of other hormones in young children and should not be used by children with certain medical conditions such as hormonal disorders, diabetes, liver or kidney disease, cerebral palsy, seizure disorders, migraine, depression, and hypertension.
- Educate students, parents and school staff about the risks involved in administering products for which no safety parameters have been established, the importance of adequate research to determine the effect of herbals preparations and the rationale for schools to establish guidelines intended to ensure safety of all students.
- Avoid dismissal of complementary or alternative medical treatments in ways that communicate a lack of sensitivity or concern for the family's perspective. It is important to support parents in their preferences for health care and help them find safe solutions to such dilemmas.

Guidelines for Medication Administration for Field Trips and School Sanctioned Events in the School Setting

Field trips and school sanctioned events often create challenging situations for schools when medication administration is necessary. It is important for all school sanctioned trips and events be planned well in advance to allow time to create an effective and safe plan and is best to include the student if appropriate, parent/guardian, and school nurse.

Schools are to have policies and procedures that address all aspects of medication administration for school-sponsored trips or sanctioned events. The policy and procedure is to specifically address medication administration for students who are unable to self-administer medication(s) or upon the absence of a parent/guardian attending the trip or event. Students with special healthcare needs have the right to participate in school-sponsored trips

It is best practice to consistently include the school nurse in the planning and coordination for all school-sponsored trips. Students who require medication(s) on field trips or school sanctioned events that cannot self-administer or do not have a parent or legal guardian attending, it may be necessary for the school nurse to attend the school trip or event or delegate medication administration to an adult affiliated with school operations. If delegation of medication is being considered an assessment by the school nurse is necessary to determine if the medication(s) can be delegated to an UAP.

As schools consider whether to have a field trip or school sanctioned event the following considerations are advised: [NASN 2013: School-Sponsored-Trips-Role-of-the-School-Nurse](#)

- If the field trip is outside of New Mexico, the school nurse is responsible for knowing the nursing license and practice laws of that state or country.
- If the school-sponsored trip takes place in a different state or country, plans must be in place to meet the nursing license and practice laws of that state or country.
- If the state is not a part of the Nurse Licensure Compact (NLC) the school nurse will need to request and receive permission from the respective state's board of nursing, to practice in the state in which the field trip will be residing. If going outside the borders of the United States, the school nurse will need to consult with the consulate of the visiting country for permission to practice nursing.
- Students who are under a 504 plan or an IEP must have field trip and school sanctioned events outlined in each plan.
- If allowed under school policy, and the parent/guardian chooses to use a surrogate for medication administration, the nurse may choose not to delegate medication to this individual, and the instruction and guidance for medication administration will come from the parent to the surrogate and will not be under RN delegation authority.

The [NM Nursing Practice Act](#) allows school nurses to delegate medication administration, including emergency medication, to adults affiliated with school operations. The following is recommended to ensure a safe and effective field trip:

- Parent/guardian to supply a separate supply of medication(s) to be used during the field trip to avoid the act of dispensing medication (transferring medication from one container to another).
- Field trip medication(s) should not come from the student's medication supply held at school for routine use, if possible.
- All medications are to be in current pharmacy labeled container ideally be prepared by a pharmacist and brought to the school by the parent/guardian for the scheduled field trip.
- If a separate supply of medication is not available for the field trip, use or send the prescription labeled container being used at school for the field trip.
- The school nurse or the UAP delegated the task of administering the medication(s) is to return the medication(s) to the appropriate storage area after a thorough accounting has been done.
- The individual who administered the medication will initial and sign the Medication Administration Record indicating that the student received prescribed medication.

Guidelines for Off Label, Research, and Investigational Medication Administration in the School Setting.

Research or investigational medications are defined by the [U.S. Federal Drug Administration \(FDA\)](#) as medications undergoing formal study, are currently involved in clinical trials, and have not been issued final U.S. Federal Drug Administration (FDA) approval. Off-label

medications are (FDA) approved medications prescribed for non-approved purposes or indications.

According to the [National Association of School Nurses \(NASN\) 2012 Position Statement: Medication Administration in the School Setting](#), school nurses should assess each request for administration of investigational or research medications

Schools may receive requests from parents/guardians and/or health care providers to administer off-label or research medications to students. Schools must develop policies that permit or prohibit the use of an off label or research medications if use is to be permitted, schools policies and procedures are consider the following best practices:

- Requests should be evaluated by a multidisciplinary team and on a case by case basis, including but not limited to: the school nurse, the licensed prescriber, the school physician, and the parent/guardian. If a school policy permits administration of off-label and research medications, it requires a licensed prescriber 's order and parent/guardian consent.
- Schools to consider obtaining a medical opinion from their New Mexico Department of Health Regional Health Officer prior to proceeding.
- Professional standard of nursing practice for both off-label and investigational medications must be used.
- For off-label use medications, the team should have evidence to support the safe use at school.
- For clinical trials, the team should have access to the research protocol. In either case, the team should have documentation to support the safe use of this type of medication for a student who may otherwise have a negative outcome without the use of the substance.

Storage and Handling of Medications in the School Setting

As part of fulfilling the role of guardian (loco parentis) for children entrusted to their care during the school day, schools need to provide for the safe and appropriate storage of all medications.

The following guidelines are to be considered when developing school policy for storage of medications kept at school.

- Routine medications are to be stored in a locked cabinet in a secured area; in a cool, dark place, unless otherwise indicated. Exceptions are emergency medications (Epinephrine, Albuterol, Glucagon, Diastat, Intranasal Midazolam). These emergency medications are to be assessable to other adult educational staff members for quick retrieval during the school day. All medications, including emergency medications are to be stored and locked for security at the end of each school day.

- Controlled substances require special attention in the school district’s policies. FDA, DEA, and NM Board of Pharmacy rules require all controlled substances to be stored in a double locked narcotic system that is equipped with two separate locks and keys.
- For medications that require refrigeration, such as antibiotic solutions, the refrigerator is to be in a secure area, not accessible to unauthorized individuals, with temperature recorded daily when school is in session, temperature to be maintained between 36 and 46 degrees Fahrenheit and kept in a non-food containing refrigeration unit.
- All medications (prescription and over-the-counter) are to be kept in original labeled containers provided by the dispensing pharmacy/provider or the manufacturer.
- Any exceptions to the above guidelines should be noted on the relevant student’s individualized health care plan.

Documentation and Record Keeping for Medication Administration in the School Setting

Documentation of medication administration in the school is to be addressed in written school policy and procedure. Each dose of medication administered or self-administered and witnessed by school staff is to be documented on a Medication Administration Record (MAR) in ink or electronically. The MAR is a permanent health record and is subject to all confidentiality policies and laws and provides legal protection to those who assist with medications at school. It also helps ensure that students receive medications as prescribed and can help reduce medication errors.

Documentation of a medication administration in a MAR is to be done by the person administering the medication. All handwritten MARs are to be corrected by drawing a single line through the error, recording the correct information, then initialing and dating the corrected entry, as with any medical record. If a MAR is contained in the electronic student health record, use strike over to reflect the information in error, then enter correct information that reflects when and by whom the error was corrected.

MARs are to contain the following information:

- Student’s name
- Prescribed medication and dosage
- Schedule for medication administration
- Name(s) and signature(s)/initial(s) or electronic identification of individual(s) authorized and trained to supervise self-administration of medications
- Picture of the student for identification purposes (optional)

Disposal of Medications in the School Setting

Unclaimed medications at school each year pose a potentially huge environmental risk when disposed of improperly. It is feasible to implement an environmentally responsible medication disposal protocol at schools (Taras, 2014). Schools are to establish policy and procedures that address safe disposal of medications to include over the counter, prescription medications to include controlled substances, Hydrofluoralkane (HFA) inhalers, and sharps.

The school policy, procedure, and handbook is to address the following:

- The parent's or guardian's responsibility in being owners of the medication to retrieve any unused doses of medication after treatment cycle ceases, upon transfer or withdrawal from school, and at the end of the school year.
- Written parent or guardian notification is to be sent with specific date to retrieve medication or the medication will be disposed by the school.
- Unclaimed medications are to be disposed of by school nurse in the presence of another school employee by documenting date of disposal, means of disposal, student name, name of medication and amount disposed. Both individuals should sign the documentation.
- Disposal of medications and sharps using best practices environmental considerations should be kept in mind when disposing of unused medications.
- Unused medications should not be released to the student regardless of age, even with parental/guardian consent.

The FDA supports the responsible disposal of medicines and all medicines can be safely disposed of by using medicine take-back programs or using U.S. Drug Enforcement Agency (DEA)-authorized collector programs. When these options are not available; schools can dispose of student medication in the trash using the following steps:

- Scratch out all personal information on the prescription label of the empty medication bottle or empty medicine packaging to make it unreadable.
- Flush medication down toilet if specific disposal instructions on the medication label. If no specific disposal instructions on the medication label, schools are to dispose of medications in regular trash after mixing the medication (do not crush tablets or capsules) with, kitty litter, or used coffee grounds.
- Place the mixture in a container such as a sealed plastic bag or sealed hard container.
- Dispose of the mixture in the regular school trash.
- Dispose of the container.

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Diabetes Emergency Response Plan [Carbohydrate Counting Worksheet](#)

[Emergency Allergy Plan Form](#)

[Federal Drug Agency: Dietary Supplements and Using Dietary Supplements](#)

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[Guide to Helping the Student with DM Succeed](#)

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Helping the Student with Diabetes Succeed Training

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[Level 2 Training](#) - Powerpoint

[Level 3 Training](#) - Powerpoint

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[Medication Self Administration Agreement Form](#)

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New Mexico Regulation & Licensing Department,

Ph (505)476-4500 Toney Anaya Building, 2550 Cerrillos Road, Santa Fe, NM 87505

[The New Mexico Board of Pharmacy](#)

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CHAPTER SEVEN – PROCEDURE GUIDELINES

This Chapter is Under Construction



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CHAPTER EIGHT – EMERGENCY SERVICES/FIRST AID

Guide to Providing Emergency Care

The school nurse is often the first health professional who responds to a school emergency. The school nurse has the education and knowledge to identify emergency situations, manage the scene until emergency medical services (EMS) arrives.

- Assess the situation.
- Is the area safe for YOU? (Remember Infection control/Universal precautions.)
 - Seek needed help if situation is unsafe.
- Assess the student or staff member.
 - Are they conscious or unconscious?
 - Gently tap and ask, “Are you okay?”
- Assess individual to determine if situation is an emergency.
 - Assess airway, breathing, and circulation. Intervene as necessary.
 - Do not give oral fluids
 - Activate 911 if indicated
- Contact responsible school authority and parent/legal guardian

Emergency Procedures for Injury or Illness

- Assess the situation. Be sure the situation is safe to approach. The following dangers will require caution:
 - live electrical wires,
 - gas leaks,
 - building damage,
 - fire or smoke,
 - traffic,
 - violence.
- A responsible adult should stay at the scene and give help until the person designated to handle emergencies arrives.
- Send word to the person designated to handle emergencies of the situation. This person will take charge of the emergency, render any further first aid needed and request additional resources as required.
- DO NOT give medications unless there has been prior approval by the parent or guardian. Follow school district medication policy.
- DO NOT move a severely injured or ill student, staff member or other individual unless necessary for immediate safety. If moving is necessary, follow guidelines for “Neck/Back Injuries” in this section.
- Under no circumstances should a sick or injured student be sent home without the knowledge and permission of the parent/legal guardian.
- In the presence of a life-threatening emergency, call 911 or local Emergency Medical Services (EMS). The responsible school authority or a designated individual should then notify the parent/legal guardian of the emergency as soon as possible to assist in determining the appropriate course of action.

- If the parent/legal guardian cannot be reached, notify a parent or legal guardian substitute and call either the physician or the hospital designated on the school Emergency Information Card to alert the receiving entity to expect the injured student. If necessary, arrange for transportation of the injured student by ambulance/EMS.
- A responsible individual should stay with the injured student.
- Fill out a report for all incidents requiring above procedures as required by school policy and document as required by school policy.

Automatic External Defibrillator (AED) Guidelines

In cardiac arrest cases due to cardiac fibrillation, a combination of early advanced medical care access, early cardiopulmonary resuscitation (CPR) and early defibrillation can save lives. The shorter the time between collapse of the person and defibrillation, the greater the chances of survival for a victim. Response from community emergency teams and school emergency teams can be instrumental in increasing survival rates in cardiac arrest victims through the use of AEDs that have been demonstrated to be safe and effective even when used by lay people. The ideal location of AEDs is typically targeted to public facilities, businesses, meeting areas, buildings or any location where large quantities of people gather.

New Mexico Regulations

The Emergency Medical Services Act [24-10B-4.M NMSA 1978] authorizes the NM Department of Health (NMDOH) to adopt “rules to establish a cardiac arrest targeted response program pursuant to the Cardiac Arrest Response Act. [They](#) include AED Program registration with NMDOH that provides limited immunity protections for persons or entities associated with the Program. These protections are provided when the AED Program is established, registered, and operated in accordance with the NM Administrative Code. Initial registration with NMDOH EMS Bureau is for a period of 4 years at a cost designated in the administrative code. Registration renewal occurs with submission of a new application along with appropriate fee. School districts with multiple schools or schools with multiple AEDs just pay the one fee, and complete only one application. [NMAC 7.27.8](#)

The [Registration Packet](#) include the following requirements:

- An identified AED Program Director who manages the Cardiac Arrest Targeted Response Program. The AED program manager is the person responsible for maintaining the quality checks and documentation on the AED(s) and requisite documentation and who maintains the current roster of all CPR and AED certified personnel on campus. In the school setting, the best person to serve as the AED program director would be the school nurse lead, supervisor, or director.
- Schools who do not have a school nurse must declare a AED program manager(s). This person(s) must be CPR and AED certified. This person will be responsible for maintaining the quality checks and documentation on the AED(s) and requisite

documentation, maintain the current roster of all CPR and AED certified personnel on campus.

- Select individuals to be trained on the use of an AED (Trained Targeted Responders).
- Note- a medical director is no longer required (NM law changed in 2015). Just put N/A in the box on the registration form.

Schools or school districts are to submit written policy on use of their AED, procedures and protocols with the registration application or renewal.

Emergency Response Protocols

The following information should be included when developing emergency response protocols for the school/school district when an AED is available as part of emergency response equipment in the school setting.

School districts should identify an AED program director who is on site at a school district facility.

All front-line trained targeted emergency responders should receive appropriate training in cardiopulmonary resuscitation (CPR) and in the use of AEDs through a recognized course such as American Heart Association or American Red Cross.

When choosing and/or purchasing an AED, the selected model should be approved by the U.S. Drug Administration and have the capability of reporting life-threatening cardiac arrhythmia in read-out format.

Written procedures on appropriate use of the AED should be available and indicate establish the energy setting of each shock to be delivered using the AED as well as when and how CPR and other life-saving measures are used.

School/school district policy should address responsibilities of trained targeted emergency responders, location of AED in school setting and availability of the AED during non-school hours such as school outings, sporting events, etc.

In the event the AED is used; schools or districts are to contact the manufacture of the AED and complete the AED use form contained in the registration packet. Forms are to be submitted to Alyssa.Patterson@state.nm.us.

Allergic Reaction

Students with life-threatening allergies should be known to all staff. An emergency plan should be developed for these students. Children may experience a delayed allergic reaction up to 2 hours following food ingestion, bee sting, etc.

Symptoms of severe allergic reaction include:

Hives all over body

Flushed face

Weakness

Paleness

Seizures

Confusion

Dizziness

Blueness around eyes, mouth

Loss of Consciousness

Drooling or difficulty breathing

Symptoms of mild allergic reaction include:

Red itchy eyes

Itchy, sneezing, runny nose

Several hives, or rash on one part of the body.

For signs and symptoms of severe allergic reaction:

Use student's epinephrine pen, if available.

Use stock epinephrine if available at school.

Always CALL 911 (EMERGENCY MEDICAL SERVICE).

Contact responsible school authority & parent/legal guardian.

If child stops breathing, give rescue breaths.

For signs and symptoms of mild allergic reaction:

Refer to student's emergency plan. Administer guardian-approved medication or use student's epinephrine pen, if available.

If student's epinephrine pen is used, student needs to be transported to ER for further evaluation.

Adult(s) supervising student during normal activities should be aware of the student's exposure and watch for any delayed reaction for up to 2 hours.

If child is unable to participate in school activities, contact appropriate school authority & parent/legal guardian.

Asthma/Wheezing or Difficulty Breathing

Students with a history of breathing difficulties, including asthma/wheezing need to be known to all school staff and need to have an asthma plan in place. These students also need an emergency care plan. A student with asthma/wheezing may have breathing difficulties which include the following.

Rapid breathing

Flaring (widening) of nostrils

Tightness in chest

Blueness of lips, tongue or nail beds

Excessive coughing

Taking a breath in between words when speaking

Wheezing (high-pitched) sound during breathing out

Increased use of stomach and chest muscles during breathing.

If available, refer to student's health/emergency care plan. Follow asthma action plan.

Check pulse oximetry and give oxygen if available and part of student's action plan.

If student has medication as part of their action plan, administer and repeat medication as prescribed.

Encourage the student to sit quietly, breathe slowly and deeply through the nose and out through the mouth.

Encourage the student to sit quietly, breathe slowly and deeply through the nose and out through the mouth.

Is student's condition worsening?

Are the lips, tongue or nail beds turning blue?

Are the symptoms not improving or getting worse?

Did breathing difficulty develop rapidly?

CALL 911 and transport for further care.

Contact responsible school authority & parent/legal guardian.

Behavioral Emergencies

See Chapter 14 Mental Health, Child Abuse and Neglect

Bites Human & Animal

Wear gloves for potential exposure to blood and other body fluids. Wash the bite area with soap & water.

If student is not bleeding, hold bite area under running water for 2-3 minutes.

If student is bleeding, press firmly with a clean dressing.

Check student's tetanus immunization status.

Human and animal bites are treated as lacerations or punctures.

Is bite animal or human?

If it is human:

Contact responsible school authority & parent/legal guardian.

URGE *IMMEDIATE* MEDICAL CARE.

Remember body fluid exposure protection.

Notify parent/legal guardian of student who was bitten and student who was biting that their children may have been exposed to blood from another student.

If it is animal,

Bites from the following animals can carry rabies and may need medical attention:

dog, bat, opossum, cat, bat, raccoon coyote and fox

Report animal bite to proper authorities so that animal can be caught and observed for rabies.

If bite is from snake see "*Poisoning.*"

If bite is from insect see "*Sting.*"

Call Emergency Medical Services if:

Bite is large or gaping

Bleeding is uncontrollable

Report animal bite to proper authorities so that animal can be caught and observed for rabies.

Contact responsible school authority & parent/legal guardian.

Bleeding

Wear gloves for potential exposure to blood or other body fluids.

Is there an amputation?

YES:

CALL EMS

Place detached part in a plastic bag.

Tie bag and put bag in container of ice water.

Send bag to hospital with student.

DO NOT PUT AMPUTATED PART DIRECTLY ON ICE.

Contact responsible school authority & parent/legal guardian.

NO:

Press firmly with clean bandage to stop bleeding.

Elevate bleeding body part gently,

If fracture is suspected, gently support part and elevate.

Do not use a tourniquet.

Is there uncontrolled bleeding, signs of shock or suspect fracture?

- If there are, call EMS
- See “shock” if dizziness, blueness, sweating, clammy skin. fainting occurs.
- Contact responsible school authority & parent/legal guardian.

If wound is gaping:

- Student may need stitches.
- Contact responsible school authority & parent/legal guardian.
- *URGE MEDICAL CARE.*

Establish student’s tetanus immunization status.

Blisters from Friction

Wear disposable gloves for potential exposure to blood and other body fluids.

Wash area with soap and water.

If blister is broken:

Apply clean dressing and bandage to prevent further breakdown of skin integrity

Contact parent/legal guardian

If blister is unbroken:

DO NOT BREAK BLISTER.

Blisters heal best when kept clean and dry.

Bruises

If student comes to school with unexplained, unusual or frequent bruising, consider the possibility of child abuse. See "*Child Abuse/Neglect.*"

Assess closely student who presents with bruises.

If there is swelling or student is in great pain:

Contact responsible school authority & parent/legal guardian (if it is safe to contact parent/legal guardian).

If indicated, responsible school authority decides if report to CYFD is required.

If student isn't in great pain with significant swelling:

Rest injured part.

Apply cold compress or ice bag covered with a cloth or paper towel for half an hour.

If skin is also broken see "*Cuts/Scratches/Scrapes.*"

Burns

Partial Thickness

The partial thickness burn involves the outermost layer and lower layers of skin, and the symptoms include redness, mild swelling, pain, mottling, and blisters. It is frequently caused by sunburn, brief contact with hot objects, steam, chemicals, or hot liquids. It may be wet and oozing. This is often the most painful burn due to still intact nerve endings.

Full Thickness

The full thickness burn is the most serious burn. It extends through all skin layers and can extend into underlying muscles and bones. It may look white or charred. The nerve endings may be destroyed; therefore, little pain may be experienced. This is a medical emergency immediately call 911- EMS.

Burn Treatment

- Make sure the situation is safe before assisting a burn victim.
- What type of burn is it?

HEAT

- Flush burn with large amounts of cool running water or cover it with a clean, wet cloth,
- DO NOT USE ICE.
- CALL EMS IF:
 - Burn is large or deep,
 - Is on face, eye or genitalia,
 - Student is having trouble breathing
 - Student is unconscious

- Bandage loosely
- Check tetanus immunization status.

Electrical Burns

- All electrical burns need medical attention.
- CALL EMERGENCY MEDICAL SERVICES.
- See Electric Shock

Chemical Burns

- Wear gloves and if possible, goggles.
- Remove student's clothing & jewelry if exposed to chemical.
- Rinse chemicals off IMMEDIATELY with large amounts of water.
- CALL NEW MEXICO POISON CONTROL CENTER & ask for instructions.
- Phone 1- 800-222-1222.

Child Abuse/Neglect

See Chapter 14 Mental Health, Child Abuse and Neglect

Chocking

Activate EMS after starting rescue efforts.

Infants One Year Old or Less

For infant one year old or less...if conscious, and able to cough or cry, call EMS, Calm child, monitor for worsening of symptoms. If cough is ineffective, then follow STEPS 1-7.

- 1 Position the infant, with head slightly lower than chest, face down on your arm and support the head (support jaw; do NOT compress throat).
- 2 Give up to 5 back blows with the heel of hand between infant's shoulder blades.
- 3 If object is not coughed up, position infant face up on your forearm with head slightly lower than rest of body.
- 4 With 2 or 3 fingers, give up to 5 chest compressions near center of breastbone, about one finger width below the nipple line.
- 5 Open mouth and look. If foreign object is visible, reach in and get object.
- 6 Tilt head back and lift chin up and out to open the airway. Try to give 2 breaths.
- 7 Repeat steps 1-6 until object is coughed up, infant starts to breathe or infant becomes unconscious.

Children Over One Year of Age & Adult

If individual is conscious, able to cough or cry, call EMS, calm individual, monitor for worsening of symptoms.

If cough is ineffective, then follow STEPS 1-4.

- 1 Stand or kneel behind person with arms encircling the individual.
- 2 Place thumb side of fist against middle of abdomen just above the navel. Do NOT place your hand over the very bottom of the breastbone. Grasp fist with other hand.
- 3 Give up to 5 quick inward and upward thrusts.
- 4 Repeat steps 1-2 until object is coughed up, individual starts to breathe or becomes unconscious.

Obese or Pregnant Person

Stand behind person and place arms under the individual's armpits to encircle the chest. Press with quick backward thrusts. [American Heart Association CPR](#)

Concussions

A concussion is mild traumatic brain injury resulting from traumatic biomechanical forces. Concussion is common in youth participating in sports and is increasingly viewed as a significant public health concern. Typically, the effects of a single concussion are thought to be benign and long-lasting negative effects are not expected. Only 10-25% of concussions involve a loss of consciousness. Best practice recommends that all youth sports organizations build a protocol and assemble a concussion management team in advance to effectively deal with concussion when it happens. Recognition of a concussion and immediate assessment is critical in prevention further injury and for post-concussion management. Research has demonstrated that recovery for the school-age student generally occurs within three weeks from injury. During the recovery phase, the student may have an array of physical, mental, and emotional symptoms, which can affect the student in the school setting, Children diagnosed with concussions require cognitive rest and a graduated re-entry plan to pre-concussion activities. (NASN Position Statement., [Concussions-The Role of the School Nurse](#))

Cuts/Scratches/Scrapes

- Wear disposable gloves for potential exposure to blood or other body fluids.
- If the wound is:
 - Large?
 - Deep?
 - Bleeding freely?
- See "*Bleeding*" section.
- If not, use wet gauze to wash the wound gently with clean water and soap.
- Rinse under running water.
- Pat dry with clean gauze or paper towel.
- Apply clean gauze dressing (non-adhering/non-sticking type for scrapes) and bandage.

Establish student's tetanus immunization status. If 5 years or more since last vaccination recommend booster dose to parent/legal guardian

Contact responsible school authority & parent/legal guardian.

Diabetes

A student with diabetes should be known to all school staff. A history should be obtained and a health plan developed at time of enrollment. See *Diabetes* in “Students with Special Needs” section.

If the student with diabetes is feeling bad they SHOULD ALWAYS BE ACCOMPANIED BY AN ADULT TO THE HEALTH ROOM.

Assess the student with diabetes for the following symptoms:

- Irritability/feeling upset,
- Seizure
- Cramping
- Change in personality
- Confusion
- Listlessness
- Sweating/feeling shaky
- Dizziness
- Loss of consciousness
- Paleness
- Rapid, deep breathing
- Rapid pulse
- If the student is:
 - Unconscious or
 - Having a seizure (See “Seizure”) or
 - Unable to speak
- CALL EMERGENCY MEDICAL SERVICES.

If the student is not having the above signs:

- If available, follow student’s health or emergency plan.
- If blood sugar monitor is available,
- If the blood sugar is less than 60 or “LOW” according to individual care plan:
 - Give student SUGAR such as:
 - Fruit juice or soda pop (not diet) 6-8 ounces
 - Hard candy (6-7 lifesavers or 1/2 candy bar)
 - Sugar (2 packets or 2 teaspoons)
 - Cake decorating gel (1/2 tube) or icing
 - Instant glucose, such as glucagon.
 - The student should begin to improve in 10 minutes.
 - Continue to observe student in quiet place.
- If the blood sugar is “HIGH” according to individual care plan:
 - CALL EMERGENCY MEDICAL SERVICES.

If no blood sugar monitor is available:

- Give student SUGAR such as:
 - Fruit juice or soda pop (not diet) 6-8 ounces
 - Hard candy (6-7 lifesavers or 1/2 candy bar)
 - Sugar (2 packets or 2 teaspoons)
 - Cake decorating gel (1/2 tube) or icing

- Instant glucose.
- The student should begin to improve in 10 minutes.
- Continue to observe student in quiet place.
- Contact responsible school authority & parent/legal guardian.

Diarrhea

Wear disposable gloves for potential exposure to blood or other body fluids. Consider use of disposable gowns also, especially if norovirus is a possible cause. Use good hand-washing technique.

A student may present because of repeated diarrhea or after an “accident” resulting in soiled clothing.

Contact responsible school authority & parent/legal guardian and URGE MEDICAL CARE if:

- Student has repeated diarrhea (3 or more times).
- Blood is present in stool.
- Student is dizzy and pale.
- Student has severe stomach pain.
- If the student’s clothing is soiled, wear disposable gloves while assisting with clothing change and double-bag soiled clothing if it is to be sent home with the student.

Ears

An earache may be caused by an infection of the middle ear. A student may be irritable and experience pain, dizziness, hearing loss, ringing or fullness in the ears, fever, headache, runny nose, and drainage from ears.

Drainage from Ear

- Do NOT try to clean out drainage from ear canal.
- Contact responsible school authority & parent/ legal guardian.
- URGE MEDICAL CARE.

Earache

- A warm water bottle or heating pad (NOT HOT) against the ear can give comfort to the student with an earache.
- Contact responsible school authority & parent/ legal guardian.
- URGE MEDICAL CARE.

Object In Ear Canal

- DO NOT ATTEMPT TO REMOVE ANY OBJECT IN THE EAR CANAL.
- Contact responsible school authority & parent/ legal guardian.
- URGE MEDICAL CARE.

Electric Shock

For unresponsive victim, if no one else is available to call EMS, perform CPR first for one minute and then call EMS.

If individual is receiving an electrical shock:

- TURN OFF POWER SOURCE, IF POSSIBLE.
- DO NOT TOUCH PERSON UNTIL POWER SOURCE IS SHUT OFF.

- Once power is off and situation is safe, approach individual and ask, “Are you okay?”
- If student is unconscious or unresponsive:
- CALL EMS.
- Check breathing. Look, listen & feel for breath. If individual is not breathing, give rescue breath.
- Check pulse by placing fingers on side of individual’s neck.
- If individual has no pulse, start chest compressions.
- Contact responsible school authority & parent/ legal guardian.
- Activate 911 and transport.

If student is conscious and responsive:

- Treat any burns. See “Burns.”
- Contact responsible school authority & parent/ legal guardian.
- URGE MEDICAL CARE.

Eyes

With any eye problem if student wears contact lenses, have him/her remove contacts before giving any first-aid to eye.

Eye Injury

Keep student lying flat and quiet with any eye injury.

- Is injury severe?
- Is there a change in vision?
- Has object penetrated eye?
- If object has penetrated the eye, DO NOT REMOVE OBJECT. (DO NOT FLUSH)
- Cover injured eye with a paper cup or similar object to keep student from rubbing it.
- DO NOT TOUCH INJURED EYE OR PUT ANY PRESSURE ON IT.
(Uninjured eye may also be covered.)
- CALL EMERGENCY MEDICAL SERVICES.
- Contact responsible school authority & parent/legal guardian

- If injury is not severe or penetrating:
- Contact responsible school authority & parent/ legal guardian.
- ARRANGE FOR IMMEDIATE MEDICAL CARE

Particle in Eye

Keep student from rubbing eye if particle in the eye is suspected

- Have student lie down and tip head toward affected side.
- Gently pour tap water over the open eye to flush out the particle.
- If particle does not flush out of eye or if eye pain continues, contact responsible school authority and parent/ legal guardian.

Chemical in Eye

- Wear gloves and, if available, goggles.
- Immediately flush the eye with large amounts of clean water for 20-30 minutes.
- Let the water run over the eye with head tipped so water washes eye from nose out to side of face.

- CONTACT POISON CONTROL CENTER @ 1-800-222-1222 while eye is being flushed. Follow their instructions.
- If eye has been burned by chemicals, CALL EMERGENCY MEDICAL SERVICES.
- Contact responsible school authority and parent/legal guardian.

Fainting

Fainting may have many causes including but not limited to: injuries, blood loss, poisoning, severe allergic reaction, diabetic reaction, illness, heat exhaustion, fatigue, stress, not eating, standing “at attention” for too long, etc. If the cause of the fainting is known, see the appropriate guideline.

Most students who faint will recover quickly when lying down. If student does not regain consciousness immediately, see “Unconsciousness.”

Is fainting due to injury or did the student injure self when he/she fainted?

Treat as possible head or neck injury. See “Neck & Back Injuries.”

DO NOT MOVE STUDENT.

CALL EMERGENCY MEDICAL SERVICES.

Contact responsible school authority and parent/legal guardian.

If no injury is involved:

- Keep student in flat position.
- Elevate feet.
- Loosen clothing around neck and waist.
- Do not use smelling salts.
- Keep airway clear.
- Monitor breathing. Look, listen and feel for breath.
- Keep student warm but not hot.
- Control any bleeding. (Always wear gloves.)
- Give nothing by mouth.
- When student feels better and there is no danger of neck injury, she/he may be moved to a quiet, private area.
- Contact responsible school authority and parent/legal guardian.

Fever

A fever is a symptom and not an illness in itself. The body’s average temperature can vary during the day, between 97.6°F to 99.5°F. Mild elevations between 100.4°F to 101.2° F can be the result of exercise, excess clothing, a hot environment and/or infection. Oral temperatures can be elevated by hot food or drink.

- With suspected fever take student’s temperature, if possible. Assess temperature over 100.5° F as fever.
- Have student lie down in a room which affords privacy. Loosen clothing, apply damp cloth/cold pack, use fan to cool student.

- Note other signs/symptoms, such as: drowsiness, headache, nausea/vomiting, respiratory symptoms, stiff neck, rash, irritability, ear pain, pain with urination, and pallor (pale skin color).
- If it is suspected that the temperature elevation is due to exercise, excess clothing, hot environment, or warm food give fluids and take the temperature again in half an hour after removing the suspected cause. See “*Heat Stroke.*”
- Give no medication unless authorized by parent/legal guardian consent.
- Contact responsible school authority and parent/legal guardian.

Fractures/Dislocations/Sprains/Strains

Fractures are broken or cracked bones. Closed fractures have no visible open wound. In open fractures the bone may be visible and may protrude through the skin. Signs and symptoms may include an audible snap at the time of injury, a grating sensation, a crooked bone, pain, tenderness, swelling and bruising, and an inability to move the injured part.

Dislocations

Dislocation occurs when the bones at a joint are out of normal alignment due to an injury to the ligaments that hold them in place. Signs/symptoms include difficulty and pain when moving the joint, swelling, deformity, and discoloration at the affected joint.

Sprains or Strains

Sprains occur when ligaments and tendons around a joint are stretched or partially torn. Sprains are usually caused by a twisting injury. Signs/symptoms include tenderness to touch, swelling and discoloration.

- Treat all injured parts as if there might be a fracture.
- Injury symptoms might include:
 - Pain in one area
 - Swelling
 - Heat sensation in injured area
 - Discoloration
 - Limited movement
 - Bent or deformed bone.

Do not allow student to put weight on or try to use the injured part.

- Support and elevate injured part gently, if possible.
- Apply ice to minimize swelling.

Call EMS if

- Bone is deformed or bent in an unusual way.
- Skin is broken over possible fracture.
- Bone is sticking through skin.
- Gently cover broken skin with a clean bandage.
- Don't move the injured part.
- Contact responsible school authority and parent/legal guardian.
- URGE MEDICAL CARE.

Frostbite

Frostbite can result in the same type of tissue damage as a burn. It is a serious condition and requires medical attention. The nose, ears, chin, cheeks, fingers and toes are the parts most often affected by frostbite.

Frostbitten skin may:

- Look discolored (flushed, grayish-yellow, pale, white).
- Feel cold to the touch.
- Feel numb to the child.
- Deeply frostbitten skin may:
 - Look white or waxy.
 - Feel firm/hard (frozen).
- Exposure to cold even for short periods of time may cause hypothermia in children. (See "Hypothermia".)
- Take individual suspected of frostbite to a warm place.
- Remove cold or wet clothing and provide warm, dry clothes.
- Protect cold part from further injury.
- Do NOT rub or massage the cold part.
- Do not apply heat such as a water bottle or hot running water.
- Cover part loosely with non-stick, sterile dressings or dry blanket.
- Support and elevate injured part gently, if possible
- Keep individual and affected area warm.
- If affected area:
 - Looks discolored – grayish, white or waxy,
 - Feels firm-hard (frozen),
 - Has a loss of sensation?
- CALL EMERGENCY MEDICAL SERVICES.
- Contact responsible school authority and parent/legal guardian.
- URGE MEDICAL CARE.

Headache

- Headaches should be evaluated as the possible result of trauma, especially in children and adolescents.
- If a head injury has occurred, see "*Head Injury.*"

If the headache is severe:

- Are there other symptoms such as vomiting, fever, blurred vision dizziness present?
- Is there confusion, behavioral changes, disorientation?

CALL EMERGENCY MEDICAL SERVICES.

Notify responsible school authority and contact parent/legal guardian.

- If headache is not severe:
 - Have individual lie down for a short time in a private place.
 - Apply a cold cloth or compress to the individual's head.
 - Assess individual's last intake of food.
 - Give no medication unless authorized by parental/legal guardian.
 - Contact parent/legal guardian if headache persists or is recurrent.

Head Injuries

Head wounds may bleed easily and form large bumps. Head injuries from falls, sports and violence may be serious. With a head injury, always suspect neck injury as well. Do NOT move or twist the spine or neck. See "*Neck/Back Injuries.*"

- Have student rest, lying flat.
- Keep student quiet & warm.

If student is vomiting:

- Keeping head and neck in a straight line with the trunk, turn the head and body together to one side.

- CALL EMERGENCY MEDICAL SERVICES
- Monitor breathing. Look, listen and feel for breath. If student stops breathing, give rescue breaths.
- Give nothing by mouth.
- Contact responsible school authority & parent/ legal guardian.

If student is not vomiting, assess for other symptoms and call emergency services if present

- Unconscious
- Seizure
- Neck Pain
- Student unable to respond to simple commands
- Blood or watery fluid in the ears
- Student unable to move or feel arms or legs
- Blood flowing freely from the head
- Student sleepy or confused.
- Even if student is only briefly confused and seems fully recovered, contact responsible school authority & parent/legal guardian. *URGE MEDICAL CARE.* Observe for delayed symptoms.

Heat Stress

Heat stroke may occur as result of untreated heat exhaustion. During strenuous physical activity, the heat regulation mechanism of the brain may stop functioning. The person stops sweating and the skin becomes very red and hot.

This is an immediate and life-threatening emergency.

Strenuous activity in heat may cause heat-related illness. Symptoms may include the following.

- Red, hot, dry skin
- Profuse sweating
- Weakness and fatigue
- Headache
- Cool, clammy hands
- Nausea
- Loss of consciousness
- Cramping
- Normal or below normal temperature.
- Move student from heat to a cooler place, remove outer clothing. Have student lie down, use cool cloths to head/neck/groin, elevate legs, fan to cool student.

If student has loss of consciousness or hot, dry, red skin:

- cool rapidly by completely wetting clothing with room temperature water.
- DO NOT USE ICE WATER.
- CALL EMERGENCY MEDICAL SERVICES.

- Contact responsible school authority & parent/legal guardian.

If still conscious and skin is not hot, dry and red:

Give clear fluids such as water frequently in small amounts.

Contact responsible school authority & parent/ legal guardian.

Hypothermia (Exposure to Cold)

Hypothermia happens after exposure to cold when the body is no longer capable of warming itself. Young children are particularly susceptible to hypothermia. It can be a life-threatening condition if left untreated. Hypothermia can occur after an individual has been in cold air or cold water. Symptoms may include the following.

- Confusion
- Weakness
- Blurry vision
- Slurred Speech
- Shivering
- White or grayish skin color
- Sleeplessness
- Impaired judgment.
- Take individual to a warm place.
- Remove cold/wet clothing and wrap in a warm, dry blanket.

If individual has any of the following:

- Loss of consciousness
- Slowed breathing
- Confused or slurred speech
- White, grayish/blue skin (see Frostbite)

CALL EMS and

- Give nothing by mouth.
- Continue to warm individual with blankets.
- If individual is sleepy or losing consciousness, place him/her on side to protect airway.
- Look, listen and feel for breathing. If no indication of breathing start CPR.
- Contact responsible school authority & parent/legal guardian.

If none of the above signs are present:

- Continue to warm individual with blankets.
- If he/she is awake and alert, offer warm (NOT HOT) fluids but NO food.
- URGE MEDICAL CARE.

Menstrual Difficulties

Mild cramps, recommend regular activities.

Severe cramps, A short period of quiet rest with a warm (NOT HOT) pad over the lower abdomen will help provide relief. See “*Stomach Aches/Pain.*”

Give no medications unless previously authorized by parent/legal guardian.

URGE MEDICAL CARE if patient has fever (above 101.0°), disabling cramps, or heavy bleeding occurs. Contact responsible school authority & parent/ legal guardian.

Mouth or Jaw Injuries

See *“Head Injuries”* if a head injury other than mouth or jaw is suspected

Assess mouth/jaw injury for breathing difficulty.

If airway is not clear:

- Start CPR.
- CALL EMS.
- Contact responsible school authority & parent/ legal guardian.
- If teeth have been injured, see *“Teeth.”*

Jaw is injured,

- DO NOT TRY TO MOVE JAW.
- Gently support jaw with hand.
- Contact responsible school authority & parent/ legal guardian.
- URGE IMMEDIATE MEDICAL CARE.
- If tongue, lips, or cheek are bleeding, apply direct pressure with sterile gauze or clean cloth.
- Place a cold compress over the area to minimize swelling.

If cut is large or deep, or if bleeding cannot be stopped, contact responsible school authority & parent/ legal guardian.

URGE MEDICAL OR DENTAL CARE.

Neck/Back Injuries

A stiff or sore neck from sleeping in a *“funny”* position is different than neck pain from a sudden injury. Non-injured stiff necks may be uncomfortable, but they are not emergencies.

If student is so uncomfortable that he/she is unable to participate in normal school activities, contact responsible school authority & parent/legal guardian.

If student walked in:

- Have student lie down on his/her back.
- Support head by holding it in a *“face forward”* position.
- TRY NOT TO MOVE NECK OR HEAD.

If student was found lying down:

- Do not move student.
- Keep student quiet and warm.
- Place rolled up towels/clothing on both sides of head so it will not move.
- CALL EMERGENCY MEDICAL SERVICES.
- Contact responsible school authority & parent/legal guardian.

Nose

Nosebleed

A nosebleed may be caused by colds, allergies, chronic illness, injuries to the nose, medications, high altitudes, blowing the nose, foreign bodies in the nose, and low humidity. Nosebleeds are rarely serious and usually can be controlled.

- When individual presents with nosebleed wear gloves for protection from exposure to blood or other body fluids.
- Place student sitting comfortably with head slightly forward or lying on side with head raised on pillow.
- Encourage mouth breathing and discourage nose blowing, repeated wiping or rubbing. If blood is free flowing, provide constant uninterrupted pressure by pressing nostrils firmly together for about 10 minutes. If bleeding continues, repeat pressure an additional 10 minutes, applying ice to nose
- If blood is still flowing freely after applying pressure and ice, contact responsible school authority & parent/legal guardian.

Object in Nose

- When a student or staff presents with object lodged in nasal passage:
- Attempt to remove object without use of force.
- If unable to easily remove object, contact responsible school authority & parent/legal guardian.
- URGE MEDICAL CARE.

Poisoning/Overdose

Poisons can be swallowed, inhaled, absorbed through the skin or eyes, or injected. Call Poison Control when poisoning is suspected from the following.

- Medicines
- Insect Bites & Stings
- Snake Bites
- Plants
- Chemicals/Cleaners
- Drugs/Alcohol
- Food Poisoning
- Unknown Substance

Be aware of your own safety when responding to potential poisoning.

Warning signs of possible poisoning include the following.

- Pills, berries or unknown substance in student's mouth
- Burns around mouth or on skin
- Strange odor on breath
- Sweating
- Upset stomach or vomiting
- Dizziness or fainting
- Seizures or convulsions
- Unconsciousness
- Unusual behavior.

In assessing potential poisonings obtain the following information.

- Age and weight of student
- Type of poison in question
- When poisoning occurred
- Amount of poison ingested

CALL POISON CONTROL CENTER @ 1-800-222-1222 & ask for instructions.

Do NOT induce vomiting UNLESS instructed to do so by Poison Control.

CALL EMERGENCY MEDICAL SERVICES:

If student is:

- Unconscious,
- In shock,
- Requires CPR,
- If directed to do so by the Poison Control Center.

Contact responsible school authority & parent/legal guardian.

Send sample of any vomited material or ingested material with its container (if available) with EMS crew.

Pregnancy

Keep in mind that any student who is old enough to be pregnant might be pregnant.

Pregnancy may be complicated by any of the following.

- Morning Sickness:
 - Treat as vomiting. See “Vomiting.”
 - If severe, contact responsible school authority & parent/legal guardian.
- Severe Cramps (Labor):
 - Short, mild cramps in a near term student may be normal.
 - If NOT near term or if due date unknown, contact responsible school authority & parent/legal guardian.
- Vaginal Bleeding
 - This should be considered abnormal and requires further evaluation.

Seizure: See “Seizure” and contact responsible school authority & parent/legal guardian.

Amniotic Fluid Leakage:

This is *NOT* normal and may indicate the beginning of labor.

Contact responsible school authority & parent/legal guardian.

Puncture Wounds

A puncture wound is caused when a pointed object such as splinters, a nail, pencil, piece of glass, or knife pierces the skin. Puncture wounds do not bleed a lot, so there is greater concern for the risk of infection associated with them.

Wear gloves for potential exposure to blood or other body fluids.

If eye has been wounded, see “Eyes.”

- DO NOT TOUCH EYE.

If object is still in wound?

- DO NOT PROBE OR SQUEEZE WOUND.
- DO NOT REMOVE OBJECT.
- Wrap bulky dressing around wound to protect it.
- Offer calming support as needed.

Wash wound gently with soap and water.

Make sure nothing was left in the wound.

Cover with a clean bandage.

If wound is deep or bleeding freely, treat as bleeding. See “Bleeding.”

Establish student’s tetanus immunization status.

CALL EMS if:

If object is large,

Wound is deep,

Wound is bleeding freely or squirting blood.

Contact responsible school authority & parent/legal guardian.

Rashes

Rashes have multiple causes, including heat, infection, illness, reaction to medications, allergic reactions, insect bites, dry skin or skin irritations. Some rashes may be contagious (*pass from one person to another*). Wear gloves for self-protection when in contact with any rash.

Rashes include the following.

Hives

Red spots (large or small)

Purple spots

Small blisters.

CALL EMERGENCY MEDICAL SERVICES if the student has any of the following:

Loss of consciousness

Difficulty breathing or swallowing

Purple spots.

Contact responsible school authority & parent/legal guardian.

If following symptoms are present, see “*Allergic Reaction.*”

- Headache
- Fever (See “*Fever*”)
- Diarrhea
- Sore throat
- Vomiting
- Bright red rash sore to touch
- Rash (hives) all over body
- Discomfort (e.g. itchy, sore, feels ill) preventing participation in school activities.
- Contact responsible school authority & parent/legal guardian.

Seizures

Seizures (or convulsions) have multiple causes including epilepsy, fever, overdose of poisons, street drugs or alcohol, and head injury. During a convulsive seizure, the individual becomes unconscious and may fall. The eyes may roll back or they may stare. The body becomes stiff and arms and/or legs jerk. The individual may lose bladder control. *(Note that seizures occur in less dramatic forms such as staring spells or partial seizures in which the person seems confused or one extremity may jerk. These are usually not medical emergencies.)*

Any student with a history of seizures should be known to all teachers. A detailed description of the onset, type, duration, and after-effects of previous seizures should be kept available at all times. If available, refer to student’s health or emergency care plan.

If student seems off balance, place him/her on the floor (on a mat) for observation & safety.

- **DO NOT RESTRAIN MOVEMENTS.**
- Move surrounding objects to avoid injury.
- **DO NOT PLACE ANYTHING BETWEEN TEETH** or give anything by mouth.

Observe details of the seizure for parent/legal guardian, emergency personnel or physician that includes the following:

- Duration of seizure
- Kind of movement or behavior
- Body parts involved
- Loss of consciousness

Is student having a seizure:

- Lasting longer than 5 minutes?
- One after another with short intervals?
- With *no known history* of seizures?
- CALL EMS
- Contact responsible school authority & parent/legal guardian.

- After seizure keep airway clear by placing student on his/her side.

- Do not elevate head.
- Seizures are often followed by sleep.
- Student may also be confused for up to an hour or more.
- After sleeping, student should be encouraged to participate in normal class activities.
- Contact responsible school authority & parent/legal guardian.

Splinters

Wear gloves for potential exposure to blood or other body fluids.

Gently wash area with clean water and soap.

If splinter is:

- Protruding above the surface of the skin?
- Small?
- Shallow?
- Remove with tweezers.
- DO NOT PROBE UNDER SKIN.
- Rewash and apply clean dressing.

If splinter is not protruding above the skin:

- Leave in place.
- DO NOT PROBE UNDER SKIN.
- Contact responsible school authority & parent/legal guardian.
- *URGE MEDICAL CARE*
- Establish student's tetanus immunization status.

Shock

Shock occurs when vital tissues of the body do not receive enough blood; it can occur because of severe injuries resulting in blood loss, burns, or fractures. When shock occurs, the blood pressure drops below what is needed to get blood to the brain and other organs. Shock can also occur from minor injuries in which case the body is so stunned by the injury that it goes into shock. This condition can also occur when someone experiences an emotional trauma which develops into emotional shock. It is important to know that fainting is very similar to shock; however, one recovers from fainting quickly.

Wear gloves for potential exposure to blood or other body fluids.

Symptoms of shock can include any of the following.

- Cold and clammy skin
- Pale skin color
- Nausea
- Dizziness
- Weakness
- Sweating

- Fast, but weak, pulse
- Fast breathing

If any of the above symptoms are these associated with obvious injury, bleeding or trauma:

CALL EMERGENCY MEDICAL SERVICES.

Contact responsible school authority & parental/legal guardian.

If no association with obvious injury, bleeding or trauma:

Refer to student's health care plan to determine if the student has severe, life-threatening allergies.

Have student lie down and raise legs 8-10 inches above level of heart. However, if injury to neck, spine or leg/hip bones is suspected student should remain lying flat.

Determine if other injuries have occurred and treat accordingly.

Cover student with sheet or blanket.

Do not give anything to eat or drink.

Remain with student and provide reassurance.

Contact responsible school authority & parent/legal guardian.

Urge medical care.

Stings

Students with a history of allergy to stings should be known to all school staff. An emergency care plan should be available.

Does student have the following?

- Difficulty breathing
- A rapidly expanding area of swelling, especially of the lips, mouth or tongue
- A history of allergy to stings.

If available, follow student's emergency care plan.

CALL EMERGENCY MEDICAL SERVICES.

Contact responsible school authority & parental/legal guardian.

Adult(s) supervising student during normal activities should be aware of the sting and should watch for any delayed reaction. A student may have a delayed allergic reaction up to 2 hours after a sting.

To remove stinger (if present) scrape area with a card. **DO NOT SQUEEZE.** Apply cold compress. See *"Allergic Reaction."*

Stomach Aches/Pain

Stomach aches can have many causes including the following:

Injury

Menstrual cramps

Appendicitis

Pregnancy (tubal)

Bladder Infection

Illness

Overeating

Diarrhea

Food Poisoning

Hunger

Constipation

Gas Pain

Assist student to lie down in a room that affords privacy.

If an injury occurred:

- Assess student for severe pain, signs of shock, unconsciousness.
- CALL EMERGENCY MEDICAL SERVICES.
- Contact responsible school authority & parent/legal guardian.

If there is no injury:

- Take the student's temperature. Assess temperature of 100.5 F or higher as fever. See "*Fever.*"

Does student have fever with severe stomach pains?

- CALL EMERGENCY MEDICAL SERVICES.
- Contact responsible school authority & parent/legal guardian.

If stomach ache persists or becomes worse, contact responsible school authority & parent/legal guardian.

See: "*Pregnancy,*" "*Vomiting,*" "*Fever,*" "*Menstrual Difficulties,*" "*Shock.*"

When student feels better, allow him/her to return to class.

Teeth

Bleeding Gums

Generally related to chronic infection.

This condition can be a direct threat to the student's general health, not just local tooth problems.

No first aid in the school will be of significant value.

URGE PARENT/LEGAL GUARDIAN TO OBTAIN DENTAL CARE.

TOOTHACHE

This condition can be a direct threat to the student's general health, not just local tooth problems.

No first aid measure in the school will be of any significant value. Relief of pain at school often postpones dental care.

DO NOT PLACE ASPIRIN ON GUM TISSUE OF ACHING TOOTH. ASPIRIN CAN BURN TISSUE!

Contact responsible school authority and parent/legal guardian. **URGE DENTAL CARE.**

BROKEN OR DISPLACED TOOTH

If tooth is broken

- Save tooth or tooth fragments in a cup of warm water.
- Apply cold compress to face to minimize swelling.
- Contact responsible school authority and parent/legal guardian to
- **SEEK DENTAL CARE IMMEDIATELY. TIME IS CRITICAL!**

If tooth is displaced:

- *Do NOT try to move tooth into correct position.*
- Contact responsible school authority & parent/legal guardian.
- OBTAIN EMERGENCY DENTAL CARE.

Knocked-out Tooth

- Find tooth.
- Do *NOT* handle tooth by the root.
- If tooth is dirty, clean gently by rinsing with water.
- **DO NOT SCRUB THE KNOCKED-OUT TOOTH.**
- If permanent tooth place gently back in socket and have student hold it in place
Or place in glass of milk.
- TAKE STUDENT AND TOOTH TO DENTIST IMMEDIATELY. TIME IS CRITICAL!
- Contact school authority & parent/legal guardian.

ALL TOOTH TRAUMA SHOULD BE EVALUATED BY A DENTIST WITHIN 60 MINUTES!

For tongue, cheek, lip, jaw, or other mouth injury not involving the teeth, See *"Mouth/Jaw Injuries."*

Unconsciousness

If student stops breathing and no one else is available to call EMS, perform rescue breathing first for one minute and then call EMS.

Unconsciousness may have many causes including:

- injuries,
- blood loss,
- poisoning,
- severe allergic reaction,
- diabetic reaction,
- heat exhaustion,
- illness,
- fatigue,
- stress,
- not eating.

If cause of unconsciousness is known, see the appropriate guideline.

Did student regain consciousness immediately?

- See “*Fainting.*”

Is unconsciousness due to injury?

- Treat as possible neck or head injury.
- See “*Neck/Back Injuries*” and “*Head Injuries.*”
- DO NOT MOVE STUDENT.

If no injury is suspected:

- Keep student in flat position.
- Elevate feet.
- Loosen clothing around neck and waist.
- Do not use smelling salts

For all causes of unconsciousness:

- Keep airway clear.
- Monitor breathing. Look, listen and feel for breath.
- Keep student warm but not hot.
- Control bleeding (always wear gloves).
- Give nothing by mouth.

If student is not breathing begin rescue breathing.

CALL EMS

Contact responsible school authority & parent/legal guardian.

Vomiting

If a number of students or staff become ill with the same symptoms suspect food poisoning.

- CALL POISON CONTROL CENTER @ 1-800-222-1222 and ask for instructions.
- See “Poisoning.”
- Notify Public Health officials.

Vomiting can have many causes including the following.

- Illness
- Heat exhaustion
- Over exertion
- Injury
- Food poisoning
- Pregnancy

If cause of vomiting is known, see the appropriate guideline.

Wear gloves for potential exposure to blood and other body fluids.

Care of student:

- Assist student to lie down on his/her side in a room which affords privacy.
- Apply cool, damp cloth to student’s face or forehead.
- Have an emesis container available.
- Give no food or medications.
- Give small sips of clear fluids containing sugar (such as 7-Up or Gatorade) if the student is thirsty.

Contact responsible school authority & parent/legal guardian.

URGE MEDICAL CARE.

Student Emergency Medical Authorization Form

It is highly recommended that all information on the form be included on any emergency medical form used by a school district

The transportation of ill students is a liability concern of school district administrators. Without parental direction on treatment options school personnel become uncertain about how to address potential emergency health care needs. The purpose of the emergency medical authorization form is to establish prior parental authorization for the transport and treatment of a student in a medical emergency when the parent(s)/guardian(s) cannot be reached.

Any emergency medical authorization forms must be renewed annually.

Each student who comes on campus for any school activity as well as students who take part in school-sponsored activities off campus should have an emergency medical authorization form on file with the school of his/her grade level. Emergency authorization form requirements for home-schooled students and technology-based students engaged in

distance learning curriculums should be the same as for campus-based students. Ideally forms include authorization for school nurse to contact student's providers regarding student's health care. The form also needs to give permission for screenings to be done.

Form Criteria

- Statement of Purpose: This statement enables parents/guardians to authorize emergency treatment for their children while under school authority when a parent/guardian cannot be reached.
- Statement of Use: This statement makes a copy of the original form acceptable when identifying medical options listed by the parent/guardian for student emergency treatment.
- Demographic Information:
- Student Insurance Information:
- Grant Consent Information: This section must contain the following information.
- Statement authorizing transportation of the referenced child to a medical facility.
- Statement authorizing a specified doctor, dentist, nurse practitioner/physician assistant and/or hospital to give any reasonable and customary medical/health care deemed necessary for the referenced child.
- Statement releasing liability of any school official or employee who, in good faith, attempts to comply with this request.
- Parent/guardian signature and date.
- Statement that parent/guardian is financially responsible for all emergency care administered to the referenced child.
- Student Medical History: This section of the form must contain a minimum of all items listed on the PED-approved form. Even though a separate immunization record may be kept on the student, it along with the medical history should accompany the student on any medical emergency transportation.

References and Resources

[Emergency Algorithms](#)

[Emergency Medical Authorization Forms](#)

[Emergency Medical Authorization Forms- Spanish](#)

NASN Position Statement., [Concussions-The Role of the School Nurse](#)) posted
03-13-2017

New Mexico Administrative Code. [NMAC 7.27.8](#) Emergency Medical Services, Cardiac
Arrest

New Mexico Administrative Code 7.27.2 Scope of practice for EMS personnel in New
Mexico, [NMAC 7.27.2](#)

[National Association of School Nurse Position statement on school nurse role in
Emergency preparedness](#) <http://www.nasn.org/Default.aspx?tabid=194>

[National Association of School Nurse Position statement on school nurse role in
Preparing for school emergencies](#)
<http://www.nasn.org/Default.aspx?tabid=238>.

[National Center for Early Defibrillation](#), <http://www.safeathletes.org/earlydefibrillation.html>

Targeted Response Program. Virtual School Nurse and Emergency Medical Services
Learning Project (VSNEMS),
UNM. Health Services Center, Division of Pediatric Emergency Medicine.
Interactive online instruction.
[https://emed.unm.edu/pem/programs/pediatric-emergencies-
course/index.html](https://emed.unm.edu/pem/programs/pediatric-emergencies-course/index.html) and [https://emed.unm.edu/pem/programs/school-nurse-
program/index.html](https://emed.unm.edu/pem/programs/school-nurse-program/index.html)

CHAPTER NINE – IMMUNIZATION

New Mexico Immunization Law

[New Mexico \(NM\) Immunization Law](#) requires that all students be immunized against certain vaccine preventable communicable diseases. These requirements are determined by the NM Department of Health (NMDOH) in collaboration with the New Mexico Vaccine Advisory Committee (VAC) using recommendations from the national Advisory Committee on Immunization Practices (ACIP). The State's [NM Childcare/Pre-School/School Entry Immunization Requirements](#) are released annually.

In the school setting, the school nurse is best qualified to determine which students are missing required vaccinations and subsequently notifies parents/guardians. The NM Immunization Program surveys immunization records twice a year. The first survey is a self-reporting survey submitted by all Public, Private and Charter Schools in New Mexico. This survey is reported to the New Mexico Immunization Program by November first of each year. The second survey is a cohort of school districts identified through a random selection process by the Centers for Disease Control and Prevention (CDC) each year. Each selected school is notified of its survey status early in the school year to provide adequate time to establish survey dates with selected sites.

Immunization Assessment

- For the student who up to date in accordance with the current [NM Childcare/Pre-School/School Entry Immunization Requirements](#) schedule, that student meets New Mexico immunization standards and may enroll in and attend school.

- For the student who has no immunization record but was formerly enrolled in a school in the United States, a formal request for immunization records must be made by the school nurse to the previous school attended. The student should not be enrolled until the records are received. If the student is up to date, according to [NM Childcare/Pre-School/School Entry Immunization Requirements](#), the student may be enrolled. If the student was formerly enrolled in a school in another country and has no record or any contact information to acquire records, initiation of required immunizations must begin immediately for the student to be enrolled in any Public, Private or Charter School in New Mexico. The only exception to this rule is if the child is certified as homeless or if the child's parent or guardian is active military. If either of these exceptions exist the student may be enrolled.

- Students, whose immunizations are not up-to-date but who have received all immunizations currently permissible by medical practice, are considered in process and they may be enrolled.

- For the student who is attempting to reach compliance but is behind on a vaccination series, s/he is no longer considered in process. The [CDC Catch-up Immunization Schedule](#) should be used to help assess what the student needs to become compliant. If the student is currently enrolled, disenrollment proceedings should be initiated immediately. When any student is kept out of school longer than five consecutive days for noncompliance, the school nurse must notify the local Regional Health Officer (RHO) for NMDOH. [Immunization Requirements](#)

- Children who are younger than five years of age and who attend childcare or early childhood development programs must comply with the [NM Childcare/Pre-School/School Entry Immunization Requirements](#).

- For immunization questions, some resources available are:
 - CDC’s Epidemiology and Prevention of Vaccine-Preventable Diseases – [The Pink Book](#)
 - NMDOH’s [Immunization – Rules, Regulations & Protocols](#)
 - The School Health Advocate (SHA) assigned to your respective Public Health Region
 - The local Public Health Office for your County

New Mexico Administrative Codes

Title 7	Health
Chapter 5	Vaccinations and Immunizations
Part 2	Immunization Requirements
Title 6	Primary & Secondary Education
Chapter 12	Public School Administration – Health and Safety
Part 2	Health Services– Immunizations of School Children

Exemptions From immunizations

Title 7	Health
Chapters 5	Vaccinations, and Immunizations.
Part 3	Exemption for school, childcare, and pre-school immunization

A student in New Mexico may be exempt from NM Department of Health (DOH) and NM Public Education Department (PED) immunization requirements by completing the [Exemption from Immunization Form](#). NM law does not grant immunization exemptions for philosophical or personal reasons.

Who may use the Exemption from Immunization Form?

- Individuals requesting a religious or medical exemption to immunization may use **this form**.
- This form must be used for all children with an exemption going into any public, **private or parochial preschool, kindergarten, elementary, secondary school, or home school and for children attending daycare or childcare facilities.**
- This form must **NOT** be used for exemption from immunization for personal or **philosophical reasons. New Mexico law does not allow for such exemption.**

How to Complete the Exemption from Immunization Form:

- Fill out all blank lines and check boxes, including the check boxes for the religious or medical options.
- For medical exemptions, attach the letter from your duly licensed physician to this form.
 - For religious exemptions using an affidavit (statement of fact), attach the affidavit to this form.
 - A notary public must sign the form.
 - Mail the form to the New Mexico Department of Health at the address shown on the form. You may also submit your form in a drop box at the Department of Health in Santa Fe (Runnels Building).

Department of Health Exemption from Immunization Form Processing:

- The Department of Health has 60 days from receipt of the Exemption from Immunization Form to either approve or disapprove the form. Make sure that the Department of Health receives the form at least 60 days prior to the day your child starts school.
- Upon approval, the Department of Health will mail you two copies of the approved form. The Parent/Guardian must take one copy of the approved form to your child's pre-school, school, daycare, or childcare facility.
- If your request is not approved, you will get a letter from the Department of Health telling you why your request was denied. You will also receive information on how to arrange for a meeting with the Department of Health should you wish to protest. [Exemption from Immunization Form](#)

New Mexico Immunization Exemption Law (24-5-3):

“Any minor child through his parent or guardian may file with the health authority charged with the duty of enforcing the

immunization laws:

(1) A certificate of a duly licensed physician stating that the physical condition of the child is such that immunization would seriously endanger the life or health of the child; or

(2) Affidavits or written affirmation from an officer of a recognized religious denomination that such child’s parents or guardians are bona fide members of a denomination whose religious teaching requires reliance upon prayer or spiritual means alone for healing;

(3) Affidavits or written affirmation from his parent or legal guardian that his religious beliefs, held either individually or jointly with others, do not permit the administration of vaccine or other immunizing agent.”

NMAC 7.5.3:

“Within 60 days of receipt of a request for exemption from immunization, the department of health immunization program manager shall review the request to determine whether the certificate has been duly completed. Incomplete requests shall be returned to the requester with information regarding what elements are missing.” [Exemption for school, childcare, and pre-school immunization](#)

School and Community Based Immunization Clinics

School Kids Influenza Immunization project (SKIIP)

School nurses may be involved in assisting with or coordinating on-site school and community based immunization activities. Collaborating in these activities usually occurs between the school nurse and the Public Health Office at the local level as well as with the Immunization Program at the state level. One such immunization initiative offered each year is the [School Kids Influenza Immunization Project](#) (SKIIP).

Vaccine for Children Providers (VFC)

Several school districts in NM are Vaccine for Children Providers (VFC). This makes it easier for children to receive their scheduled immunizations and prevents parents from missing work time to take the child to the doctor. Schools may choose to become independent Vaccines for Children (VFC) providers and obtain vaccine for their school-based immunization clinics directly from the VFC supplier. [Vaccine for Children Program Provider Agreement](#) must be completed to start the process.

Physician Coverage and Standing Orders

School and community-based immunization projects supported by the NM DOH Immunization Program are considered Public Health clinics. As such, it is not required that a licensed physician be on the premises when immunizations are being administered by a licensed nurse, pharmacist or EMT. This clarification was issued by the NM Secretary of

Health and DOH Chief Medical Officer in 1996. However, it is required that all School Nurses and School VFC providers follow the Regional Health Officers and the Public Health Divisions Medical Director Standing Order for Administration of Immunizations (Chapter 15) and the NM Department of Health [Immunization – Rules, Regulations & Protocols](#). It is also suggested that the School Nurse notify the local Public Health Office, Regional Health Officer (RHO) or School Health Advocate when engaging in any school-based immunization clinic activities.

Immunization Documentation

School Immunizations forms are downloadable on the NM Immunization Programs web site for school nurses whose districts are VFC providers or are planning an immunization clinic through the Public Health Office. The forms, [School Immunization Consent Form - English](#) [School Immunization Consent Form - Spanish](#) must be used to obtain consent and provide documentation of vaccines administered. The consent was specially designed for schools so it may be used to consent to a series of vaccinations. The immunizations needed must be identified for the parents' or guardians' information. A Vaccine Information Statement (VIS), for each vaccination needed, must accompany the consent home. The VIS date should be filled out on the form as the date the sheets were sent home to the parent or guardian. The signed immunization consent will also be used as consent to enter students' information and establish an immunization record in the NM Statewide Immunization Information System known as NMSIIS. [VIS sheets](#) are downloadable on NMSIIS or at CDC.

New Mexico Statewide Immunization Information System

The New Mexico Statewide Immunization Information System (NMSIIS) is New Mexico's web-based registry of all vaccinations administered in New Mexico. NMSIIS should be the central depository for immunization records from birth to death. NMSIIS includes a school module that can be used to track a student's immunization history and track vaccine exemptions for the student population. All schools (public and private) using the NMSIIS school module can use it to produce reports needed for this mandatory school immunization compliance reporting. A [NMSIIS Guide for School Users](#) helps School Nurses effectively use NMSIIS.

Nurses who want to use NMSIIS must request access by completing the [NMSIIS Training Request Form](#). The PDF form must be fill out electronically. The most current Adobe program will be required to fill out the form electronically. All fields outlined in red are required and must be filled out before saving the document to a file on a computer.

After the form is completed “save as” with a unique name to a file on your computer, then hit the submit option and it will email to the appropriate person at the Immunization

Program. Training can now be done online or in person depending on what works best for the nurse.

Online training is through [NMDOH Global Classroom](#) at no charge to you. If you have never utilized the Global Classroom, you will need to self-register for an account. If utilizing the online course a NMSIIS Certificate of Training Completion document must be emailed along with the completed [NMSIIS User Security and Confidentiality Agreement](#) to Felicia.martinez2@state.nm.us.

It is now a State Law that all immunizations given in the State of NM must be entered into the NM Statewide Immunization Information System known as NMSIIS (Statute 24-5-8.,2013) The signed consent gives authorization from parent or guardian for this to occur. School Nurses may have access to NMSIIS and use it to look up records, enter records from school records and enter any immunizations that school nurses give during school immunization clinics. If collaborating with public health for a vaccine clinic the responsibility of entering the vaccine falls to public health.

24-5-8. Reporting. (2013)

“Physicians, nurses, pharmacists and other health care providers shall report on immunization to the immunization registry unless the patient, or the patient's guardian if the patient is a minor, refuses to allow reporting of this information.”

History: Laws 2004, ch. 45, § 3; 2005, ch. 45, §1; 2013, ch. 93, § 1.

Public Health Authority for School Health Offices State law requires NM Schools:

- Maintain records of student’s immunizations
- Make those records available to NMDOH
- Report immunization status on students to NMDOH
- Commence disenrollment proceeding on students who do not have satisfactory evidence of immunizations or valid exemption.

To accomplish this, NMDOH grants school nursing offices the authority under the Health Insurance Portability and Accountability Act (HIPAA) to serve as “[Public Health Authority](#)” to collect immunization information for school-aged children without a release of information from parents. This Public Health Authority Letter (See Resources) may be used as proof of this role. Some resources for school nursing offices to use to obtain immunization information include:

- NMSIIS
- Health care providers who give immunizations to children
- Immunization records supplied by parents

- Immunization records from other schools

Foreign Language Vaccine-Related Terms

Many immunization records come from outside the USA. Many are from Mexico and there are good resources to assist with [Interpreting Immunization records from Mexico.](#)

The [Pink Book Appendix B has foreign vaccine tables to assist with interpretations from other countries. The Pink Book can answer almost any question related to immunizations.](#)

References and Resources

[Center for Disease Control and prevention, \(CDC\).](#) 1600 Clifton Road Atlanta, GA 30329-4027 USA. 800-CDC-INFO (800-232-4636), TTY: 888-232-6348.

[CDC Catch-up Immunization Schedule](#)

[Center for Disease Control and prevention, \(CDC\).](#) 1600 Clifton Road Atlanta, GA 30329-4027 USA. 800-CDC-INFO (800-232-4636), TTY: 888-232-6348.

[Interpreting Immunization records from Mexico.](#)

[Center for Disease Control and prevention, \(CDC\).](#) 1600 Clifton Road Atlanta, GA 30329-4027 USA. 800-CDC-INFO (800-232-4636), TTY: 888-232-6348. [Email CDC-INFO](#)

[The Pink Book](#)

[Center for Disease Control and prevention, \(CDC\).](#) 1600 Clifton Road Atlanta, GA 30329-4027 USA. 800-CDC-INFO (800-232-4636), TTY: 888-232-6348.

[VIS sheets](#)

[For Parent: Vaccines for Your Children](#)

[Immunization – Rules, Regulations & Protocols](#)

[New Mexico Department of Health, Exemption from Immunization Form, June, 2017](#)

[NMDOH Global Classroom](#)

[NMDOH Childcare/Pre-School/School Entry Immunization Requirements](#)

New Mexico Administrative Code, Title 6.12.2., Primary and Secondary Education.

[Health Services– Immunizations of School Children](#)

New Mexico Administrative Code, Title 7.5.3., Health, Vaccinations, and Immunizations.

[Exemption for school, childcare, and pre-school immunization](#)

New Mexico Administrative Code, Title 7.5.2., Health, Vaccinations, and Immunizations.

[Immunization Requirements](#)

[NMSIIS Guide for School Users](#)

[NMSIIS Training Request Form](#)

[NMSIIS User Security and Confidentiality Agreement](#)

[No Shots? No Record? No School - Poster](#)

[Parent's Guide to Childhood Immunizations](#)

[Public Health Authority](#)

[School Immunization Consent Form - English](#)

[School Immunization Consent Form - Spanish](#)

[School Kids Influenza Immunization Project](#)

[Vaccine for Children Program Provider Agreement](#)

[Vaccine Storage & Handling Toolkit](#)

CHAPTER TEN – COMMUNICABLE DISEASE CONTROL

Notifiable Conditions in New Mexico

Here's the link to [Notifiable Conditions in New Mexico](#)

Public Health Emergency Hotline: (505) 827- 0006

Infectious diseases occur frequently in the school setting. Factors that affect the risk of disease in schools include age of students, immunity of the group, number of students, the degree of close contact between children and providers, and the hygienic habits of students and staff.

Medical events with community wide consequences occur hundreds of times each year in New Mexico, some in the school setting. Cost effective care can take on a whole new meaning when a single case of certain diseases translates into many cases, with scores of contacts needing screening, protection and surveillance. In such cases, there are substantial resources available twenty-four hours a day, seven days a week through the Epidemiology and Response Division (ERD) of New Mexico Department of Health. ERD provides expert consultation through a telephone hotline linked to health professionals experienced in management and control of outbreaks as well as laboratory assistance in making diagnoses and obtaining vaccines and/or prophylactic medications.

This system is not merely a convenience; it is required by New Mexico statute and administrative code. As a part of this system, physician offices, laboratories, and other health care agencies are required to report suspected or actual cases of notifiable diseases to the Epidemiology and Response Division.

Under the same statutes and rules, the Office of Epidemiology is required to identify and control outbreaks of these diseases and to report this information to the Centers for Disease Control and Prevention as a part of national data collection. Reports from health care providers to the Epidemiology and Response Division are forwarded to the CDC as New Mexico data.

To report a notifiable disease, receive expert consultation and support during a potential outbreak or to speak with an epidemiologist, call (505) 827-0006.

Procedures for Control of Communicable Diseases

Classroom Cleanliness

Definition: Maintaining cleanliness to prevent the transmission of communicable diseases in the classroom.

Guidelines:

- Adequate hand washing facilities should be available to students and staff. This includes a sink, hot and cold running water, liquid soap, and disposable paper towels. Separate storage areas for clean clothing and linens apart from soiled clothing and linens should be provided.

- All soiled disposable items should be held in waste receptacles lined with plastic bags which should be discarded by staff twice daily. These plastic bags should never be reused! Contaminated items, including disposable diapers, discarded in an uncovered waste receptacle should be placed in a separate small plastic bag before being discarded.
- Approved bactericidal solutions should be used to clean toys, tables, chairs and other environmental surfaces. A solution of 1:9 bleach may be used (one part household bleach to nine parts water), but it must be mixed fresh weekly if stored in opaque container or daily if in clear container to maintain efficacy. All disinfectants should be properly labeled and stored safely out of reach of students.
- Only washable toys should be available in the classroom.
- All equipment, toys, tables, chairs, mats, therapy equipment, etc., used by students who drool or mouth them should be washed with appropriate disinfectant at the end of each day or before use by another student. The use of non-washable furniture and equipment in the classroom is Strongly Discouraged.
- Wheelchairs and trays must be washed with soap and water after feeding. If students eat in the classroom, all soiled tables and chairs should be cleaned.
- Physical or occupational therapists should be contacted before cleaning orthopedic equipment such as braces, splints, etc. to be sure disinfectant choice is appropriate.
- The sink area should be cleaned with disinfectant at the end of each day. NEVER scrape food into sink or rinse soiled dishes in sink. Food should be returned to the school cafeteria or scraped into plastic bags and discarded into a waste receptacle. All eating utensils and equipment should be washed in a dishwasher. They should be collected in a suitable container that can also be washed and taken to the kitchen as soon as possible. Clean dishes should be transported back to the classroom in a container that has also been washed.
- Adaptive feeding equipment and other non-disposable dishes should be kept in a clean storage area.
- Students' personal grooming items should be kept in separate containers.
- Soiled rugs or carpet should be cleaned immediately and not be used until the area is dry. Students who are unable to control body fluids should NEVER be placed directly on a carpet/rug but should be placed on a washable mat or blanket. Diapering should
- NEVER be done on carpet or a rug.
- Changing tables, portable potties and toilet seats should be nonporous and be cleaned with approved disinfectant after each use. Portable potties should be emptied into the toilet and disinfected after each use.
- All toilets, potties (both seats and bowls), sinks, diaper changing tables and floor around changing mat should be disinfected daily. Tile areas of classroom floor should be wet mopped with disinfectant daily in classrooms where students eat and when floor becomes soiled with body fluids. Routine carpet care/shampooing should be provided as needed but not less than twice a year.

Laundering Clothes

Definition: When necessary, laundering clothes in a way to prevent the transmission of communicable diseases in the classroom.

Guidelines:

- Garments heavily soiled with stool should be handled carefully by wearing gloves, and placing garments in a plastic bag for disposal. If stool can easily be removed using toilet paper, the garment may be laundered as described below. Lightly soiled clothing (stained with no solids attached) may be washed as described below.
- Wash clothing in a washing machine, preferably with hot water (temperature $\geq 165^{\circ}\text{F}$).
- Use household detergents for washing clothing.
- Household bleach can be used in the rinse water.
- Dry clothes in a hot dryer (temperature $\geq 171^{\circ}\text{F}$).
- There is no need to disinfect the tubs of washers or tumblers of dryers if cycles are run until they are completed.
- Hands should be washed with soap and water or cleaned with alcohol hand gel after handling soiled linens.

Note: These guidelines apply primarily to laundering clothing and articles soiled with stool. All the common pathogens causing diarrheal illness are effectively treated by using the above methods.

Classroom Cooking

Definition: Preparing food for teaching students skills, reinforcing learning or meeting other educational goals.

Guidelines:

- Before use in classroom cooking, tables and work areas should be cleaned with an approved disinfectant such as a fresh solution of 1 part chlorine bleach to 10 parts water. (If an opaque container is used, the solution needs to be changed weekly; if a clear container is used, the solution must be changed daily to maintain efficacy.)
- Students and instructional personnel should wash hands with soap and water before and after handling food. This process must be repeated any time a student leaves the activity or puts hands to mouth, nose or perineal area.
- Students who have symptoms of illness, or who drool excessively should be excluded from the cooking activity.
- It is recommended that disposable scoops, spoons, tongs and gloves for handling food be used as often as possible and that disposable dishes and dinnerware be used for serving food.
- Students should not be allowed to use fingers to taste food from the preparation bowls.
- Leftovers should be properly stored or disposed and not left out in the classroom or in the trash can overnight. Food should not be disposed of nor should dishes be rinsed in a classroom sink, unless the sink is equipped with a garbage disposal.
- Any non-disposable dishes, pans, utensils and adaptive equipment should be washed in a dishwasher or in the school cafeteria or kitchen.
- Tables and work surfaces used in any cooking activity should be cleaned as in step one above. All individuals participating in the cooking activity should wash hands as in step two.

Diapering

Definition: Changing diapers in such a way so that potential for communicable disease transmission is decreased.

Guidelines:

- Students who are not toilet trained should be checked at least every 2-3 hours and changed when soiled.
- Assemble the following equipment.
- Wet disposable towelettes
- Dry disposable towels/pads
- Disposable diapers
- Covered waste receptacle lined with plastic bag
- Small plastic bag for disposing of diapers if they contain feces or blood
- Disposable gloves
- Washable changing table
- Disinfectant for cleaning changing table
- Place student on changing table with a nonporous surface in bathroom or other appropriate setting. Diapers should NEVER be changed in the classroom. A STUDENT SHOULD NEVER BE LEFT UNATTENDED ON THE CHANGING TABLE.

- Place disposable pad, towel, or paper under student’s buttocks. Remove clothing or lift as necessary to assure all clothing is above the area of the navel.
- Use disposable gloves per universal precautions.
- Remove diaper and discard directly into waste receptacle or plastic bag. NEVER place a soiled diaper on the floor, carpet or furniture.
- Wash perineal area with disposable towelette. In girls, wash from top to bottom and discard towel after each stroke to prevent organisms from entering the vaginal or bladder area. Dispose of towelette with diaper. Place clean diaper on student.
- Remove dry towel from under student. Remove disposable gloves. Discard into waste receptacle.
- Wash student’s hands before returning him/her to class.
- Wash changing table with disinfectant.
- Wash hands per hand washing procedure described in this section.

Handwashing

Purpose: Handwashing is the single most effective technique in preventing transmission of infectious diseases due to individuals carrying or incubating disease without symptoms.

Guidelines: Access to adequate hand washing facilities is necessary, including a sink, hot and cold running water, liquid soap and disposable towels. Poster in Resource Section: **When to Wash Hands – English, When to Wash Hands - Spanish**

- Hands should be washed with soap:
 - Before eating and drinking
 - Before handling dining equipment or utensils
 - Before and after handling any food
 - Before and after assisting in toileting, diapering or feeding
 - After contact with body fluids or blood
- It is recommended that rings and bracelets be removed before hand washing, because microorganisms can become lodged in jewelry settings.
- Recommended procedures for hand washing include the following.
 - Wet hands with warm, running water and apply liquid soap. Warm water helps to get the organisms, dirt and debris into suspension and running water carries them away. Bar soap in a dish provides a place for bacteria to grow.
 - Wash, using a circular motion and friction, for 10 to 30 seconds. Include front and back of hands, between fingers, around nails and wrist area.
 - Hold hands so that water drains from wrist area to finger tips and rinse well under warm, running water.
 - Dry hands well with paper towels. Turn off water faucet with towel and then discard towel in wastebasket.
 - Apply lotion as desired to prevent chapping, because chapped skin breaks open easily, permitting bacteria to enter the system.

Bloodborne Pathogen Exposure List

Definition: Potential for exposure to communicable disease through contact with contaminated/infectious blood/body fluids.

Guidelines:

- The Occupational Safety and Health Administration (OSHA) Standard 29 CFR 1910.1030 Bloodborne Pathogens requires employers to identify the risk to employees of exposure to bloodborne pathogens in the

work place. Those regulations apply to all employees who potentially might come into contact with blood or infectious materials in the scope of job duties.

- Each school district should identify a person responsible for writing and implementing an occupational exposure plan. Risk management and nursing staff may be involved in the development of an exposure plan.

Chapter 17 of this Manual contains the OSHA reference guidelines, a sample school exposure plan and training material. Federal requirements can be accessed through the OSHA Occupational Safety and Health Administration, [Bloodborne Pathogens and Needlestick Prevention](#).

Toileting

Definition: Training, monitoring and/or assisting a student with toilet needs when the student is unable to do this independently, decreasing the risk of spreading diseases through fecal oral contamination.

Guidelines:

- Assemble all equipment
 - Suitable sized and adapted toilet/portable potty
 - Toilet tissue or disposable towelettes
 - Covered, plastic lined waste receptacle
 - Disinfectant
 - Disposable gloves
 - Disposable plastic bag
 - Clean diaper if necessary
 - Remove diaper or lower underpants and assist student onto toilet seat or potty. Soiled diaper should be discarded in covered waste receptacle. It is inadvisable to give the student toys during toileting or to allow the student to remain longer than 10 minutes on the toilet/potty. **THE STUDENT SHOULD NEVER BE LEFT UNATTENDED IN THE BATHROOM.**
 - After toileting needs, have been met, the student should be taught to wipe him/herself with tissue from front to back and discard tissue in toilet. If the perineal/rectal area is still unclean after the student's effort, the gloved supervising adult should complete cleaning with a disposable towelette.
 - Student should be re-diapered and clothing should be appropriately arranged.
 - Disinfecting/rinsing of the potty/toilet seat should be performed as appropriate.
 - Hand washing by both the student and supervising adult is the most effective method to remove any fecal contamination before the student is returned to class.

Communicable Disease Information Sheets

See index for CDC website for [Diseases and Conditions](#) and [Manual for Investigation and Control of Communicable Disease in New Mexico](#).

Introduction

The fact sheets presented here summarize communicable diseases that commonly affect students and school staff. They were designed to be used as educational and informational material for students, staff and parents, particularly when outbreaks occur in the school setting.

Several general methods of disease prevention available to schools are listed below:

- Surveillance- Observation for cases, monitoring the incidence (new cases) and prevalence (total cases) of diseases in the school population are the crux of surveillance.
- Medical Evaluation- Referral of possible cases to a health care professional (the personal physician or other practitioner, clinic or the local Health Office) for diagnosis and treatment usually generates the medical evaluation.
- Reporting to Department of Health- See list reportable conditions; reports can be made to the Epidemiology and Response Division (ERD) hotline at (505) 827-0006. Immediate reporting of highly contagious diseases like measles and shigellosis, serious conditions such as meningitis and outbreaks of gastroenteritis (vomiting or diarrhea) that may be due to a food or waterborne disease are especially important. Please see Notifiable Conditions in New Mexico.
- Contact prophylaxis- Some severe infections are likely to affect close contacts of cases and may be preventable by antibiotic prophylaxis (preventive treatment). Such treatment may be recommended by the Department of Health (DOH) to close contacts within a classroom, athletic team or another school group.
- Fever- Communicable diseases often present with fever. Because of the normal variation in body temperature, there is no single value that is defined as fever. However, according to the American Association of Pediatrics “A fever is a body temperature that is higher than normal. While the average normal body temperature is 98.6°F (37°C), a normal temperature range is between 97.5°F (36.4°C) and 99.5°F (37.5°C). Most pediatricians consider a temperature above 100.4°F (38°C) as a sign of a fever” (American Academy of Pediatrics, [Signs and Symptoms of Fever](#)).
 - Oral temperature above 100.4°F (37.8°C)
 - Axillary (armpit) temperature above 99°F (37.2°C)
 - Ear (tympanic membrane) temperature above 99.5°F (37.5°C) in oral mode
 - Forehead (temporal artery) temperature above 100.4°F (38°C)Axillary, ear and forehead temperature measurements are easier to obtain than oral temperature, but they are less accurate and may need to be confirmed orally.
- Isolation- Isolation refers to the exclusion (e.g. from school) of a person with a communicable disease during the period of communicability.
- Standard Precautions- An infection control practice that considers all persons’ blood and body fluids potentially infectious for some pathogens is known as standard precautions. Thus, it is not necessary to know that a person

is a carrier of a particular disease to protect one's self from exposure. Practices include avoidance of contact with blood, body fluids and excreta; wearing gloves when contact might occur; frequent hand-washing; decontamination of blood, etc. in the environment; and frequent washing and decontamination of counters, sinks, play areas, toys, etc.

- Immunization- Schools are called upon to enforce the immunization statutes and rules regarding routine immunizations. Some vaccine-preventable disease outbreaks occurring in schools have been controlled by school-based immunization programs. Immunization programs in schools also offer protection to older students before they leave the "captive population" of the school.
- Prevention Education- Schools can model, teach and reinforce the simple habits of personal hygiene, environmental cleanliness and food-handling procedures that promote good health and minimize exposure to infectious diseases.

The format used for entry of each specific condition outlined in these guidelines includes the following topics:

Disease/ Condition	Proper and commonly used name of the disease or condition
Agent	Name of the infectious agent and its categorization (viral, bacterial, fungal, parasitic)
Clinical Description	Mechanism by which the disease is produced, typical symptoms and complications
Transmission/ Exposure	<p>Modes of Transmission</p> <ul style="list-style-type: none"> • Direct: Individual to individual, such as exchange of body fluids, exposure to droplets from the nose or mouth or hand-to-hand contact • Indirect: From an inanimate object, such as hard surfaces, tissues or dishes • Routes of Exposure <ul style="list-style-type: none"> Inhalation: Airborne (from a sneeze or cough) • Contact: Actual contact of some kind, such as contact with body fluids through an opening in the skin, mucous membrane, sexual contact or contaminated equipment • Ingestion: Swallowing • Intermediary: A vector-borne transmission, such as flea, mosquito or rodent
Contagious person, Period until after recovery	<p>Period of time that the infectious agent can be passed to another at times beginning before symptoms develop lasting</p> <p>Many infections are subclinical (do not produce symptoms), but the person is still contagious. A carrier state may occur if the agent continues to be present in a contagious form either before or after the illness.</p>

Incubation	Period of time between exposure to an infectious agent and the onset of symptoms
Diagnosis	Method by which the cause or nature of a disease or condition is determined. Clinical diagnosis is determined by physical examination; laboratory diagnosis by lab testing.
Management of Case	Steps to be taken in diagnosis and treatment of the person with the condition, including a requirement for exclusion from school
Management of Of contacts	Steps to be taken in prevention of infection in persons who have been exposed to infection
Immunization	Availability and recommended use of vaccines and impact of immunization in control of the disease
Public Health Action	Requirement for reporting of diseases or conditions to the NM Department of Health and action to be taken by the Department of Health
Prevention Education	Information on behaviors that individuals can adopt to reduce exposure to communicable diseases

School Action Summary of actions by schools to detect and manage communicable diseases in the school community

Animal or Human Bite

Condition, Disease	Bite by a human or animal
Agent	Bacterial agents include <i>Streptococcus</i> , <i>Staphylococcus</i> , <i>Pasteurella</i> , <i>Bartonella</i> (cause of cat-scratch fever); viral agents include herpes simplex, hepatitis B and C, rabies
Clinical Description	An infected bite wound may cause increasing pain and swelling, redness, warmth and discharge of pus or bloody/serous fluid. Herpes simplex infections of these wounds show blisters and ulcers.
Transmission, Exposure	Bacteria or virus present in the mouth or throat of a person or animal inoculated into a bite or scratch contaminated with saliva.

Contagious Period	Bacteria, herpes simplex and other viruses can be carried indefinitely by a healthy person or animal. Rabies virus is present in saliva for a few days before the onset of symptoms.
Incubation	Depends on agent: 1-5 days for bacteria or herpes simplex virus, several weeks for cat scratch fever, weeks or months for hepatitis B, for rabies 4-6 weeks with range of 5 days to one year.
Diagnosis	Cultures or serologic tests are required to determine the specific cause.
Management Of Case	<p>First aid for all bites using standard precautions is very important. Immediately wash the wound with water and antibacterial soap rinse thoroughly with water. Cover wound with a loose sterile dressing. Control bleeding with local pressure over a clean cloth or sterile gauze dressing. Refer to physician for further management.</p> <p>Report all animal bites to the local Animal Control Officer and provide the name, age, home address and phone number of the victim as well as a description and location of the animal. Do not kill the animal unless necessary to protect the safety of human or other domestic animals. If it is necessary to kill the animal, attempt to preserve the head and brain intact for rabies testing.</p> <p>Consider evaluation for tetanus and possible immunization.</p>
Management of Contacts biter of hepatitis B, it is	<p>For human bites, review the health and immunization records of the biter and the victim. If the victim has been immunized against hepatitis B, it is very unlikely that he/she would be infected regardless of the infection status of the biter. If preventive treatment for hepatitis B is needed, it should be given as soon as possible.</p>
Public Health Action and	<p>Report animal bites to the Animal Control Officer as described above. Confine and immunize domestic animals. Also, report handling bats and bat exposures to Animal Control Officer.</p>
Prevention stray Education	<p>Teach children to avoid unfamiliar domestic animals and all wild or stray animals. Children should not feed or handle animals. Ill or injured animals present special hazards.</p>
School Action	<p>-Apply first aid for wounds and possible shock. -Clean and bandage wound and refer victim to physician or emergency facility.</p>

- Report animal bites and stray or injured animals to the Animal Control Officer (as described above).
- Offer prevention education.

Bacterial Enteritis

Condition, Disease, Agent	<i>Salmonella, Shigella, Campylobacter, E. coli O157-H7, Yersinia enterocolitica</i>
Clinical Description	Often acute onset of diarrhea with abdominal pain/cramps, fever, nausea and vomiting, headache and malaise. Stools may be watery or mucoid and may become bloody. Potential complications: dehydration, bacteremia and distant infection, hemolytic uremic syndrome.
Transmission, Exposure	Person to person or animal to person by fecal-oral route and by contaminated food, milk or water. <i>Shigella</i> is carried only by humans. <i>Salmonella</i> is carried by many animals including reptiles and may be transmitted by contaminated eggs, meat and milk. <i>Campylobacter</i> is carried by poultry and domestic animals; <i>E. coli O157</i> and <i>Yersinia enterocolitica</i> by cattle; they may be transmitted by contaminated milk, meat and water or produce contaminated with manure.
Contagious Period	Shortly before onset of symptoms, during the symptomatic illness, and sometimes after the bacterial shedding has stopped as with <i>Salmonella</i> .
Incubation	Depends on agent: <i>Campylobacter</i> - 2-5 days, with range of 1-10 days; <i>E. coli O157-H7</i> - usually 3-4 days, range 1-8 days; <i>Salmonella</i> - 12-36 hours, with range of 6-72 hours; <i>Shigella</i> - 2-4 days, with range of 1-7 days; <i>Yersinia enterocolitica</i> - usually 4-6 days, with range of 1- 14 days.
Diagnosis	Through culture of feces to determine etiology.
Management of Case	Begin hydration with increased intake of plain water or other fluids at the onset of diarrhea. Children with other than mild to moderate watery diarrhea without fever or vomiting should be sent home. Refer for medical evaluation if fever, substantial abdominal pain, inability to maintain hydration are present or stools are bloody or contain pus. Some enteric infections may be treated with prescribed antibiotics. Any person with infectious diarrhea must avoid handling food. Mild diarrhea is not usually a cause for exclusion from school if the student practices good hygiene. Children in diapers or with poor hygiene should be excluded if environmental contamination cannot be avoided. Children may return to school or daycare when symptoms are subsiding and do not interfere significantly with school activities.

Persons with salmonella can return when under treatment or when afebrile and diarrhea has improved so it does not interfere with normal activities; as with other etiologies, mild diarrhea with good hygiene is not a cause for exclusion.

Persons with Salmonella, Shigella and E. coli O157 should not handle food until two stool cultures are negative 24 hours apart for the pathogen. Contact should not resume until diarrhea ceases and two consecutive fecal samples or rectal swabs, collected at least 24 hours apart and at least 48 hours after completion of antibiotic therapy, are negative.

Management
of of Contacts

Symptomatic cases of shigellosis should avoid recreational water until two weeks after diarrhea stops.

Public Health Action

Surveillance for secondary cases. Contacts should practice good personal hygiene, especially hand washing and careful food handling.

Report outbreaks of bacterial enteritis and possible food or waterborne outbreaks to the Department of Health (DOH). The Epidemiology and Response Division will coordinate outbreak investigation and management. Individual cases of *Salmonella*, *Shigella*, *Camphylobacter*, *E.coli O157-H7*, or *Yersinia* should be reported to DOH.

Prevention
after
Education

Prevention requires good personal hygiene, especially hand washing using the toilet and changing diapers, and before preparing food or eating; environmental hygiene includes safe food handling (separating raw and cooked food, washing utensils, counters and cutting boards).

School Action

With acute diarrhea of any cause, prevent dehydration by increasing fluid intake.

Students with fever, vomiting or significant diarrhea should be sent home. Refer persons who have diarrhea with fever, bloody or pus containing stools for medical evaluation.

For E. coli cases in daycare setting, center needs to notify parents in writing of case.

Students may return to school when afebrile and diarrhea has decreased to the extent that they can participate in normal activities.

Report outbreaks of diarrhea to the DOH, especially if there is a suspicion of food or water transmission.

Frequent hand washing should be stressed with students and staff.

Provide prevention education.

Avoid recreational water use by cases until symptoms resolved; for shigellosis symptoms, should be resolved for two weeks before resuming recreational water contact.

Bed Bugs

Disease, Agent
hemipterus

Climicidae family ectoparasites, *Cimex lectularius* and *Cimex*

Clinical Description

Bed bugs include insects from the *Climicidae* family. They are small (1mm to 7mm), oval, flat reddish-brown ectoparasites that feed on the blood of people and animals. They typically only come out to feed in dim or dark lighting. The bites cause a local hypersensitivity reaction to saliva and typically appear as erythematous, pruritic, maculopapular wheals often noticed on the body after waking up in the morning. However, some reactions may take up to 9 days to present. Lesions are typically 2mm to 2cm in diameter and are often scattered but sometimes occur in a linear pattern as the bugs bite along clothing lines and body folds. The areas most often affected are the face, neck, arms, shoulders and legs. Although secondary infections can also occur at the site of the bite, bed bugs are not known to transmit or spread disease.

Transmission

Bed Bugs are usually spread by traveling in clothing, baggage and other items from an infested area. High risk areas for bed bug infestation include accommodations with rapid turnover like motels/hotels, low income housing, shelters, public transportation and even movie theaters. They hide during the day in crevices of furniture and walls, usually found to be within eight feet of where people sleep. Transmission and infestation are NOT related to personal hygiene or cleanliness of the infested site.

Contagious Period

Bed bugs can live several months without a meal. As the insects do not infest the body, direct person-to-person transmission does not occur.

Incubation

Eggs hatch after 4-12 days and go through 5 nymphal stages before becoming an adult. They need to feed on blood at all stages after they hatch. Females lay about 5 eggs daily as adults. Adults live 6-12 months.

Diagnosis

Bites are not always obvious. The typical response is an allergic reaction after several exposures. Signs of an infestation are bed bugs

in the folds of mattresses, bedding, nearby cracks and crevices, or their exoskeletons after they molt. Rust-colored blood spots from their fecal matter and a sweet musty odor (rotting raspberries) can also be taken as evidence of infestation. Clinicians must rule out bites from other arthropods, and skin conditions such as staphylococcus infections or allergic reaction from other allergens.

Management
Of Case

Treatment for skin lesions is symptomatic and may include the use of antihistamines, topical or oral corticosteroids, topical or oral antibiotics for secondary infections and epinephrine may need to be used for more severe allergic reactions. Lesions that are uncomplicated typically heal in about one week, but more severe reactions may take 2-6 weeks to resolve. The cornerstone is prevention by eradication of the infestation.

The EPA recommends the Integrated Pest Management approach (IPM). First, a careful inspection of bedding, mattresses, luggage, bags, and nearby cracks and crevices should be done to identify the bugs. If bugs are found then a sample should be taken to show an expert if or when needed. Records of the dates and locations(s) where the bugs were found are helpful to track the lifecycle. A wide range of methods for environmental eradication exist (including pesticide and mechanical approaches – such as heat, cold, vacuuming, diatomaceous earth, isolation) although cost/adverse effects/effectiveness may vary. It is also important to clean and de-clutter the areas of infestation in order to decrease sites for the bugs to live, hide, and reproduce. Items that can be washed in the washing machine should be done with hot water. Washing alone does not generally kill bugs, so drying on a high heat setting is recommended. Items that can't go into the washer can be washed with hot soapy water, scrubbing along folds. Other items can be heated to 113°F for one hour or frozen to 0°F for at least 4 days. The EPA's IPM strategy also recommends chemical control. On the EPA website a link is available to help find pesticide products in your area that can be used: <https://www.epa.gov/bedbugs> Note that chemical eradication has been complicated by pesticide resistance. Help can also be sought by a licensed pest control professional in your area.

Management
of Contacts

Education of administration, faculty, staff, students and parents

Public Health
Action

Bug bites and infestation are not reportable conditions.

School Action

If large infestation is suspected, then school administration should be alerted and proper IPM in the school or classroom, as appropriate,

should be recommended to prevent further spread to students, faculty, staff and their families.

Note that bed bug bites in the school is very unlikely, as the insects only emerge and bite at night/in dim light. An infestation of the school may be suspected if multiple affected families with a common feature (e.g., classroom) are identified, as infestation of the classroom and transmission to the home in bags/clothing may be the source of spread.

Provide educational material to families, faculty and staff regarding

- no linkage of infestation to personal hygiene or housing cleanliness,
- recommended inspection and eradication strategies

Chlamydia, Gonorrhea

Disease, Agent	<i>Chlamydia trachomatis</i> (CT, bacteria-like); <i>Neisseria gonorrhoeae</i> (GC, bacteria)
Clinical Description	These infections are described together because there is overlap in the clinical presentation, and dual infections are common. CT and GC infect mucous membranes often resulting in inflammation with burning on urination and urethral or vaginal discharge; infections of other sites may cause sore throat, conjunctivitis, rectal pain and discharge. Complications include pelvic inflammatory disease (PID) in women and epididymitis in men. PID is responsible for an epidemic of tubal infertility and ectopic pregnancy in the US. Disseminated GC with arthritis, tenosynovitis and skin lesions occurs infrequently.
Transmission, Exposure	These infections are described together because there is overlap in the clinical presentation, and dual infections are common. CT and GC infect mucous membranes often resulting in inflammation with burning on urination and urethral or vaginal discharge; infections of other sites may cause sore throat, conjunctivitis, rectal pain and discharge. Complications include pelvic inflammatory disease (PID) in women and epididymitis in men. PID is responsible for an epidemic of tubal infertility and ectopic pregnancy in the US. Disseminated GC with arthritis, tenosynovitis and skin lesions occurs infrequently.
Contagious Period	If untreated, the infected individual may remain contagious indefinitely; after treatment, the contagious period is one to several days.
Incubation	GC is 2-5 days after exposure; CT is 7-14 days.
Diagnosis	Examination may reveal inflammation (tenderness, swelling, pus discharges) of the infected genitals or eyes. Laboratory testing by DNA

probes is highly sensitive and specific. Bacterial culture for GC is recommended.

Management of Case	Suspected cases should be referred for medical evaluation and treatment. Minors may seek care for sexually transmitted disease without parental knowledge or consent. In addition to GC and chlamydia, at risk individuals should be evaluated for other sexually transmitted diseases. School exclusion is not necessary. Gonococcal and genital or rectal chlamydial infections in young children indicate that at least inappropriate sexual contact has occurred; refer children under the age of consent and older children who give a history of sexual assault to Child Protective Services and/or other appropriate authority.
Management for of Contacts	Intimate (sexual) contacts of infected individuals should be evaluated infection and treated.
Public Health Action	Report gonorrhea and chlamydial infections to the DOH/STD Program.
Prevention Education	Postpone sexual activity and limit partners; use condoms. Nonoxynol spermicides have some antimicrobial effect and may enhance the efficacy of condoms.
School Action for STD/STI	<p><u>School Nurse Role with Sexually Transmitted Diseases (STD or STI):</u> School Nurses can help address those problems by conveying a simple and nonjudgmental message to those students with whom they interact:</p> <ul style="list-style-type: none">▪ Delay having sexual intercourse until you are ready. Despite the sexualized cultural climate in which we live, it is important to remind teenagers that not everyone is having sexual intercourse▪ If you are going to have sex, use condoms to prevent STD's and reliable contraception such as birth control pills or a long-acting progesterone injection▪ Limit number of sexual partners <p>When indicated, refer students to physician, Department of Health or school-based clinic for diagnosis and treatment. Support school-based clinics, peer counseling, and education to increase availability and acceptability of health care services to adolescents. School exclusion not necessary. Consider the possibility of child or sexual abuse and refer to Child Protective Services as appropriate. Provide prevention education to include safer sex practices.</p>

Students should be encouraged to talk to their parents about sexual issues that concern them. The ideal situation is for teens to talk to a parent or other adult family member about their sexual feelings, intimate relationships, about becoming sexually active, birth control, and STDs. However, the reality is that many students are unwilling or unable to broach these subjects with their families. Sometimes the student simply needs encouragement to open lines of communication with a parent or relative about these subjects. Sometimes, however, it is the parent who makes it clear that they are unwilling to address these matters with their child. Some students fear parental violence or being banned from the home should their parent or family become aware of their sexual activities. In these situations, the school nurse can be of assistance in referring the student to proper medical or counseling interventions.

The School Nurse can also help students by letting them know that they are legally entitled to receive confidential medical services for family planning and STDs. Many students believe that their parents will be told that they have an STD. This is not true. Students can be referred to a School-Based Health Center (SBHC) or to a local Public Health Office where they may receive free and confidential services for the diagnosis and treatment of a STD, for prevention services such as the provisions of condoms, or for family planning services. It is most helpful for School Nurses to know the public health nurses in their communities in order to facilitate such referrals especially in a crisis or emergency situation.

When questioning a student about sexual activity, it is important that a nurse not assume that the student is heterosexual. It would be best to ask directly whether the student has sexual partners who are males, females or both. This will enable a gay, bisexual or lesbian student to disclose their activities in a more supportive and nonjudgmental context.

Students who present to the school nurse with possible symptoms of a STD should be asked about their risks for STDs and referred to a medical facility which can diagnose and treat these problems. Many STDs have no symptoms or may have only vague and non-specific symptoms, especially in females.

STD SIGNS and SYMPTOMS

Signs and symptoms may occur in areas other than the genitals, depending on the type of sexual exposure.

Male:

- A penile discharge
- Burning with urination
- Any sore, growth or ulcer on the penis or groin area

Female:

- An abnormal vaginal discharge, especially with itching, burning or odor
- A sore, growth or ulcer on the external or internal genitalia
- Pain with intercourse
- Burning on urination
- Abnormal vaginal bleeding
- Lower abdominal pains with or without vomiting, nausea or fever

Either gender:

- Unusual rashes, especially on the palms or soles
- Sore throat
- Rectal discharge and/or discomfort
- Sores, growths or ulcers on the rectal area
- Sore and swollen cervical or inguinal lymph nodes

STD Tests

Tests are available which enable gonorrhea or chlamydia to be diagnosed on a urine specimen. Contact your local Public Health Office to determine availability of these tests. These PCR (polymerase chain reaction) and LCR (lygand chain reaction) tests are extremely accurate and are well accepted by teens since they do not require a potentially embarrassing genital or speculum examination. They can be used to screen students who are sexually active and who have no symptoms; however, any student who has symptoms of a STD should be FULLY examined. These urine tests can be used during sports physicals, in school-wide screening campaigns, for girls who are having pregnancy tests or upon request in partnership with the Department of Health (DOH). All positive tests should be treated according to DOH protocols.

Public Health Services

Almost every county in the state of New Mexico has at least one public health office where people with STDs including HIV may be evaluated or referred for services. Disease Prevention Specialists provide outreach and follow up services through public health offices across the state. A school nurse can be a valuable resource for information about sexuality, contraception, and STD's. Excellent written materials, videos, and posters are available from many sources. Contact your local Public Health Office for obtaining or borrowing these materials.

Conjunctivitis (Pink-eye)

Condition, Disease, Agent *Adenovirus, Enterovirus* and many respiratory viruses; *Hemophilus influenza* and other bacteria

Clinical Description	Infectious conjunctivitis produces a variably red eye with swelling and discharge which may be watery or with mucus or pus and crusting of the eyelids. Discomfort ranges from minimal itching or a grainy sensation to substantial pain, sometimes mild photophobia (light sensitivity) or blurring of vision. In contrast, allergic conjunctivitis is usually accompanied by other signs of allergy (red conjunctiva; swollen, itching eyelids; nasal congestion, watery eye and nasal discharge, sneezing).
Transmission, Exposure	Person-to-person by contact with infected secretions from the eye or respiratory tract either directly or through contact with contaminated objects such as shared towels or eye make-up. Viral conjunctivitis is highly contagious. Bacterial conjunctivitis is somewhat less contagious and antibiotic treatment reduces the period of communicability.
Contagious Period	Bacterial – during course of infection; adenovirus – late in incubation period to 14 days after onset; enterovirus – at least 4 days after onset
Incubation	1-3 days for most bacterial infections; 4-5 days for adenovirus with average of 8 days; 12 hrs to 3 days for enterovirus
Diagnosis	Diagnosis is usually by clinical evaluation. Definitive diagnosis usually requires culture of the eye drainage.
Management treatment. of Case cause.	Refer students with conjunctivitis for medical evaluation and An outbreak of conjunctivitis requires determination of the Specific antibiotic treatment is available for conjunctivitis due to bacterial infection; symptomatic treatment is used for viral disease. Exclusion from school is usually not necessary if a child can practice frequent hand washing. In the case of outbreaks of bacterial conjunctivitis, a patient is considered non-contagious after 24 hours of antibiotic therapy.
Management of Contacts a	During outbreaks, prevention depends on scrupulous personal hygiene therapy. Outbreaks of viral conjunctivitis will usually run their course in relatively closed community such as a school. Bacterial conjunctivitis may require intensive surveillance to detect new cases as early as possible. Proper disinfection of all medical and eye examining equipment is recommended. Ensure prompt hand washing before and after eye treatment, administering eye drops, or cleansing.
Public Health Action	Report school outbreaks of conjunctivitis to the Department of Health.

Prevention Education	Hand-washing and avoidance of touching one's eyes are the most effective defense against eye and respiratory infections. Avoid sharing towels, eye makeup and other items that may be contaminated with infectious discharges. Ensure proper disposal of contaminated materials.
School Action	<ul style="list-style-type: none"> -Refer children with eye irritation or discharge for medical evaluation and treatment. -Report outbreaks to the Department of Health for assistance in management. -School exclusion is usually not necessary for isolated cases but may be necessary for control of outbreaks. Recommend exclusion of children from daycare while disease is active. -Provide prevention education.

Cytomegalies Infection (CMV)

Condition, Disease, Agent *Cytomegalovirus*

Clinical Description	Mononucleosis-like syndrome with fever, malaise, and mild enlargement of lymph nodes is common in older children and adults. Infections range from sub-clinical (usual in young children) to severe systemic infection in the fetus and immune-impaired patients; manifestations may include hepatitis, pneumonia, encephalitis and chorio-retinitis. Complications for babies born after exposure of the virus from intrauterine infection may be normal or may be growth retarded, fail to thrive, have developmental delay, visual and hearing deficits. Severe disease in immune-impaired individuals, including AIDS, may result in blindness or respiratory failure.
Transmission, Exposure	Contact with infected secretions (saliva, urine, genital secretions) or by blood transfusion. Infected infants or children can infect their mothers and other caregivers because of prolonged virus shedding in the urine. CMV infection can be sexually transmitted; genital contact is the mode of transmission for the average young adult who becomes infected.
Contagious Period	Weeks to many months. The virus becomes latent and can reactivate with periodic viral shedding in saliva and urine.
Incubation	3-12 weeks
Diagnosis	Confirmation of infection requires positive culture (urine) and/or serology (IgM antibody).
Management of Case	Most treatment is symptomatic. Treatment of life/sight-threatening infection with antiviral drugs is at least temporarily effective. Exclusion

from school is not necessary.

Management of Contacts or	Avoid contact with urine and saliva. Personnel who care for non-toilet-trained children or who come in contact with saliva or other body fluids secretions should practice careful personal hygiene, especially hand washing. Wash contaminated toys and other objects regularly. Women who are pregnant or trying to become pregnant may wish to consult their physician to determine whether they are susceptible.
Public Health Action	Reporting is not required.
Prevention Education	Hand washing is the best defense, especially after using toilet, changing diapers, assisting student with toileting and contact with saliva.
School Action	Emphasize personal and environmental hygiene and standard precautions. School exclusion is not appropriate. Provide prevention education.

Diarrhea (Acute)

Condition, Disease, Agent	Viral Diseases: Rotavirus, Norwalkvirus, Adenovirus, Coronavirus. Bacterial Agents: <i>Salmonella</i> , <i>Shigella</i> , <i>Campylobacter</i> , <i>Vibrio</i> , <i>Yersinia</i> , <i>E. coli</i> O157-H7, <i>Staphylococcus</i> , <i>Bacillus cereus</i> , <i>Clostridium</i> . Parasitic Agents: <i>Giardia</i> , <i>Cryptosporidium</i> , <i>Entamoeba histolytica</i> . Note: See bacterial enteritis section also.
Clinical Description	Gradual to explosive onset of diarrhea with or without fever, nausea, vomiting, abdominal pain, and/or systemic toxicity.
Transmission, Exposure	Person-to-person by fecal/oral route and by contaminated food, water or milk. Environmental contamination may occur especially when changing diapers.
Contagious Period	Generally, patients are contagious while symptomatic; asymptomatic carrier states may occur.
Incubation	Usually 1-3 days for viruses, 2-4 days for bacteria, often weeks for parasites
Diagnosis	Diagnosis requires culture for bacteria and microscopic exam or antigen

testing for parasites.

Management of Case	Begin hydration with increased intake of plain water or other fluids at the onset of diarrhea. Refer for medical evaluation if fever, substantial abdominal pain, inability to maintain hydration is present or stools are bloody or contain pus. Students with diarrhea should be considered for exclusion from school primarily because of hygiene issues. Those in diapers should be considered for exclusion if environmental contamination cannot be avoided. Those excluded may return to school or daycare when under appropriate treatment (if treatment is indicated) and when symptoms do not interfere with routine school activities. Any person with infectious diarrhea should avoid handling food. Those with bacterial diarrhea should avoid handling food until stool cultures are negative for the pathogen. With vibrio infections, need to be excluded until asymptomatic with formed stools.
Management of Contacts	Testing of asymptomatic contacts may be necessary to control outbreaks. Contacts should practice good personal hygiene, especially hand washing and careful food handling.
Public Health Action	Report outbreaks of diarrhea and especially gastroenteritis suggestive of a food, milk or waterborne outbreak to the Department of Health.
Prevention the Education	Prevention requires good personal hygiene (hand washing after using the toilet and changing diapers and before preparing food and eating) and kitchen hygiene (separating raw and cooked food, washing utensils, counters and cutting boards). Community prevention requires a safe water supply and uncontaminated food and milk.
School Action	<ul style="list-style-type: none">-With acute diarrhea of any cause, prevent dehydration by increasing fluid intake.-Students with fever, vomiting or diarrhea that interferes with school activity should be sent home and excluded from school until symptoms do not interfere with routine school activities.-When cleaning up diarrhea, wearing disposable gowns is recommended.-Refer persons who have diarrhea with fever, bloody or pus-containing stools for medical evaluation.-Students may return to school when afebrile and diarrhea has improved to the extent that they can participate in normal activities. (See Bacterial Enteritis section for exceptions).-Report outbreaks of diarrhea to the Department of Health immediately, especially if there is a suspicion of food or water transmission.

- Frequent hand washing should be stressed by all school staff.
- Provide prevention education.

Fifth Disease (Erythema Infectiosum)

Condition, Disease, Agent Human parvovirus B19

Clinical Description	Symptoms are a mild fever in a minimally ill child with flushed cheeks or bright red and slightly edematous "slapped" cheeks. Later in the infection, a lace-like or lattice-like rash may appear on the trunk and extremities accentuated by heat or sunlight. Many children have a history of mild gastroenteritis or upper respiratory infection a week previously. Older children and adults typically have transient arthritis lasting a few days.
Transmission, Exposure	Person-to-person transmission by droplets or contact with respiratory secretions. Subclinical and atypical infections are very common and are contagious.
Contagious Period	Approximately one week before the rash appears; usually not contagious by the time the rash develops. Immune-impaired patients may be contagious for a prolonged period.
Incubation	4 to 20 days
Diagnosis	Clinical diagnosis of typical disease occurring in outbreaks is reliable. The diagnosis can be confirmed by serology (IgM antibody) or PCR.
Management without of Case	There is no specific treatment, but most cases in children resolve without intervention. School exclusion is not beneficial because transmission to other susceptible individuals will have occurred before the infection is recognized.
Management of Contacts	Parents of children with chronic anemia or immune deficiency and pregnant women should be notified of possible exposure. Pregnant women should avoid exposure due to potential fetal risk.
Public Health of Action	Report outbreaks and infections with complications to the Department Health.

Prevention Education	Frequent hand washing will minimize the risk of exposure.
School Action	-School exclusion is not helpful. -Notify parents of children with chronic anemia or immune deficiency and pregnant women when outbreaks occur. -Frequent hand washing should be stressed for all students and school staff.

Genital Warts

Condition, Disease, Agent Human Papillomavirus (HPV)

Clinical Description Single or massed warty or cauliflower-like growths may be found on external genitals, urethral opening, anus, and inside the vagina. They may cause irritation. Some strains cause neoplasia of the cervix and other genital and non-genital structures.

Transmission, Exposure Person-to-person genital contact and possibly by contaminated articles.

Contagious Period May be indefinite but probably at least as long as lesions exist.

Incubation 2-3 months with a range of 1-20 months

Diagnosis The typical lesion usually confirms diagnosis, but it can be excised and examined histologically. Microscopic examination of cells is an effective method for detecting cellular abnormalities associated with malignancy in women (e.g., cervical cancer screening with Pap.)

Management of Case Treatment which may be chemical or physical destruction will decrease the amount of wart virus available for transmission. The warts may regress spontaneously within months to years. Avoidance of direct contact with lesions by others prevents transmission. Studies have indicated that the male condom does not prevent infection. School exclusion is not appropriate.

Management of Contacts Sexual contacts of patients with genital warts should be examined and treated if indicated.

Public Health Action Not reportable to Department of Health.

Prevention Education	Avoidance of contact with lesions on another person prevents infection. HPV vaccine is effective if initiated before exposure to genotypes covered by vaccine (ideally before initiation of sexual activity).
School Action	-School exclusion is not appropriate. -Provide prevention education as part of sex education curriculum.

Giardiasis, Cryptosporidiosis

Condition, Disease, Agent Giardia lamblia, Cryptosporidium (protozoan parasites)

Agent

Clinical Description	Diarrhea with loss of appetite, nausea, abdominal discomfort and flatulence. Patients may have altered sense of taste or a metallic taste and frequently note headache, malaise and similar non-specific toxic symptoms. The diarrhea is often chronic and/or recurrent and may alternate with constipation; symptoms may last for weeks or months. Individuals may carry the parasite without symptoms (asymptomatic carriers).
Transmission, presence Exposure	Contamination with animal and human feces has resulted in the presence of Giardia cysts in virtually all untreated surface water accounting for cases in campers and hikers who drink untreated water. Transmission by food prepared by infected individuals or those caring for diapered infants with giardiasis has resulted in outbreaks. Person-to-person transmission by caretakers and children in day care institutions has resulted in outbreaks involving substantial proportions of the children at risk. Only a small number of viable cysts (10-100) are required to establish infection, especially in persons with reduced stomach acidity. Contaminated municipal water systems have resulted in community-wide outbreaks.
Contagious Period	Variable; an untreated case may excrete Giardia cysts indefinitely.
Incubation	For giardiasis, 1 to 4 weeks. For cryptosporidiosis, incubation period 7 days, range 1-12 days.
Diagnosis	Identification of parasites by microscopic exam or antigen test (EIA) in the stool or by antigen testing. Repeated examinations may be necessary.
Management of Case	Symptomatic patients should be treated with repeat treatment using same drug if initial therapy fails. Alcohol gels do not kill cryptosporidiosis. No water play or swimming for daycare cases. As long as sanitation is adequate, there is no reason to exclude a student with giardiasis or cryptosporidium after the diarrhea stops.

Management from of Contacts	Symptomatic contacts should have stool examined and be excluded handling food. Personal hygiene habits should be monitored for adequacy.
Public Health Action	Notify the Department of Health of outbreaks. The Epidemiology and Response Division will coordinate outbreak investigation and management. In some cases, stool surveillance within a school may be indicated. Evaluation of the water supply for fecal contamination may be indicated.
Prevention Education	Avoid contact with animals with diarrhea. Animals in the school with diarrhea should be taken to the vet and isolated from children. Wash hand carefully after using the toilet or changing diapers and before preparing food and eating. Avoid ingesting untreated water. Separate diaper changing areas from play or food prep areas.
School Action	<ul style="list-style-type: none"> -Refer suspected cases for diagnosis and treatment. -Report outbreaks to the Department of Health. -School exclusion is usually not necessary unless the student is unable to maintain continence of stool. -Exclude symptomatic contacts from handling food. -Classroom animals with diarrhea should be isolated. -Provide prevention education. -For day care setting, center should notify parents in writing of a case in the daycare.

Haemophilus influenzae Invasive Disease

Condition, Disease, Agent *Haemophilus influenzae*

Clinical Description *Haemophilus influenzae* are gram-negative coccobacilli that cause a broad range of infections. The organism is transmitted person to person by respiratory droplets. The most common manifestations of invasive disease are bacteremia, meningitis, pneumonia epiglottitis, septic arthritis or other musculoskeletal disease. Signs and symptoms may include fever, headache, meningismus, cough, respiratory distress, bone or joint pain or general ill appearance. Non-encapsulated or nontypeable strains of *H. influenzae* usually cause noninvasive infections including otitis media, sinusitis, conjunctivitis, pneumonia, and bronchitis.

Transmission, Exposure	The organism resides in the human upper respiratory tract. Person-to-person transmission occurs through inhalation of respiratory tract droplets or through direct contact with respiratory tract secretions. Pharyngeal colonization is common, especially with non-type b strains. For Type B, widespread use of Hib conjugate vaccine has markedly reduced colonization rates. Colonization rates increase following recent exposure in closed populations (such as family or child care contacts of a person with disease). Colonization can persist for months.
Contagious Period	Period of communicability is undefined as the organism can be transmitted as long as it is present in the nasopharynx. Type B: For patients with invasive Hib disease, the patient is considered noninfectious 24 hours after initiation of appropriate antimicrobial therapy.
Incubation	Incubation period is unknown.
Diagnosis	<i>H. influenzae</i> can be cultured from blood, cerebrospinal fluid (CSF), synovial fluid, sputum, and pleural fluid. A gram stain of infected body fluid can demonstrate the organism and allow a presumptive diagnosis to be made. Because the type b capsular antigen can be detected in body fluids, including urine, blood, and CSF of patients, clinicians often request a rapid antigen detection test for diagnosis of Hib disease.
Management of Case	Patients with invasive <i>H. influenzae</i> must receive antimicrobial therapy. The choice of specific therapy should take into account local antibiotic susceptibility patterns of invasive isolates. Treatment decisions are made by the patient's health care provider; consultation with infectious disease specialists can be beneficial in treating invasive infections.
Management of Contacts	For close contacts of patients with invasive Hib Type b disease, prophylaxis with rifampin is indicated. Consultation with the Epidemiology Response Division of the Department of Health (505 827-0006), is recommended for specifics on who needs prophylactic treatment.
Public Health the Action	Cases of invasive <i>Haemophilus influenzae</i> disease are reportable to the Department of Health.

Prevention Education	Age appropriate vaccination is the primary way to prevent invasive Hib disease. Infants routinely begin the primary immunization series at age 2 months with subsequent vaccines at ages 4 and 6 months. A booster dose is given at ages 12- 15 months. A schedule is available for
	unvaccinated children up to 72 months (6 years) of age. Hib vaccine is not typically given after age 6 years.
School Action	<ul style="list-style-type: none"> -Refer suspected cases for diagnosis and treatment. -Report suspected cases to the Department of Health. -Ensure appropriate immunization of students, especially for those in day care or pre-kindergarten programs. -Encourage good hand washing in school. -Encourage staff and students to cover their mouth and noses when coughing or sneezing and to wash their hands afterwards.

Hand, Foot and Mouth Syndrome

Condition, Disease, Agent Groups A and B Coxsackieviruses

Clinical Description	This illness is characterized by a non-specific rash and tiny blisters in mouth and on fingers, palms of hands, buttocks, and soles of feet. Mouth discomfort may make it difficult to eat or drink.
Transmission, Exposure	Direct contact with respiratory secretions and by fecal-oral route
Contagious Period oral	Respiratory route – less than a week after symptoms appear; fecal oral route – several weeks after symptoms appear
Incubation	3-6 days
Diagnosis	Usually clinical diagnosis is sufficient; however, coxsackievirus can be identified by culture.
Management at of Case	Ill students unable to perform usual activities at school should not be school, especially if diarrhea is uncontrolled. Hydration should be encouraged in spite of discomfort in the mouth. School staff should be alerted to watch for symptoms in other students. Hand washing and appropriate disposal of contaminated articles are important in disease control in the school setting.
Management	Encouraging good hygiene is the most effective management along

of Contacts with preventive education. Symptomatic contacts should not be handling food for consumption by others.

Public Health Action Not notifiable

Prevention Education Prevention education should include: covering mouth when sneezing and coughing, proper disposal of contaminated articles, good hand washing technique, adequate fluid intake, and good diapering technique.

School Action

- Refer suspected cases for diagnosis and treatment.
- Report outbreaks to the Department of Health (505-827-0006).
- School exclusion is not necessary unless the student is unable to maintain continence of stool.
- Exclude symptomatic contacts and cases from handling food.
- Encourage adequate hydration.
- Provide prevention education.

Hantavirus Pulmonary Syndrome (HPS)

Condition, Disease, Agent RNA virus of Bunyaviridae family

Clinical Description The prodromal illness consists of fever and myalgia with variable respiratory symptoms, abdominal pain, vomiting or diarrhea followed by progressive cough, shortness of breath and dizziness which reflect cardio-respiratory insufficiency. May progress to respiratory failure or shock.

Transmission, Exposure Contact with aerosolized feces and urine of deer mice or saliva is the presumed mode of transmission. Indoor exposures in closed, poorly ventilated homes, vehicles and outbuildings with visible rodent infestations are especially suspect.

Contagious Period No person-to-person infections of the disease has been documented.

Incubation Approximately 2 weeks with range of 1-6 weeks

Diagnosis Clinical diagnosis is made by demonstration of specific IgM antibodies in specialized laboratory testing.

Management of Case There is no specific treatment; supportive care including intensive management of pulmonary edema, severe hypoxemia and hypotension needs occur within the first 48 hours. Patients should be rapidly

transferred to a tertiary care facility. Bed rest and early diagnosis are critical in disease outcome. School exclusion is not a consideration.

Management of Contacts None

Public Health Action Report outbreaks and infections to the Department of Health (505-827-0006).

Prevention Education Exterminate rodents in home and avoid contact with rodents. Store human and animal food in rodent proof containers, and disinfect rodent contaminated areas by spraying a disinfectant such as 10% bleach solution prior to cleaning. Eliminate food sources and limit possible rodent nesting sites. Seal holes and other possible rodent entrances (mice can squeeze through holes the size of a dime). Brooms and vacuums should not be used to clean rodent infested areas. Avoid inhalation of dust in infested areas by wearing approved respirators when cleaning these areas.

School Action -School exclusion is not appropriate.
-Provide prevention education.

Hepatitis A (Acute)

Condition, Disease, Agent Hepatitis A virus

Clinical Description Symptoms include fever, nausea, vomiting, loss of appetite or distaste for certain foods followed in 3-10 days by dark brown urine, pale feces and jaundice (yellow discoloration of eyes, skin and mucous membranes). About 70% of hepatitis A infections in young children are without symptoms or are a gastroenteritis-like illness without jaundice compared to 50% of infections in school-age children and 20% in adults.

Transmission, Exposure Person-to-person by fecal-oral mechanism both direct and indirect. Contaminated food or water may lead to outbreaks. Secondary cases occur in families and other close groups where people share food and drinks. Persons at high risk of transmission in schools are food handlers and staff who do diapering and toileting. Good handwashing is key to preventing transmission.

Contagious Period Latter half of incubation period through first week after onset of jaundice.

Incubation	Usually 5- 50 days with an average of 30 days.
Diagnosis	Exam shows jaundice with liver enlargement and tenderness as with other types of hepatitis. Laboratory testing results in elevated enzymes (SGPT/ALT), and elevated bilirubin reveals mild to severe liver injury. Hepatitis A IgM antibody is usually present at the onset of jaundice.
Management of Case	Refer students with jaundice for medical evaluation. Students in the active phase of illness may be too sick to attend school. Those with a clinical diagnosis of Hepatitis A should be excluded until one week after onset of jaundice or in absence of jaundice for 14 days after appearance of symptoms.
Management of Contacts	Hepatitis A postexposure prophylaxis is not routinely indicated when a single case occurs in an elementary or secondary school, and the source of infection is outside the school or work setting. Hepatitis A vaccine or IG should be administered to persons who have close contact with index patients if an epidemiologic investigation indicates HAV transmission has occurred among students in a school. Hepatitis A vaccine is generally recommended for post-exposure prevention within two weeks after exposure for contacts ages 12 months to 40 years. Immune globulin (IG) within two weeks after exposure is recommended for persons >40 years of age, children aged <12 months, immunocompromised persons, persons who have had chronic liver disease diagnosed, and persons for whom vaccine is contraindicated.
Immunization	One dose of Hepatitis A vaccine is required for child care enrollment at 16 months and older in New Mexico and is recommended for all children in high incidence communities. It can be given to children 12 months of age or older. Hepatitis A vaccine may also be recommended to school populations when one or more students have acute Hepatitis A disease.
Public Health Action	Report cases of suspected hepatitis to the Department of Health. Confirmed cases will be investigated and contacts will be given treatment. Promote vaccination of students at increased risk of exposure.
Prevention Education	Hand washing after using the toilet, changing diapers and assisting children with toileting, and before handling food and eating is the most important preventive measure. Keeping toilet and food preparation areas clean and will minimize risk of disease transmission. Use standard

precautions for blood borne pathogens.

- School Action
- Refer jaundiced students for medical evaluation.
 - Report suspected cases to the Department of Health.
 - Consider exclusion of Hepatitis A confirmed cases until one week after onset of jaundice.
 - Encourage use of IG and Hepatitis A vaccine as recommended by the Department of Health. Prophylaxis not recommended after exceeding 2 weeks of exposure.
 - Prophylaxis not necessary with a single case unless behavior defined as “close contact with a confirmed case is documented.”
 - Exclude confirmed cases from food handling.
 - Provide prevention education.
 - Use standard precautions for blood borne pathogens.

Hepatitis B and C (Acute)

Condition, Disease, Agent Hepatitis B virus (HBV) and hepatitis C virus (HCV)

- Clinical Description Symptoms may include anorexia, nausea, malaise, jaundice, arthritis and skin rashes. Complications may include liver failure, chronic hepatitis and eventual cirrhosis or liver cancer.
- Transmission, Exposure Usually by direct and indirect contact with infected blood or body fluids or objects contaminated with blood or genital secretions.
Contact

may be parenteral (injection drug use, accidental needle stick, or transfusion) or by sexual contact (rare); HB can potentially be transmitted by close family contact (e.g., sharing toothbrushes, razors, tweezers, scissors and/or nail-clippers).
- Contagious Period Anytime virus is present in blood, secretions and body fluids containing blood, in genital secretions (semen, vaginal fluid) and for many weeks before onset of symptoms. Chronic carrier states for both viruses are common.
- Incubation HBV is an average of 90 days with a range of 45-160 days. HCV is usually 36-63 days with a range of 14 days to 6 months.
- Diagnosis Serology for acute hepatitis B usually shows hepatitis B surface antigen and IgM antibody to core antigen (IgM anti-HBc). Serology for hepatitis C

	is a test for total antibody (anti-HCV).
Management School Of Case	Refer students with suspicion of hepatitis for medical evaluation. exclusion is unnecessary; however, the student may be too ill to participate in school activities.
Management of Contacts Hepatitis	Contacts of Hepatitis B and C should be evaluated for risk of infection. Needle sharing, sexual contact or close family contact with an infected individual is indication for serologic testing and immunization for B.
Immunization	Infants should receive hepatitis B vaccine along with other routine immunizations. As of 2002 it is required for required for school entry in in NM. Any unvaccinated person at increased risk of hepatitis B infection should receive vaccine.
Public Health Action	Report cases to the Department of Health.
Prevention Education	Avoid contact with blood and body fluids; avoid injections, tattoos, etc. with unsterile equipment. Practice safe sex including use of latex condoms. Persons who inject illicit substances (including steroids) should be encouraged to stop or to obtain sterile needles and equipment from local PHO under the Harm Reduction Program (505) 476-3136. Use standard precautions for blood borne pathogens.
School Action	-Refer children with jaundice or other suspicion of hepatitis for medical evaluation. -Monitor immunization status of students. -Report confirmed cases to the Department of Health. School exclusion is not necessary. -Observe standard precautions for blood borne pathogens. Monitor students who are chronic carriers of HBV for behavior that may place others at risk (biting for example). -School staff identified at high-risk for exposure to HBV in the school districts blood borne pathogen exposure plan should receive Hepatitis B vaccine. -Provide prevention education. -Refer sexual contacts of an infected person to the Department of Health for testing and appropriate immunization. -Respect the right to confidentiality of infected persons.

Herpes Simplex-Genital Infection

Condition, Disease, Herpes simplex virus (HSV), type 2

Agent

Clinical Description	Symptoms include vesicles (small blisters) on the skin and/or mucous membranes that rupture quickly leaving painful ulcers and dry crusts (on skin); satellite vesicles form for several days with primary infection. There may be fever and malaise lasting 5 or more days following infection. Recurrent infections are common and usually occur in the same area as the primary lesion. Recurrent genital lesions may be initiated by trauma, emotional stress, menstruation, illness or fever. Recurrent lesions are usually smaller and heal more quickly.
Transmission, Exposure	Direct contact with genital secretions or lesion; indirect contact highly unlikely although virus remains viable on contaminated objects at least for several hours.
Contagious Period	7-50 days following onset of primary infection and typically 3-4 days after onset of recurrent episode; during asymptomatic shedding of the virus.
Incubation	2-12 days for primary infection
Diagnosis	Diagnosis is made on the clinical evaluation of lesions that are initially thin-walled vesicles and/or blisters that ulcerate on moist surfaces or crust on dry skin; laboratory testing includes cultures.
Management of Case	Refer for medical evaluation for apparent primary infection or for frequent or severe recurrences. Genital herpes in a student may be indicative of sexual abuse. Specific treatment: Oral (or in severe cases, intravenous) acyclovir is effective in shortening the duration of the primary and recurrent episodes including viral shedding. Those with frequent recurrences may suppress them with continuous oral acyclovir. Valacyclovir and famciclovir are newer medications that may be used in these cases.
Management of Contacts	Refer contacts for medical evaluation and provide prevention education.
Public Health Action	Not reportable condition
School Action	-Support school-based clinics, peer-counseling, education, and other

measures to increase availability and acceptability of health care services to adolescents.

-Affected students should not be excluded from school.

-If sexual abuse or inappropriate sexual contact is suspected, report to Child Protective Services or other appropriate authority.

-Provide prevention education to include safer sex practices.

Herpes Simplex, Non-Genital Infections

Condition, Disease, Agent Herpes simplex virus (HSV), type 1

Agent

Clinical Description	Symptoms include vesicles (small blisters) on the skin and/or mucous membranes that rupture quickly leaving painful ulcers and dry crusts (on skin), satellite vesicles form for several days with primary infection. There may be fever and malaise lasting 5 or more days. Recurrent infections are common and usually occur in the same area as the primary lesion. "Cold sores" and "fever blisters" may be initiated by trauma, emotional stress, menstruation, illness or fever. Recurrent lesions are usually smaller and heal more quickly. Herpes gladiatorum is a herpetic skin infection (usually HSV-1) usually of the trunk or extremities of wrestlers and other athletes probably resulting from salivary inoculation of minor skin abrasions. HSV-1 may spread to the eye and cause inflammation and ulceration of the cornea. Patients with eczema (rarely other types of dermatitis) may develop widespread herpetic infection of their skin lesions.
Transmission, Exposure	Contact with oral secretions of infected person with or without symptoms; contact with open lesions from which eyes or genitals may become infected.
Contagious Period	7-50 days following onset of primary infection and for typically 3-4 days after onset of a recurrent episode. Patients may have asymptomatic shedding of the virus and may be capable of spreading the infection when they have no symptoms.
Incubation	2-12 days for primary infection
Diagnosis	Diagnosis is made on clinical evaluation of the lesions which are initially thin-walled vesicles and/or blisters that ulcerate on moist surfaces or crust on dry skin; laboratory cultures to confirm diagnosis.

Management of Case Refer for medical evaluation for apparent primary infection or for frequent or severe recurrences. Oral (or in severe cases, intravenous) acyclovir is effective in shortening the duration of primary episode and reduces viral shedding. Those with frequent recurrences may be able to suppress them with continuous oral acyclovir. Valacyclovir and famciclovir are newer medications that may be used in these cases. Topical Carmex and camphor products have been used as OTC treatment.

Management of Contacts Protect students with eczema or severe immune deficiency and newborns from exposure to persons with active herpes infections. Covering lesions with clothing or a loose dressing will curtail most transmission since hand contact with lesions will be minimized. Promoting the avoidance of kissing and sharing drinking utensils with infected persons is important.

Public Health Action Not a reportable condition

School Action

- School exclusion is not necessary.
- Infected students should be taught to frequently disinfect surfaces and objects routinely contaminated with oral secretions.
- Persons in physical contact with students who have active lesions and who cannot control their oral secretions should wash their hands frequently and use standard precaution for blood-borne pathogens.
- Children with primary HSV gingivostomatitis who do not have control of oral secretions should be excluded from child day care or school until symptoms resolve.
- Exclude athletes in contact sports from competition while they have open lesions that cannot be covered.
- Disinfect sports equipment (especially mats) after practice and competition.
- Provide prevention education.

HIV Infection/AIDS (Acquired Immunodeficiency Syndrome)

Condition, Disease Agent Human immunodeficiency virus (HIV)

Clinical Description Initial infection with HIV may be subclinical or may cause an acute mononucleosis-like illness with fever, malaise, sore throat, lymph node enlargement and skin rash. Progressive symptoms may occur years later including fever, weight loss, chronic diarrhea or symptoms of opportunistic infection or cancer that occur when immune function

becomes severely impaired. HIV infects cells of the immune system and causes progressive impairment of immune function. Early combination anti-retroviral treatment has prolonged the symptom-free period, delayed the onset of AIDS and prolonged the lives of HIV infected people.

Transmission, Exposure	Contact with blood or body fluids or genital secretions of an infected person commonly by sharing injection equipment or sexual contact with an infected person. Infants born to an infected mother may be infected at birth or by breast feeding. Infection is <u>not</u> a risk with casual household, school or social contact.
Contagious Period	Early on after infected to indefinitely since infection is chronic. Periods of greatest infectivity are soon after infection with HIV and with advanced HIV/AIDS illness.
Incubation	1-3 months to seroconversion for HIV infection. 1 to many years for development of AIDS.
Diagnosis	HIV infection can be suspected by clinical symptoms and signs, but laboratory confirmation requires testing for HIV antibodies using the Enzyme immunoassay (EIA) and/or Western Blot tests.
Management of Case	Students with HIV infection may be absent from school frequently and may need medication frequently and regularly at school. They may be more susceptible to some infections and may not be completely protected by immunizations. Observing standard precautions with these students is especially important.
Management of Contacts	Casual contacts are not at risk of infection. People at risk are those who have unprotected sexual contact, share needles or syringes for injection of illicit drugs or have blood or body fluid contact with non-intact skin or mucous membranes with someone who is HIV positive. Post-exposure preventive treatment is recommended for any percutaneous exposure to blood from a person with known HIV infection. This anti-retroviral treatment must be given within 72 hours of exposure to be optimally effective. Such contacts should be referred for medical evaluation immediately. Any person at risk of HIV infection should be tested to facilitate early treatment.
Public Health Action	Report cases of HIV infection or AIDS to the Department of Health. Refer

exposures who are uninsured to the DOH/STD Program (505) 476-3136 immediately for post-exposure preventive treatment and testing.

Prevention Education	Avoid contact with blood and body fluids; avoid injections, tattoos, etc. with unsterile equipment. Practice safe sex. Persons who inject illicit substances (including steroids) should be encouraged to stop or to obtain sterile needles and equipment through the Harm Reduction Program at their local PHO. Practice standard precautions.
School Action	<ul style="list-style-type: none">-School exclusion is not appropriate (possible exceptions may occur with opportunistic infections (e.g., TB). Infected students may participate in all school activities compatible with their medical condition.-Practice standard precautions and conform to OSHA regulations.-Monitor students for behavior that may place others at risk (biting for example).-Provide prevention education.-Respect the right to confidentiality of infected persons and provide with as normal a school environment as possible.

Impetigo

Condition, Disease, Agent

Group A *Streptococci* (GAS), *Staphylococcus aureus*

Clinical Description	Flat yellow crusty or weeping lesions seen commonly on face and arms that are usually superficial at first proceeding through vesicular, pustular and encrusted stages. Impetigo can occur as a complication of abrasions, insect bites and chicken pox. Outbreaks can occur in populations with much skin-to- skin contact and a high rate of GAS carriage.
Transmission, Exposure	Direct person-to-person contact of colonized skin or lesion to skin transmission most common; respiratory droplets of asymptomatic persons.
Contagious Period	Variable, at least while lesions are actively weeping and crusting and carrier state exists; not contagious 24 hours after initiation of effective antibiotic.
Incubation	Streptococcal – 7to 10 days; staphylococcal – 4 to 10 days
Diagnosis	Clinical diagnosis is reliable but culture and sensitivity of the base of the

lesion is recommended.

Management
of Case

Local skin infection is managed by cleaning the area and applying appropriate topical antimicrobial ointment under primary care provider's direction. Systemic antimicrobial therapy is usually not indicated unless an infection spreads significantly or there is impetigo in multiple family members or school attendees. A student with this disease should not return to school until 24 hours after antibiotic treatment has been started; large weeping lesions should be covered by clothing or a loose dressing.

Management
Contacts
of

Careful surveillance of contacts and persons living in close contact of (home and school). Improved personal hygiene will minimize the risk of infection of minor wounds. Use standard precautions for blood borne pathogens.

Public Health Action

Outbreaks of impetigo and complications of streptococcal infection should be reported to the Department of Health.

School Action

- Refer suspected cases for medical evaluation and treatment.
- Exclude infected students from school until after 24 hours of antibiotic treatment is completed.
- Stress good personal hygiene and avoidance of contact with lesions by unaffected. Monitor students with lesions and cover with clothing or a loose dressing as appropriate.
- Provide prevention education.
- Use standard precautions for blood borne pathogens.
- Properly dispose of wound dressings.

Influenza

Condition, Disease,
Agent

Influenza virus (types A and B)

Clinical Description

Acute respiratory infection ("flu") characterized by sudden onset of fever, chills, headache, malaise, myalgias and respiratory symptoms including sore/scratchy throat, nasal congestion and cough, usually initially harsh and dry then becoming productive of sputum if secondary bacterial infection occurs. Abdominal pain, vomiting and diarrhea are not uncommon in children infected with influenza. Infections may be

	subclinical or very mild. Bacterial super-infections are relatively common, including bronchitis, pneumonia, otitis media and sinusitis.
Transmission, Exposure	Direct and indirect contact with respiratory secretions either by large droplets through sneezing and coughing or contact with contaminated surfaces or objects via hand inoculation of the eye and nose. May be transmitted via airborne route also.
Contagious Period	1 day prior to onset of symptoms and up to 5 days after onset. With young children, communicability can be from several days prior to onset and up to 10 days after onset.
Incubation	1-4 days
Diagnosis	Clinical diagnosis is usually reliable when symptoms are typical and influenza is circulating in the community. Viral antigen testing of nasal or throat swab can be used for point of care diagnosis. Cultures for influenza take more time for results but can identify the influenza type which is important for surveillance activities and in developing influenza vaccine. PCR testing is also used. Although not standardized, it offers the opportunity for better sensitivity and specificity.
Management fever of Case	Children and adults with clinical influenza should be sent home until (greater than 100°F) subsides. Fluids are important to maintain hydration. Bed rest, analgesics (other than aspirin) may help symptomatically. The influenza cough may persist for weeks and may require some limitation of activity, especially for those with asthma. Students should not return to school until they are afebrile (less than 100°F) after 24 hours without anti-pyretic and systemic symptoms have subsided (usually 3-7 days).
Management vaccine of Contacts	All individuals 6 months of age or older should receive influenza annually as soon as it is available. Encourage good hand hygiene and appropriate disposal of contaminated articles. Emphasis should be placed on obtaining flu vaccine for those individuals at risk for influenza complications and those who come into contact with persons at increased risk.
Immunization	Influenza vaccine changes each year, so it should be repeated annually.

Public Health Action	Notify the Department of Health (505-827-0006) when outbreaks of respiratory disease appear in a school.
School Action	<ul style="list-style-type: none"> -Exclude students and staff with clinical influenza until afebrile (less than 100°F) after 24 hours without anti-pyretic use and symptoms do not affect participation in routine school activities. -Report suspected outbreaks of respiratory disease to the Department of Health. -Emphasize hand washing and respiratory droplet precautions. -Offer influenza vaccination to students and staff through school health program. -Consider student absenteeism and staff availability when making decisions regarding school closure when outbreaks occur. -Provide prevention education. -In the case of a novel influenza virus with pandemic activity, the Department of Health will provide updated guidance.

Meningitis (Bacterial)

Condition, Disease Agent	Neisseria meningitidis (meningococcus), Streptococcus pneumoniae (pneumococcus)
Clinical Description	Invasive bacterial disease is manifested by fever, chills, malaise, rash that may be macular/maculopapular/petechial, stiff neck, headache, vomiting, and possibly stupor or loss of consciousness. Potential complications include shock, respiratory failure, seizures, coma and death. Neurologic complications of meningitis include deafness, seizure disorders, acquired learning disabilities or developmental retardation, paralysis (cerebral palsy).
Transmission, Exposure	Direct person-to-person transmission through droplet spread or contact with respiratory secretions; may be carried in the throat or nasopharynx by asymptomatic individuals
Contagious Period	Healthy carriers are potentially infectious. Patients with bacterial meningitis once started on appropriate antibiotic therapy are generally non-contagious within 24 hours.
Incubation	Usually 3-4 days with a range of 2-10 days
Diagnosis	Examination of the spinal fluid and culture of blood and spinal fluid are required to confirm the clinical diagnosis and guide therapy.

Management of Case	Bacterial meningitis is a life-threatening illness requiring immediate hospitalization and antibiotic treatment and respiratory isolation for 24 hours after initiating therapy. The infected student may return to school at the advice of a medical provider with any limitations specified by him/her.
Management of Contacts	It is important to start surveillance of contacts of infected person for antibiotic prophylaxis. Secondary cases of <u>meningococcal disease</u> may occur in contacts of any age, so prophylaxis is indicated for face-to-face, household and close social contacts within the previous 7 days; this may include close friends at school. All young contacts in child care should be considered for prophylaxis. Secondary cases of <i>Haemophilus influenza</i> and pneumococcus tend to occur in contacts less than 5 years of age within the family. Secondary cases are uncommon in classroom or school contacts. Surveillance of household contacts for invasive <i>Haemophilus</i> disease should include exposed unimmunized or incompletely immunized children.
Immunization	Infants should receive <i>Haemophilus influenzae</i> (Hib) vaccine according to the recommended schedule. Meningococcal vaccine may be recommended for community or school outbreaks.
Public Health Action Epidemiology	Report cases immediately to the Department of Health; the and Response Division will coordinate contact assessment and implementation for antibiotic prophylaxis and surveillance.
School Action	<ul style="list-style-type: none"> -Refer students with suspected meningitis for emergency medical care. -Report suspected cases to the Department of Health. -Assist the Department of Health in identification and prophylaxis or vaccination of contacts as well as communication with parents and staff. -Provide prevention education. -Exclude infected students until a release to return is provided by the primary care provider and accommodate students with any specified limitations.

Meningitis (Viral or Aseptic)

Condition, Disease, Agent Enteroviruses (ECHO and Coxsackie), other viruses

Clinical Description Symptoms include fever, headache, stiff neck, back pain, vomiting,

malaise, drowsiness, altered consciousness, prostration and possibly rash. Although enteroviral infections can occur year-round, they are most common in summer and early fall. Seizures, coma and neurologic complications can occur. Children with suspected meningitis represent a medical emergency and should be immediately evaluated by a healthcare provider and excluded from childcare until the cause of the meningitis is identified.

Transmission, Exposure	Direct person-to-person infected secretions from throat or nose; fecal-oral contamination for many enteroviruses.
Contagious Period	Weeks to months depending on causative agent; most infectious during stage of illness.
Incubation	Variable depending on virus, 3-6 days for enteroviruses
Diagnosis	Examination of spinal fluid and spinal fluid culture can help to confirm clinical diagnosis.
Management of Case	There is no specific treatment. Supportive treatment is provided as indicated by the specific clinical indications. When the infected student has recovered, he/she may return to school with limitations according to primary care provider's recommendations.
Management school of Contacts	Other cases of enteroviral infection are likely to occur in the same or other group setting, but it is not likely that there will be other cases of meningitis or other serious illness. Contacts with symptoms suggestive of meningitis should be referred for medical evaluation immediately. Good hand washing practices by all should be enforced at school.
Public Health Action	Not required
School Action	-Refer suspected students for medical evaluation. -School exclusion is not necessary unless prescribed by medical provider. -Provide prevention education to include good hand washing practices.

MRSA (Methicillin-Resistant Staphylococcus Aureus)

Condition, Disease, Agent Staphylococcus aureus

Clinical Description	MRSA is a type of <i>Staphylococcus aureus</i> that is resistant to some antibiotics including methicillin (note: methicillin is not used for therapy, but is used to indicate resistance to common antibiotics such as amoxicillin or cephalexin). “Staph” aureus is found on the skin of many people, but does not cause infection or illness until these bacteria get into a cut, scrape or other break in the skin. Many people carry staph bacteria on their skin but have no symptoms of disease. Infections can look like a pimple, rash, boil or open wound.
Transmission, Exposure	Direct skin-to-skin contact such as holding hands or engaging in contact sports with hands being most common instrument of transmission; indirect through contact with items touched or used by infected person or staph carrier such as razors, towels, athletic equipment, clothing.
Contagious Period	As long as bacteria is carried on the skin.
Incubation	Variable and indefinite
Diagnosis	Isolation of <i>S. aureus</i> from culture is definitive.
Management of Case	Early treatment can help prevent MRSA infection from worsening. All skin lesions should be covered with clean, dry pads. The infected student may need to avoid certain activities such as contact sports or gym activities so that lesion dressing remains intact and the body can heal. Gloving, hand washing and proper disposal of contaminated materials is essential in care delivery. Prescribed antibiotics should be taken as directed; provider should be contacted if improvement is not evident in a few days. Students or staff infected or with suspect infection need <u>not</u> be excluded from school.
Management of Contacts	Good hand washing practices and observation are important for known contacts. There is no vaccine or preventive medication available for MRSA exposure.

Public Health Action	Notify Public Health (505-827-0006) if more than one diagnosed case of MRSA is suspected in the same school. Support services are available through Public Health as well as follow-up services if more than one MRSA case is suspected in the same school.
Prevention Education	Wash hands frequently with soap and water; keep cuts and scrapes clean with soap and water and covered with dry pads; do not pick, touch or scratch skin lesions or touch another's sores/lesions; avoid skin contact and sharing personal items with anyone suspected of having MRSA; to prevent antibiotic-resistance from occurring do not request antibiotics for colds or other viruses and take all antibiotics prescribed even if symptoms disappear before finishing the medication.
School Action	-Do not exclude students or staff with MRSA infections or suspected infections. -Alert parents of school cases only after collaboration with Public Health.
Health.	-Monitor cases and suspected cases. -Encourage frequent hand washing and proper coverage of all skin wounds. -Ensure access to sinks, soap and clean towels and/or alcohol-based sanitizers. -Infected students may need to avoid gym activities and contact sports to prevent wound dressings from coming off. -Clean athletic equipment daily if used by more than one individual. -Follow standard precautions when providing care for infected student. - Report <u>more than one case</u> to Public Health (505-827-0006).

Mononucleosis (Infectious Mononucleosis, Mono)

Condition, Disease, Agent Epstein-Barr virus (EBV)

Clinical Description	Persons with "mono" usually have fever, sore throat which may be severe, splenomegaly and enlargement of cervical lymph nodes. Malaise and fatigue may be severe and prolonged. Symptoms may return after a period of convalescence. Children infected during adolescence or young adulthood tend to have more typical disease.
Transmission, Exposure	Direct transmission and indirect exposure through person-to-person contact with saliva and by droplets contaminating hands or objects. Kissing facilitates disease spread. The virus may also be transmitted by blood transfusion.

Contagious Period	Viral shedding begins before onset of symptoms; periodic shedding occurs even after complete recovery for as long as a year or more and is probably the source of most new infections.
Incubation	4-6 weeks
Diagnosis	Clinical diagnosis of typical illness is reliable. Laboratory diagnosis is by typical findings in the blood (increase in lymphocytes with many "atypical lymphocytes"). Serologic tests are usually positive by the second week of illness.
Management of Case	Because of a small risk of rupture of the enlarged spleen, infected students should be excluded from contact sports until the spleen has returned to normal size. There is no specific treatment for "mono". Infected students who are well enough to attend school should not be excluded.
Management of Contacts	Because the virus is present in saliva, hand washing and washing of objects contaminated with saliva should reduce transmission from person to person. Discourage engaging in activities involving exchange of saliva with infected individuals.
Public Health Action	Not a reportable condition.
School Action	-Refer children with suspected infectious mononucleosis for medical evaluation. School exclusion is not appropriate unless student is unable to participate in routine activities. Exclude student with enlarged spleen from contact sports until medical clearance is received.

Mumps

Condition, Disease, Agent Mumps virus, RNA virus

Clinical Description Mumps is an acute viral infection characterized by fever and enlargement of the salivary glands. Pancreatitis, orchitis in males, oophoritis in females, and encephalitis may occur, but rarely. Complications are more common in adults.

Transmission, Exposure	Direct airborne transmission or respiratory droplets or direct contact with saliva of infected person.
Contagious Period	6-7 days before until 9 days after swelling begins
Incubation	16-18 days after exposure with a range of 12-26 days
Diagnosis	Clinical diagnosis of symptomatic mumps is reliable in outbreaks; however, isolated cases of salivary gland swelling may be caused by other viruses, blockage of a salivary duct or bacterial infection. Virus isolation and serology including detection of IgM antibody are recommended. Confirmation of the disease is important before extensive surveillance or immunization is undertaken.
Management no of Case	Refer students with suspect mumps for medical evaluation. There is specific treatment; most school-age children only have mild illness. School exclusion is for 5 days after onset of swelling.
Management of Contacts	Contacts of mumps cases who have not had two doses of mumps vaccine should be immunized preferably with MMR vaccine. Contacts with no prior history of mumps illness or immunization should be excluded from school from the 12 th through 25 th day after exposure and should be considered for mumps vaccine. Testing adults to determine susceptibility should be considered before vaccination with MMR since a majority of adults without a history of mumps will be immune because of subclinical or unrecognized infection. Mumps in adults is more likely to be severe with systemic involvement.
Immunization	All students are required to have two doses of MMR vaccine before school entry.
Public Health Action School Action	Report cases and suspect cases to the Department of Health. -Refer students with enlarged salivary glands for medical evaluation. -Exclude students with confirmed mumps for 9 days following onset of swelling. -Exclude susceptible contacts from 12 th through 25 th day after exposure. Excluded students can be readmitted immediately after immunization.

-Exclude students who are exempted from mumps immunization until at least 26 days after onset of swelling in the last contact case of exposure.

Norovirus

Condition, Disease, Agent Norovirus, RNA virus

Clinical Description Noroviruses are the leading cause of acute gastroenteritis which is sometimes referred to as “stomach flu” or “winter vomiting disease”. Illness is generally short-lived and self-limiting. Illness is characterized by acute onset of vomiting, watery, non-bloody diarrhea with abdominal cramps, and nausea. Some persons may experience only vomiting or diarrhea. Muscle aches, malaise, and headache are also commonly reported. Low-grade fever may be present. Symptoms usually last 24 to 60 hours. Dehydration is the most common complication. Up to 30% of infections may be asymptomatic.

Transmission, Exposure Noroviruses are highly contagious. These viruses can remain viable and infective on surfaces for up to two weeks. Outbreaks are most commonly spread person to person. Humans are the only known reservoir. Noroviruses are found in the stool or vomitus of infected people or on contaminated surfaces not properly cleaned and disinfected.

Contagious Period Persons are most contagious with the greatest amount of viral shedding during the illness and for 72 hours after symptoms end.

Incubation Generally 24 to 48 hours after ingestion of the virus; however, symptoms can appear as early as 12 hours after exposure.

Diagnosis Diagnosis relies on the detection of viral RNA in stools or vomitus of affected persons by use of reverse transcription-polymerase chain reaction (RT-PCR) assays.

Management of Case Treatment is supportive with an emphasis on maintaining hydration. Most people recover completely within 1 to 2 days, with no long-term complications of norovirus illness.

Management of Contacts Persons with suspected norovirus infection should be managed with standard precautions with careful attention to hand hygiene

	practices. Contact precautions should be implemented when caring for diapered or incontinent persons.
Public Health Action	Individual cases are not reportable, but outbreaks are often reported to the Department of Health.
Prevention Education	Prevention requires good personal hygiene (hand washing after using the toilet and changing diapers and before preparing food and eating).
School Action	-With acute diarrhea of any cause, prevent dehydration by increasing fluid intake. -Students with fever, vomiting or diarrhea that interferes with school activity should be sent home and excluded from school until symptoms do not interfere with routine school activities. -When cleaning up diarrhea, wearing disposable gowns is recommended. -Students may return to school when afebrile and diarrhea has improved to the extent that they can participate in normal activities. -Report outbreaks of diarrhea to the Department of Health immediately, especially if there is a suspicion of food or water transmission. -Frequent hand washing should be stressed by all school staff.
Additional	and more intensive cleaning measures, with a focus on use of agents with appropriate virucidal activity, may be necessary to prevent transmission. -Provide prevention education.

Pediculosis (Head Lice)

Condition, Disease, Agent Pediculus humanus capitis, parasitic arthropod

Agent

Clinical Description Head lice are parasitic insects with six legs and no wings. They hold
onto
head hair with specially adapted claws and move swiftly on dry hair.
They
feed by biting and sucking blood through the scalp. Infestation of head
lice occurs in the hair. They very often cause itching but this is not
always
the case, particularly when newly arrived to the head. Most cases are
light- only about 10 lice on the head. Lice will not leave the scalp
unless

they are dead or dying. Lice and their eggs are well hidden on the head.
Healthy lice tend to stay close to the scalp as it is their feeding ground.

Transmission, Exposure	Lice are spread by close head to head contact with someone who has head lice. Lice cannot jump, fly or swim, but spread by climbing rapidly from head to head (directly or through sharing of fomites such as hats, hairbrushes, hair ties). Anyone with hair on the head can get lice. Head lice that are off the head are usually damaged and cannot crawl back on a head. Survival off the scalp for more than 48 hours is very unlikely.
Contagious Period	Full grown lice move frequently between heads when they have the opportunity. Lice mature to the adult stage approximately 9-12 days after hatching. Lice nits (lice eggs) remain on the head where they hatch for a minimum of 6 days.
Incubation	Eggs hatch in 7-10 days and reach maturity in 6-14 days. At maturity they are fully capable of reproduction.
Diagnosis	Inspect for live crawling lice. Proper diagnosis of head lice is the most important step in controlling infestation. Please see CDC for pictures of live lice. Most persons with head lice will have between 10 and 20 lice.
Management of Case	Two methods of treatment are commonly used: 1. Use of chemicals (pediculicides) to kill the lice and nits: Chemical treatment has been the first line of defense for many years; consequently, lice have become resistant to the insecticide. Pediculicide resistance is approaching 50%. Educate the parent on the proper regime by following the manufacturer's recommendations. All household members should be checked for live lice and everyone with lice in the household should be treated at the same time. 2. Non-chemical treatment: Involves applying hair conditioner to wet washed hair; then combing with a louse comb (special fine toothed comb). The caregiver sections off the hair and removes the lice a section at a time combing from the scalp out. Rinse and dry the hair once the entire head has been combed. Repeat this process every two days over a 10 day period. Recheck the head for re-infestation once a week for one month. If adult lice are found, then restart the combing process. Check all household members for live lice and nits and treat using this same regime. Change or launder pillow cases exposed to lice within the last day. No extra household cleaning is necessary.

Children, when diagnosed with head lice, should be sent home from school at the end of the day and return after the first treatment (either method) has been completed. Educate parents on treatment and management methods.

Excluding any child from school due to head lice or nits is unjustified.

In the case of apparent resistance to topical treatment, i.e. when a child has been treated twice with topical agents and lice persist, consider referral to the child's primary care provider for a prescribed medication.

There are many other treatment options that are described on the internet – effectiveness (as well as risk) varies and should generally not be encouraged.

Management
parents
Contacts

School wide head checks are no longer recommended. Educating and teachers on head lice is essential.

Public Health Action

Pediculosis is not a reportable condition.

School Action

-According to the American Academy of Pediatrics, “no-nit policies in schools are detrimental to children, causing students to lose time in the classroom, causes an inappropriate use of the school nurse’s time for lice screening, and causes a response by parents that is out of proportion to the medical significance”. (See Red Book in reference section of chapter).

-At the end of the school day send students who have lice home. They may return to school after the first treatment is completed.

-Provide educational material including treatment recommendation to parents and recommend treatment options and regimes to follow for each method of treatment.

-Maintain confidentiality of affected student and his/her family.

-Mass screening of children for head lice has been shown to be ineffective.

-Consider referral to the child’s primary care provider for a prescribed medication in the case of apparent resistance to topical treatment.

Lice Identification Chart

Lice Management Algorithm for Schools

Pertussis (Whooping Cough)

Condition, Disease, Agent Bordetella pertussis, Bordetella parapertussis

Clinical Description Pertussis has three stages: the catarrhal stage with sore throat, coryza, mild cough and low grade or no fever lasts 1-2 weeks; the paroxysmal stage with increasingly severe spasms of cough with post-tussive whoop or vomiting lasting 2-6 weeks; and the convalescent stage with gradual lessening of coughing spasms disappearing in 2-6 weeks. Infants under six months of age may have apnea but no whoop. Complications may include pneumonia, seizures, encephalopathy and death. Less serious complications are otitis media, anorexia and dehydration.

Transmission, Exposure Direct person-to-person by respiratory droplets or by direct contact with respiratory secretions from infected person.

Contagious Period From onset of symptoms until 3 weeks of coughing; most contagious period is the first two weeks of cough.

Incubation 7-10 days with range of 4-21 days

Diagnosis Laboratory diagnosis is by PCR swabbing (polymerase chain reaction). Mild cases may be difficult to recognize unless they occur in contacts of typical disease.

Management of Case Refer persons with severe or persistent cough for medical evaluation; persistent cough is a cough of more than 7 days duration. Even though they are still coughing, people are no longer considered infectious after 5 days of antibiotics. The cough may persist for weeks or months even after appropriate treatment. Students may need restriction of activity if they have exercise-induced spasms of coughing. Exclude suspect or confirmed cases until after 5 days of antibiotic treatment.

Management Contacts includes Identify close contacts and refer them for preventive treatment of The focus of identification and prophylaxis of high risk contacts infants, pregnant women, immunocompromised individuals and vaccine exemptors. Close contacts include those with direct face-to-face exposure within 3 feet of a coughing case, direct contact with respiratory, oral or nasal secretions or sharing confined space for a minimum of 1 hour with coughing case. All students 6 years of age or

younger who have not completed the primary series or did not receive a booster dose after 4 years of age should receive a pertussis vaccine booster. All students 7 years of age and older who have not completed their primary pertussis booster series should receive a dose of Tdap; Conduct surveillance for additional cases in the setting where a case exposed others for three weeks from the first date of exclusion of the case. Exclude cases while taking antibiotics for 5 days.

NMDOH will evaluate for high risk contacts in the classroom situation before advising prophylaxis for classmates.

Immunization

For school entry students are required to have completed at least 4 doses of pertussis-containing vaccine with one dose received on/after 4th birth-day. One Tdap is required for 7th-12th grade entry and is recommended for adults younger than 64 years if more than 5 years since last pertussis-containing immunization.

For case(s) occurring in a school, assess the vaccination status of all contacts and students in the same school as the case:

- Exposed children 6 years of age who have received their third dose of DTaP 6 months or more before exposure should be given a 4th dose.
- Exposed children 6 years of age who received all four primary doses before their fourth birthday should receive a fifth (booster) dose of DTaP.
- Persons 7-9 years of age who have not been fully vaccinated against pertussis should receive Tdap.
- Those 10 years of age or older who have not received Tdap should be immunized with it.
- No minimum interval between doses of Td and Tdap.
- Recommendation is that pregnant women with every pregnancy receive Tdap during the late 2nd or 3rd trimester (> 20 weeks gestation). Alternatively, if not administered during pregnancy, Tdap should be administered immediately postpartum.
- All adults should have documentation of one dose of Tdap. If adults have not received one dose of Tdap, they should receive it as soon as possible, particularly those who will have contact with infants
- Vaccine exemptors within affected schools should be identified and reported to NMDOH for exclusion determination.

Public Health Action Report suspected and confirmed cases to the Department of Health. The Epidemiology and Response Division will coordinate testing, contact identification and treatment.

- School Action
- Exclude cases and symptomatic contacts until completion of 5 days of antibiotic treatment or until three weeks after onset of cough if not treated.
 - Refer suspected cases for medical evaluation and treatment immediately and monitor school for additional cases for 21 days after last contact with known case(s).
 - Report confirmed and suspect cases to Department of Health (505-827-0006) who will coordinate all follow up and parental notification.
 - Review immunization status of students and staff to identify susceptible contacts.
 - Provide access to immunization.

Plague

Condition, Disease, Agent Yersinia pestis (bacteria)

Clinical Description Plague is a bacterial infection transmitted by fleas from rodents to humans. The most common form is bubonic; less common forms are septicemic and pneumonic.

Bubonic plague: The primary site of inoculation may resemble an infected insect bite or the site may be unapparent. The regional lymph nodes become enlarged and exquisitely tender (bubo). Most patients have fever and non-specific flu-like symptoms (vomiting, diarrhea). Untreated patients with bubonic plague may develop (secondary) bacteremia. Untreated bubonic plague has a case fatality rate of 50-60% and is the most common form of plague.

Septicemic plague: High fever with malaise and other non-specific symptoms occur, but no bubo is present to clinically distinguish symptoms from sepsis due to other agents.

Pneumonic plague: This condition may develop following bacteremia with cough and production of bloody sputum and can be spread person-to-person via airborne transmission. Untreated pneumonic plague is almost always fatal.

Plague pharyngitis: May resemble tonsillitis.

Plague should be considered in any patient who presents with fever and acute lymphadenitis and resides in a known plague area. Plague is treatable but has high fatality rate with inadequate or delayed treatment.

Transmission, Exposure

Humans infected by:

- bite from a plague infected flea,
- bite or contact with respiratory secretions from a person or animal, often a domestic animal that has pneumonic plague,
- contact with tissues from an infected animal such as a rodent, rabbit or coyote,

- ingestion of raw or undercooked meat of infected animal.

Contagious Period	Pneumonic plague - from onset of cough until completion of several days of antibiotic therapy. Bubonic and septicemic plague- usually not contagious.
Incubation	2-8 days for bubonic plague; 1-6 days for human-to-human transmission of pneumonic plague.
Diagnosis	Plague may resemble wound infections with secondary lymphadenitis; any patient presenting with these symptoms and living in known plague area should be evaluated for plague. Cultures should be obtained from blood and apparent sites of infection (such as the affected lymph node).
Management of Case	Pneumonic cases and contacts should be treated with antibiotic therapy and kept under surveillance. They should be excluded from school until completion of 48 hours of antibiotics and there is favorable clinical response. School exclusion of bubonic and septicemic plague cases is not necessary (but absence until recovery is likely due to the severity of symptoms).
Management of Contacts	Any suspect plague case should be referred immediately for medical evaluation. Contacts of pneumonic plague case should be given antibiotic prophylaxis immediately and be kept under surveillance for development of illness. Close contacts of all plague patients may have had the same environmental exposure and should be considered for prophylaxis or surveillance.
Public Health Action	Report cases or suspect cases to Department of Health (505-827-0006).
Prevention Education	Reduce rodent activity near homes and schools; control fleas on domestic animals; avoid contact with dead or ill animals; rodent proof houses and

outbuildings; wear rubber gloves when handling wild game; stack wood piles 12 inches above ground and 100 feet away from house.

School Action -Refer possible cases immediately for medical evaluation.
-Exclude from school pneumonic cases until completion of 48 hours of antibiotic; do not exclude septicemic or bubonic cases unless ill.
-Assist in identifying close contacts; contacts need not be excluded from school unless they are symptomatic of pneumonic plague.
-Report to DOH rodent activity (especially prairie dogs and ground or rock squirrels) on or near school grounds as well as unusual numbers of dead rodents in the area.

Rubella (German Measles, Three-Day Measles)

Condition, Disease, Agent Rubella virus

Clinical Description A diffuse maculopapular rash is often the first sign of rubella disease; however, a mild prodromal illness, with low-grade fever, malaise, coryza, conjunctivitis and headache may occur 1-4 days before the rash appears. It appears first on the face but spreads rapidly over the entire body. The rash consists of small, flat (nonpalpable), reddish-pink spots that rarely last more than 3 days. Adolescents and adults with rubella may have arthritis affecting a few joints and lasting a few days or weeks. Congenital rubella varies in severity from subclinical to combinations of microcephaly, mental retardation, cataracts, deafness, and heart defects.

Transmission, Exposure Droplet or contact transmission by nasal pharyngeal secretions or urine from congenital rubella cases; crossing placenta and infecting fetus in infected pregnant women.

Contagious Period A few days before the rash develops to 5 to 7 days after the rash begins;
1 year or longer after birth in congenital rubella cases for urine transmission.

Incubation Usually 16 to 18 days with range of 14- 23

Diagnosis Case definition consists of: 1) acute onset of maculopapular rash, 2) temperature greater than 99.0° F, 3) arthralgia/arthritis, lymphadenopathy, or conjunctivitis, and 4) laboratory confirmation. Confirmation by serology is essential. Virtually all patients will have specific rubella IgM antibody during the acute illness. Confirmation of acute infection may require paired sera.

Management There is no specific treatment. School exclusion is appropriate for 7 days

of Case	after onset of rash.
Management of Contacts	<p>Contacts known to be susceptible should be immunized immediately. Adult contacts born before 1957 are presumed to be immune; others may be tested for immunity if test results will be available within 24 hours (so that immunization will not be delayed). Pregnant women should contact their medical provider immediately. Exclusion from school not appropriate.</p>
Immunization	<p>Two doses of rubella (MMR) vaccine are required for school entry. Pregnant females should not be vaccinated but may be considered for IG prophylaxis. All age-appropriate females should be counseled to avoid pregnancy for 3 months after immunization.</p>
Public Health Action	<p>All suspect and confirmed cases should be reported to the Department of Health immediately (505-827-0006). Identification and immunization of susceptible contacts will be coordinated by the Epidemiology and Response Division.</p>
School Action	<ul style="list-style-type: none"> -Refer all suspected cases for medical evaluation. -Exclude infected students from school until 7 days after onset of rash. -Do not exclude contacts unless symptomatic. -Enforce 2-dose MMR immunization requirement for school entry. -Immediate notification of NM Department of Health of suspect and confirmed cases. -Provide prevention education to include risk of immunization regarding pregnancy and concerns for pregnant contacts.

Rubeola (Measles)

Condition, Disease, Agent Rubeola virus

Clinical Description Acute onset of fever coryza, non-exudative conjunctivitis, cough and rash which usually begins on the second or third day of illness characterizes rubeola. The rash begins on the face or neck under the hairline or behind the ears and progresses to the trunk and extremities over 1-2 days. The rash is red, maculopapular with some clustering which tends to become confluent on the face. Koplik's spots may be present inside the mouth. Potential complications include otitis media, pneumonia, croup, diarrhea and encephalitis. Immune-impaired children and adults usually have more severe illness and a higher risk of complications.

Transmission, Exposure	Droplet and airborne transmission of respiratory secretions that may circulate in the air up to 4 hours after infected person leaves a room. <u>Measles is one of the most highly communicable infectious diseases.</u>
Contagious Period	1-2 days before onset of initial symptoms; 3-5 days before onset of rash until 4 days after appearance of rash.
Incubation	Average of 10 days from exposure to onset of rash with a range of 7-18 days or 8-12 days from exposure to onset of symptoms; 14 days from exposure until rash appears.
Diagnosis	Clinical evaluation with history of symptoms is useful with confirmation by lab culture of respiratory secretions.
Management of Case	Refer suspect cases immediately for medical evaluation. There is no specific treatment. School exclusion is appropriate until 4 days after rash onset.
Management of Contacts	Immunization records should be reviewed to determine susceptible contacts and access to immunization should be provided within 72 hours of exposure. Immune globulin may be given to susceptible contacts who should not receive vaccine, including pregnant females and those who refuse vaccination. Susceptible contacts should be excluded from school until 21 days after rash onset in the last case contact unless they receive a dose of measles vaccine within three days of exposure. Susceptible individuals who were given post-exposure preventive treatment with immune globulin should be excluded until 21 days after rash onset in the last case contact.
Immunization	Two doses of measles vaccine (MMR) are required for school entry.
Public Health Action	All suspect and confirmed cases should be reported to the Department of Health immediately (505-827-0006). Identification and immunization of susceptible contacts will be coordinated by the Epidemiology and Response Division.
School Action	-Refer suspect cases immediately for medical evaluation. -Report confirmed and suspected cases to NM Department of Health.

- Exclude cases from school until 4 days after onset of rash.
- Review immunization records to identify susceptible individuals.
- Exclude susceptible individuals until 21 days after onset of rash in the last case.
- Provide prevention education to include risks regarding pregnancy.

Scabies

Condition, Disease, Agent *Sarcoptes scabiei*

Clinical Description Lesions caused by infestation of scabies mites are characterized by an intensely pruritic, red, vesiculopapular eruption caused by adult female mites burrowing under the skin to lay eggs. The scabies burrow appears as a gray or white threadlike line. Lesions are commonly found on finger webs, wrists and elbows, axillary folds, belt line; in men on thighs and external genitalia; and women on nipples, abdomen and lower portion of buttocks.

Transmission, Exposure Direct, prolonged contact, including sexual contact, with infected skin

Contagious Period Until mites and eggs are destroyed by treatment.
Incubation Four to six weeks in people without previous exposure. People who have been previously infested develop symptoms 1-4 days after re-exposure.

Diagnosis Exam shows typical excoriated papules and burrows. Microscopic exam of skin scrapings shows the mite, eggs, and fecal deposits.

Management of Case Infested students should be excluded from school until initial treatment is completed. Treatment with nonprescription formula containing permethrin is recommended; lindane solution is an alternative if retreatment is necessary but it is more toxic. Clothing and bed linens used by the patient in the three days prior to initiation of treatment should be laundered in hot water. Items that cannot be washed should be isolated in plastic bags for 10-14 days. The mites cannot survive more than three days without skin contact. Environmental disinfection is unnecessary and unwarranted.

Management of Contacts	Close contacts should be examined for signs of infestation. Household contacts are usually infested and need treatment; therefore, all members of household should be treated concurrently to prevent reinfestation. Manifestation of infestations can appear as late as 6 weeks after exposure, during which time infected person can transmit scabies.
Public Health Action	Not a reportable condition.
School Action	-Exclude infested students at the end of the school day until they have received initial treatment. -Examine close contacts for infestation. -Provide education including treatment recommendations.

Streptococcal Infections (Strep throat)/Scarlet Fever

Condition, Disease, Agent Streptococcus pyogenes Group A

Clinical Description	Classic strep throat is characterized by severe sore throat, malaise, toxicity, fever, tender lymph nodes in the neck, and a purulent exudate on the tonsils. Untreated strep throat develops complications including otitis media, sinusitis, and abscesses on the tonsils and pharynx. Scarlet fever is a strep throat plus a characteristic fine, sand-papery erythema rash prominent on the cheeks, trunk and extremities but less evident around the mouth, inside elbows and behind knees. Invasive streptococcal infections may follow wound infections including infected varicella lesions or respiratory infections.
Transmission, Exposure	Transmitted person-to-person mainly via respiratory secretions; outbreaks from food or milk contamination; recurrent disease from ongoing contact with carriers.
Contagious Period	Weeks to months; 10-21 days after acute illness or until 24 hours after treatment initiated.
Incubation	2 to 5 days for pharyngitis
Diagnosis	Rapid strep test from throat swab or throat culture supports clinical evaluation.
Management of Case	Suspect cases should be referred for medical evaluation. Referral is urgent if high fever, marked toxicity or respiratory distress is present. School exclusion recommended until at least 24 hours after antibiotic

treatment is initiated.

Management of Contacts	For sporadic cases of uncomplicated streptococcal infection, surveillance for additional cases is adequate.
Public Health Action	Report cases of scarlet fever, streptococcal toxic shock syndrome or invasive streptococcal disease and outbreaks of streptococcal disease within schools to Department of Health (505-827-0006).
School Action	-Refer suspect cases for medical evaluation and treatment. -Exclude cases until the infected individual has been on antibiotic treatment for at least 24 hours. -Report complicated cases and outbreaks of streptococcal infection to the Department of Health.

Tetanus

Condition, Disease, Agent *Clostridium tetani*

Clinical Description	Tetanus, or 'lockjaw', is caused by a neurotoxin produced by <i>Clostridium tetani</i> . Although tetanus occurs worldwide it is rare in the US due to immunization. Tetanus infection usually occurs from a skin wound. The wound that harbors <i>C. tetani</i> frequently is a minor one. Evidence of frank wound infection is likely to represent infection by other bacteria. Localized tetanus consists of painful tonic muscle spasms in the area of a wound and can precede generalized tetanus which presents with muscle spasms. Muscle spasms often produce trismus (inability to open the mouth fully or at all).
Transmission, Exposure	Contact of a wound in the skin with material containing tetanus spores. Contaminated wounds, deep wounds, or wounds with devitalized tissue are at greatest risk. Tetanus spores are everywhere in the environment.
Contagious Period	Not communicable from person to person.
Incubation	Most cases occur within 8-10 days of exposure; range of 3-21 days.
Diagnosis	The diagnosis should be made based on clinical presentation and exclusion of other possibilities. Culturing of wounds is low yield; treatment

should not be based on laboratory evidence.

Management of Case	Tetanus is a medical emergency requiring hospitalization. All wounds should be properly cleaned and debrided. Tetanus immune globulin (TIG) is recommended for treatment and tetanus booster vaccination if needed. Antibiotic treatment as indicated may be provided. Supportive care and pharmacotherapy to control spasms also may be necessary.
Management of Contacts	Not indicated, since not spread person to person.
Public Health Action	Report suspected cases to Department of Health (505-827-0006).
School Action	-Refer suspected cases for medical evaluation and treatment. -Assure appropriate immunization status for all students. -For wounds, make sure appropriate treatment is given.

Tinea Capitis, Corporis, Cruris and Pedis

Condition, Disease, Agent	Ringworm fungal infection of scalp, body, groin and feet Microsporum and Trichophyton
Clinical Description	Tinea lesions are generally circular, reddish, crusty, and scaly, with a vesiculopapular border; they occur on the face, scalp, and body. Lesions are often itchy. Tinea capitis may present with patchy areas of dandruff-like scaling and hair loss; discrete areas of hair loss with stubs of broken hair; numerous scaly pustules; or a kerion (boggy mass).
Transmission, Exposure	Direct or indirect contact with skin or scalp lesions of infected persons or animals; potentially any surface, especially moist surfaces.
Contagious Period	As long as lesions are present; viable fungus may persist on contaminated materials for long periods.
Incubation	Unknown, estimated to be 10-14 days
Diagnosis	Fungal culture and potassium hydroxide wet mount of scrapings from skin lesions.

Management of Case	Refer suspect cases for medical evaluation and treatment. Scalp lesions require oral therapy for at least 4 weeks. Other varieties require topical or oral antifungal therapy. Students should avoid public areas conducive to transmission such as gyms and swimming pools. School exclusion is not necessary especially if skin (not scalp) lesions can be covered by clothing or a loose dressing until treatment has been initiated.
Management examination of Contacts	Examine close contacts including household pets by visual of the skin and scalp. Monitor contacts if potential for exposure continues.
Public Health Action	Not a reportable condition
School Action	<ul style="list-style-type: none"> -Refer suspect cases for medical evaluation and treatment. -School exclusion is not necessary. -Observe contacts for development of lesions. -Decontaminate sports equipment or wading pools where the fungus may grow. -Encourage covering of lesions. -Discourage sharing of personal items with infected case.

Tuberculosis (TB)

Condition, Disease, Agent *Mycobacterium tuberculosis*

Clinical Description	Primary infection in children may produce non-specific symptoms of fever, weight loss and cough. Reactivation of infection in adolescents or adults produces an enlarging cavity in the lung containing large numbers of bacteria. Active pulmonary tuberculosis causes chronic cough with purulent, often blood-tinged sputum. Chest pain may be present especially if the pleura is involved. Systemic symptoms are common including fatigue, weight loss, night sweats and fever which is usually maximal in the late afternoon and evening.
Transmission, Exposure	Respiratory route by dissemination of either airborne droplet nuclei or dust particles, usually over a period of time with close contact with active disease case. Transmission risk dependent on number of bacteria

present in secretions, efficiency of coughing, closeness of contact, airspace size containing infected droplet nuclei.

Contagious Period	Throughout period of active infection until 1-3 weeks after initiation of effective treatment.
Incubation	Two to twelve weeks from exposure to development of positive tuberculin test; clinical disease most likely within first 2-3 years after infection but may occur decades later.
Diagnosis	Clinical diagnosis on basis of physical examination may be suggestive of tuberculosis, especially if individual is known to have been exposed. A positive tuberculin skin test means that the person has been infected with <i>M. tuberculosis</i> or has received BCG vaccine; it does not necessarily indicate that the infection is active. Interferon-Gamma Release Assays (IGRAs) may also be used to diagnose exposure/infection. Laboratory diagnosis made by microscopic examination and culture of sputum or other specimens confirms the diagnosis and identifies appropriate antimicrobial treatment.
Management of Case	Students and staff with persistent cough (longer than three weeks) should be referred for medical evaluation. For active disease, completion of treatment is critical to prevent relapse and development of secondary drug resistance. Active disease cases should be excluded from school until released by the state Tuberculosis (TB) Control Program, usually after 2 weeks of completed therapy and coughing has subsided.
Management of Contacts	The TB Control Program will coordinate tuberculin testing, and determine the need for chest x-ray, physician evaluation, and preventive treatment of contacts.
Immunization	BCG vaccine is administered in parts of the world where there is a high risk of childhood tuberculosis, but it is not utilized in the United States.
Public Health Action	All active cases of tuberculosis should be reported to the Department of Health. Children who are positive tuberculin reactors should be referred also since infection in a child indicates recent exposure to an active case. The Tuberculosis Control Program will coordinate contact evaluation.

School Action -Refer students and staff with chronic cough lasting longer than three weeks for medical evaluation.
 -Report suspected or confirmed cases to the Department of Health.
 -Exclude students and staff with active tuberculosis from school until determined by the TB Control Program to be non-contagious.

Tularemia

Condition, Disease, Agent Francisella tularensis

Clinical Description Tularemia is also known as rabbit fever. People usually become infected through tick or deerfly bites or by handling infected animals. The common symptoms of tularemia include sudden onset of high fever, chills, fatigue, general body aches, headache, and nausea and a skin ulcer at the site of entry.

Transmission, Exposure Most humans acquire tularemia through handling infected rabbits or rodents, or from deer fly or tick bites.

Contagious Period Not communicable from person to person.

Incubation Related to size of inoculum, usually 3-5 days; range of 1-21 days

Diagnosis Diagnosis done with a single positive serologic test result; confirmed by a 4-fold rise in total antibody titer in second specimen obtained two or more weeks later. Diagnosis is usually confirmed by culture.

Management of Case Tularemia is treatable with antibiotics. Prompt diagnosis and treatment are critical for preventing tularemia from progressing to more serious clinical forms. When human tularemia is suspected on clinical and epidemiological grounds, appropriate specimens for diagnosis should be obtained immediately, and the patient should be started on specific antimicrobial therapy pending laboratory confirmation.

Management of Contacts Not indicated, since not spread person to person.

Public Health Action Report suspected cases to Department of Health (505-827-0006).

School Action -Preventive measures include: avoidance of tick and deer fly bites.
 -Avoid contact with dead and sick animals.

Upper Respiratory Tract Infection, Acute Viral

Condition, Disease,	Numerous viruses, including adenoviruses, coronaviruses, enteroviruses
Agent	and rhinoviruses
Clinical Description	Rhinoviruses are the most frequent cause of the common cold. Signs and symptoms of upper respiratory tract infections include nasal discharge, nasal congestion, sneezing, cough, and low grade fever. Otitis media and pharyngitis can also occur, depending on the causative agent.
Transmission, Exposure	Occurs primarily through person-to-person contact, with self-inoculation by contaminated secretions on hands and/or aerosol spread. Some viruses can be spread via aerosol and indirect contact also.
Contagious Period	Most communicable during the first few days of acute illness.
Incubation	Depends on the causative virus, varies from 2-14 days.
Diagnosis	Usually clinical diagnosis is sufficient. Testing, depending on the type of virus, is available for some viruses although it is not widely used for typical URIs.
Management of Case	Children and adults with clinical illness should be sent home until fever (greater than 100° F) subsides. Fluids are important to maintain hydration. Bed rest, analgesics/antipyretics (other than aspirin) may help symptomatically.
Management of Contacts	No specific recommendations other than using techniques like good hand washing to avoid spreading illness. All individuals at risk for complications from respiratory illness or in contact with persons at increased risk should receive influenza vaccine annually as soon as it is available each year. Encourage good hand hygiene and appropriate disposal of contaminated articles.
Public Health Action	Notify the Department of Health (505-827-0006) when outbreaks of respiratory disease appear in a school.
School Action	-Exclude students and staff with respiratory illness until afebrile (less than 100° F) and symptoms do not affect participation in routine school activities.

- Report suspected outbreaks of respiratory disease to the Department of Health.
- Emphasize hand washing and respiratory droplet precautions as preventive measures.

Vaginitis

Condition, Disease, Agent *Trichomonas vaginalis, Candida*

Clinical Description	Thick white (Candida) or malodorous gray (Trichomonas) vaginal discharge, often with external irritation that usually includes itching or dysuria.
Transmission, Exposure	Person-to-person genital contact or genital contact with contaminated articles.
Contagious Period	Indefinite or several years in untreated persons
Incubation	Indeterminate
Diagnosis	Usually made by microscopic examination of the infecting agent from vaginal discharge.
Management of Case	Specific treatment depends on the causative agent. Sexual contact should be avoided during period of infection and during treatment of patient and partner(s).
Management of Contacts	Sexual partners are usually asymptomatic, but they should be evaluated and (depending on cause) may be treated in the case treatment is to be effective long term.
Public Health Action	Not a reportable condition.
Prevention Education	Promotion of “safer sex” behavior, including condom use, for all sexual contact.
School Action	<ul style="list-style-type: none"> -Provide preventive education with sex education curriculum. -Refer suspect cases for evaluation and appropriate treatment. -School exclusion not appropriate. -Provide preventive education to include safer sex education.

Varicella-Zoster Infections (Chicken Pox and Shingles)

Condition, Disease, Agent *Varicella zoster virus (human Herpesvirus 3)*

Clinical Description	<p><u>Chickenpox</u> is primarily a disease of childhood. Immunization is essential in preventing this very contagious disease. With increased coverage of varicella vaccine, atypical chickenpox has become increasingly common.</p> <p>Some infections are subclinical or missed because of few lesions. Children typically have low-grade fever and mild upper respiratory tract symptoms before onset of rash. Rash appears in successive crops, with several stages of maturity at the same time. If severe, lesions may occur on the conjunctiva, mucous membranes, palms and soles. Initial lesions are maculopapular on an erythematous base, and then evolve from papule to vesicle to pustule to crust over 2-5 days. Lesions usually do not scar unless unusually deep or secondarily infected. The disease can be more severe in adolescents, adults, and immunocompromised persons. In vaccinated persons who develop varicella more than 42 days after vaccination (breakthrough disease), the disease is almost always mild with fewer than 50 skin lesions and shorter duration of illness. The rash may also be atypical in appearance (maculopapular with few or no vesicles).</p> <p><u>Herpes zoster</u> (“shingles”) is a re-activation of varicella-zoster virus along a dermatome (area of skin supplied by nerve fibers from one spinal nerve) that has remained latent in the dorsal root ganglia. Grouped vesicular lesions appear in the distribution of 1-3 dermatomes. Zoster can become disseminated in immunocompromised persons.</p>
Transmission, Exposure	Person to person by direct contact with respiratory secretions and skin lesions; highly contagious.
Contagious Period	Most contagious 1-2 days before onset of rash and continuing until all lesions have crusted (usually five days). Contagiousness may be prolonged in patients with altered immunity. Susceptible exposed persons should be considered infectious from 8-21 days following exposure.
Incubation	Usually 14- 16 days (up to 21 days). May be prolonged up to 28 days after administration of passive immune globulin (Vari-ZIG).
Diagnosis	Clinical diagnosis can be more challenging than in the past because of atypical disease presenting due to increased vaccine coverage. As a result, laboratory testing to confirm diagnosis is <u>required</u> . In vaccinated persons who develop varicella more than 42 days after vaccination, the disease is almost always mild with fewer than 50 lesions and short duration of illness.

Management of Case	Children with varicella should not be treated with aspirin since it may increase the risk of Reye syndrome. Initial or sporadic cases of chicken pox should be confirmed by a physician. Any child with apparent chicken pox should be excluded from school until all lesions have crusted or until six days after onset of rash. Symptomatic treatment used.
Management of Contacts	Refer immune-impaired susceptible contacts (leukemia, cancer, organ transplantation, immunosuppression) to their physician immediately for passive immunization with varicella-zoster immune globulin (VZIG) after exposure. Nonimmune contacts should be quarantined and excluded from school 8-21 days after exposure. If post exposure varicella-zoster immune globulin is administered, quarantine through 28 days.
Immunization	Varicella vaccine is highly effective in prevention of chicken pox even in immune impaired individuals. All children who without laboratory confirmed chicken pox should receive vaccine. Immunization of susceptible exposed persons more than 5 days after exposure is not effective in preventing disease but will produce immunity in persons who are not infected.
Public Health Action	Report cases to the Department of Health.
School Action	<ul style="list-style-type: none"> -Students with apparent chicken pox should be excluded from school until all lesions have crusted or until six days after onset of rash. Students who are immune-impaired may continue to develop new vesicles for a longer period and should be excluded until all lesions have become dry and are crusted. It is not necessary for lesions to have healed completely. -Students with shingles outbreaks may return to school if all lesions are covered and can remain covered. -Contagiousness may be prolonged in patients with altered immunity. Contact NMDOH at 505 827-0006 for specific recommendations when dealing with altered immunity. -Identify all pregnant females and immunocompromised individuals (students and staff) who have been exposed to varicella and consult ERD for further recommendations -Exclude from school susceptible (i.e. unvaccinated) persons who are exposed from 8th-21st day after exposure. -Encourage immunization for the unimmunized.

West Nile Disease

Condition, Disease, *Flavivirus*
Agent

Clinical Description	Unapparent disease and mild infection are common; signs and symptoms vary in severity from mild fever, to aseptic meningitis, to encephalitis with coma, paralysis and death. The elderly are at greatest risk of severe illness with West Nile Virus. Disease in humans is most common in summer and early fall. Symptoms are quite variable depending on the virus and the age and general health of the case. Mild cases often occur as a febrile headache or aseptic meningitis.
Transmission, Exposure	Transmission is by the bite of infected mosquitoes that have acquired the virus from feeding on infected birds. Birds have the virus for only a few days, but mosquitoes remain infected for life.
Contagious Period	Not transmitted from human to human.
Incubation	Incubation period is usually 2-14 days, up to 21 days in immunocompromised people.
Diagnosis	Patients with signs and symptoms of encephalitis in which diagnosis of West Nile infection is highly suspect should have blood and cerebrospinal fluid (CSF) collected for testing. Commercial laboratories in New Mexico and other states are able to test serum and/or CSF specimens.
Management of Case	No antiviral medication is available. Supportive therapy is indicated.
Management of Contacts	None indicated.
Public Health Action	Report cases to the Department of Health.
Prevention Education	Control mosquito vectors through elimination of breeding sites (i.e., standing water).
School Action	-Avoid exposure to mosquitoes during school activities. -Ensure there are no areas with standing water on school grounds.

References and Resources

[A Guide for Parents Questions and Answers](#)

[Antibiotic Information Brochure - English](#)

[Antibiotic Information Brochure – Spanish](#)

[Antibiotic Info RC – English](#)

[Antibiotic Info RC – Spanish](#)

[Bed Bug Presentation](#)

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[Get Smart Know When Antibiotics Work](#)

[How to Wash Hands – English](#)

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CHAPTER ELEVEN – SCHOOL SAFETY

This chapter is Under Construction



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CHAPTER TWELVE – SCHOOL WELLNESS POLICY

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CHAPTER THIRTEEN – DENTAL HEALTH

Oral Health Is Essential to General Health

Promoting oral health in a school setting is important to reduce the incidence of tooth decay, a preventable condition. Tooth decay is one of the most common chronic diseases among school aged children. School administrators, nurses, counselors, teachers, students and parents should promote the existence of school-based or school-linked oral health services. The 2000 United States Surgeon General Report “Oral Health in America: A Report of the Surgeon General” stated that over more than 51 million school hours are lost each year to dental-related illness. Poor children suffer nearly 12 times more than children from higher income families. Pain and suffering due to untreated oral diseases can lead to problems in eating, speaking, and attending school. A healthy child will learn and contribute to society in later years. School-based or school-linked oral health prevention programs should provide good oral health education, provide preventive services, assist students in obtaining dental care and integrate oral health into the school curriculum (US Surgeon General, 2000).

Tooth Function

How one feels about his or her smile, mouth, and teeth may affect his/her self-image. Teeth also help maintain space in the mouth, preventing malocclusions. The primary teeth are especially important in these functions because they are the teeth that are initially present when a young child begins to eat, speak, and develop a self-image.

The oral cavity is not healthy if it has teeth missing, that are painful, broken, loose, or shifting, or gums that have sores, or are red, swollen, or tender. When any of these conditions exist, the oral cavity cannot function properly, and dental disease may develop. Food may not be chewed properly or completely before swallowing, leading to digestive problems. An individual may limit food selection to soft foods that do not require chewing. This limited food selection may lead to an unbalanced diet, and as a result, the body's general health suffers.

A healthy oral cavity has fresh breath, pink gums, cavity-free teeth, no prematurely missing teeth, and correct spacing. Maintaining a healthy oral cavity promotes overall health. Children who have poor oral health often miss more school and receive lower grades than children who have good oral health (Griffin, Wei, Gooch, Weno, & Espinoza, 2016).

Oral Disease

Tooth Decay/Cavities

An individual may be able to tell if the tooth is decaying by the following warning signs:

- A tooth sensitive to heat, cold, or sweets.
- Pain during chewing.
- Swelling or drainage at or below the gum line.

- A dark spot on a tooth.
- Persistent pain in the mouth or sinus.

If tooth decay is suspected, a dentist can determine if there is a cavity and what must be done to repair the damage.

Periodontal Disease

Tooth decay is not the only cause of oral health problems or missing teeth. Plaque is the primary cause of most periodontal conditions, but other factors may contribute to its severity or an individual's susceptibility to it. These factors include: smoking or chewing tobacco, certain metabolic diseases (such as diabetes), hormonal changes (such as puberty and pregnancy), harmful habits (such as grinding and clenching the teeth), sugar in the diet, and growth and development processes such as misaligned teeth and faulty bite (NIH,2013).

An individual may be able to tell if gum disease is developing by the following warning signs:

- Gums that bleed when they are brushed or flossed.
- Red, swollen, or tender gums.
- Gums that have pulled away from the teeth.
- Pus that appears between gums and teeth.
- Teeth that are loose or shifting.
- Changes in the way teeth fit together.
- Persistent bad breath or bad taste in the mouth.

Malocclusion

Another dental and facial problem is malocclusion, referring to the irregular way the teeth fit together. The causes of malocclusion can be inherited or acquired. The treatment of malocclusion is often provided by an orthodontist, a dentist who has additional training in this area of dentistry.

Oral Cancer

Oral cancer is another significant dental concern. The most common sites of oral cancer are the tongue, floor of the mouth, lips, soft palate, and tonsillar area. Since oral cancers vary widely in appearance, they are often difficult to recognize. Some warning signs of oral cancer are:

- Swelling, lump or growth anywhere in or about the mouth or neck.
- A sore that does not heal after two weeks.
- White or red patches in the mouth or on the lips.
- Repeated bleeding from the mouth or throat.
- Difficulty in swallowing or persistent hoarseness.

A Diet for Good Oral Health

A diet for good oral health can be achieved by eating a balanced diet from the food groups, limiting between meal sweet snacks, eliminating habits which allow foods to remain in the mouth for long periods of time (sucking on hard candies or sipping sweet beverages), and choosing more noncariogenic promoting snacks. Foods high in sugar should be eaten with other foods to reduce the amount of acid exposure. Between-meal snacks should be nutritious and low in sugar. Reading labels on processed foods and recognizing the "hidden" sugars in those foods can help to choose foods that have the necessary nutrients and promote

good oral health. A healthy diet will also contribute to reduced obesity among preschool and school aged children.

Water Consumption

A good diet includes drinking plenty of water in lieu of soda pop. Water from the tap is recommended because about 76% of New Mexico water systems provide fluoridated water to their customers. Fluoridated water combats tooth decay.

Brushing and Flossing

The purpose of brushing and flossing is to remove the plaque that is the major cause of tooth decay and gum disease. One removes surface debris and plaque. The other removes plaque and debris from between the teeth and at the gum line.

Tooth Brushing

Brushing removes the plaque from all surfaces of the teeth. Most adults should brush a minimum of once a day while children and caries-prone adults should brush more frequently, especially following meals and snacks. Teeth should always be brushed before going to bed at night as the saliva flow decreases during sleep, while the bacterial activity continues.

Flossing

Flossing removes plaque from the sides of the teeth and should be done once a day. Parents should assist young children as flossing requires a level of manual dexterity that children do not have; therefore, they should be supervised when flossing until around age ten. As with brushing, a regular pattern for flossing should be established to ensure all sides of the teeth are cleaned routinely.

Fluoride

The single most effective element in the reduction of tooth decay is fluoride. Fluoride makes teeth stronger and increases resistance to tooth decay; it is also an essential nutrient for the growth and development of teeth and bones. It may be found naturally in water, food, and soil. Fluoride is also available through dietary supplements, gels, toothpastes, and mouth rinses.

Systemic Fluorides

There are two ways that fluoride is used – systemically and topically. Systemic fluoride is ingested and enters the bloodstream. The fluoride becomes incorporated into the enamel of the developing teeth, making them more resistant to decay throughout life. Systemic fluoride is obtained from drinking water that has a fluoride content of 1 ppm (parts per million). All water from the tap contains some fluoride. Local water systems are tested to provide the optimal level of fluoride for communities and private wells can be tested to determine their natural level of fluoride before adding additional fluoride supplements. Fluoridation is supported by the American Dental Association, American Dental Hygienists' Association, American Medical Association and the American Public Health Association (CDC, 2016).

Topical Fluorides

Topical fluoride, applied directly to the enamel surface, helps provide additional protection against decay after the teeth have erupted into the mouth. The decay process can be stopped and even reversed during the initial stages by using fluoride.

There are a number of common methods for applying topical fluorides:

- Most common method is the daily use of fluoride toothpaste.
- Second most common method is fluoride mouth rinse.
- Fluoride may be applied by a dentist or dental hygienist.

Preschool and kindergarten aged children can participate in a fluoride varnish school program, where available. Students have fluoride varnish applied to their teeth three times a year.

Dental Sealants

The most common type of decay that children have today is found on the chewing surfaces of the back teeth. These teeth have irregular surfaces where bacteria and food can hide and cause tooth decay. Plastic coatings called dental sealants can be applied to these surfaces to protect them from decay. The teeth most likely to benefit from sealant applications are the first and second permanent molars just after they have erupted and before they have had a chance to decay. Sealants help maintain sound, healthy teeth by helping to prevent the need for fillings. The cost of applying a sealant to each tooth is less than the cost of a filling for that tooth. It is also a painless procedure, whereas filling a tooth may not be.

Applying a sealant is very simple and may be done by a dentist, dental hygienist, or specially trained and certified dental assistant. School sealant programs exist in some schools in New Mexico.

Prevention of Oral Injury

80% of all fractured teeth occur in children with the upper front teeth being most often involved. Injuries are the most frequent causes of mouth trauma. Biking, baseball, and skateboarding are the three main causes of tooth injuries. Home injuries, such as tripping over objects on the floor, stairway or ground, and not using handrails on stairways, cause many oral injuries. Many injuries happen on school playgrounds.

Mouth Guards

Many experts recommend that mouth guards or mouth protectors be worn during any recreational sport as they help prevent injury to the mouth area, especially to the teeth, lips, cheeks, and tongue. They also protect against head and neck injuries by cushioning blows that might otherwise cause concussions or lead to jaw fractures. Some of the sports for which mouth guards are recommended include:

Acrobatics

Handball

Skydiving

Baseball

Ice Hockey

Soccer

Basketball	Lacrosse	Squash
Bicycling	Martial Arts	Surfing
Boxing	Racquetball	Volleyball
Discus	Rugby	Water Polo
Field Hockey	Shot putting	Weightlifting
Football	Skateboarding	Wrestling
Gymnastics	Skiing	

Dental First Aid

Please see Chapter 8.

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CHAPTER FOURTEEN – MENTAL HEALTH

School's Role

Every school staff member has a crucial role in promoting healthy emotional development for all children. Students who have a healthy emotional and social development, including a sense of self-worth, contributes to their success in and outside the classroom. School staff spend every day in the company of students, who are profoundly affected by their world in which they live, develop a deep awareness of the importance of the positive influence they have on those students at school.

Since school staff spend their days with students, staff can observe student's behaviors and actions throughout the day. This gives staff the distinct advantage of detecting children who display emotional, behavioral, or mental health problems and are charged with ensuring that students are referred for the proper assessments and appropriate interventions. Mental health problems have a variety of causes, and can be made worse if the student has a learning disability or physical health problem, some may have a physiological base, others may be a result from trauma, familial dysfunction, social stresses, or other problems. Whatever the cause, there is a compelling reason for the school to be alert to the issues and respond accordingly. It is important for schools to encourage, support and participate in community of care that includes parents, mental health providers, law enforcement, and any other vested community partner to ensure proper care and action is taken when needed. School professionals such as guidance counselors, school psychologists, nurses, social workers, and school based health center providers can educate and bridge the gap between these groups to obtain a successful working relationship in integrated care for every student in need.

Possibly the most critical element to a student's success, is to develop a close and nurturing relationship with at least one caring adult. Students need to feel that there is someone within the school whom they know, to whom they can turn to and who will act as an advocate for them. (Excerpt from a Massachusetts Department of Education report.)

Developmental Stages

Developmental stages are a set of functional skills "bench marks" or age-specific tasks that most children develop by a certain age range. Understanding these stages of a child or adolescent's social emotional development is helpful in distinguishing between behavior that is typical of the development phase and what behaviors may need observation and treatment by professionals. The following are general milestones children reach within each stage of development based on Piaget's cognitive development, Erikson's psychological

development, Freud's psychosexual development and Kohlberg's moral development. These stages are broad with the primary focus on achieving general developmental milestones, however, they may differ based on the child's gender, cultural background, and other individual characteristics. It is important to note that social emotional development can be disrupted and/or halted if a child or adolescent experiences significant or prolonged trauma.

Birth to 2 Years of Age

- Develop basic trust
- Oral stage, the mouth, tongue, and gums are the focus of sensations
- Most action is reflexive, like sucking and grasping
- Objects are extensions of self
- Cry to have needs met
- Self-comforts

2 to 3 Years of Age

- Develops autonomy (toileting, feeding, walking, & talking)
- Associates words with objects (language development)
- Explores and asks many questions
- Self-centered, requires sharing/cooperation to help move beyond self-centeredness
- Parallel without much interaction or sharing play themes, toys, or activities

4 to 6 Years of Age

- Explores limits
- Very active, enjoys things that involve movement
- Speech becomes more social
- Following rules of a game not developed
- Plan and engages in symbolic play/activities with others
- Curious about body parts and genitalia differences

7 to 12 Years of Age

- Learn to be competent and productive in mastering new skills
- Learn to make good choices and exercise self-discipline
- Solves concrete problems
- Form relationships with peers
- Engage in activities/play with mutually agreed upon rules
- Becomes aware of wider rules of society/viewpoints

13 to 18 Years of Age

- Develop crushes on peers
- Explores self-identity
- Uses rational thinking
- Develops moral reasoning
- Handle competitive play-winning and losing relatively well
- Rely more on peer's evaluation, approval & direction opposed to parents
- Self-conscious and sensitive to physical development
- Exercises independency from parents

Prevention Activities

The major causes of mortality and morbidity among children and adolescents (accidents, homicide, suicide, substance abuse, and sexually transmitted diseases) are preventable. Other risk factors may be related to poverty or lack of adequate nutrition, shelter, and clothing. There are many useful intervention techniques that can be used for each type of prevention. Some techniques can be applied at any level; for example, all students can be taught social skills. Small groups focusing on social skills training can be useful as secondary prevention for children at risk. Social skills taught to a group of students having difficulty with peers can provide tertiary prevention for those children. Obviously, different problems may call for different interventions. It is important to match different problems with the appropriate interventions.

Primary Prevention (Skill Building)

Primary prevention consists of providing children with resources and skills necessary to cope with complex life situations. Such skills can help students gain a sense of competence and self-worth, which is critical to social and emotional well-being. Teachers, in concert with other school staff, such as the principal, guidance counselor, and health staff have an important role to play in building a positive and a safe learning environment for all students. Topics and activities might include the following: improving problem-solving skills, coping skills, communication skills; teaching cooperation; anger management skills and other life skills that promote tolerance; helping students resolve conflicts with other students and with adults; and providing opportunities for positive emotional expression.

In addition to organizing and facilitating student-focused prevention activities, mental health professionals may play an important role as organizational consultants to schools. They might be involved in helping the school maintain a nurturing and a safe learning environment, providing consultation to teachers and staff about positive management of different behavioral concerns, and assisting schools to develop policies and procedures to deal with social and emotional related issues.

Secondary Prevention (Resource Building)

Secondary prevention efforts focus on identifying and providing services for children who are at risk of developing social and emotional concerns that may disrupt their academic gains. Children at risk may include those with family issues, learning disabilities and/or those affected by a significant loss or effects from prolonged trauma. Teachers are in daily contact with students, and they may be able to identify these children. A typical example of secondary prevention is educational support groups with a trained professional that focuses on helping children learn positive coping strategies.

Tertiary Prevention (Linking to Appropriate Service)

The third level of prevention consists of providing services to children who are actively demonstrating social and emotional concerns that warrant further assessment and/or appropriate referral. Schools may provide tertiary services in-house or make the necessary referral needed to a licensed mental health professional in the community to provide the appropriate behavioral health care services. Trained school staff may also provide the appropriate support and follow-up services for students in need of outpatient care or transitioning from out-of-home treatment facilities. Students may be seen for individual or group counseling to maintain continuum of care.

Common Mental Health Concerns

It is extremely important for helping professionals to understand the dynamics of each individual child's situation to help that child effectively. Physiological problems, such as chemical imbalances in the brain, neurological disorders, or environmental discord, may be underlying factors in any given case. Effective intervention depends on comprehensive assessment, appropriate diagnosis, and treatment planning. The parents or guardians of children who are withdrawn or overly aggressive, those having significant problems interacting with peers or adults, and those encountering serious academic problems should be contacted and the student referred for an assessment.

Depression

Feelings of sadness, discouragement, and moodiness are normal responses to failure or distress; however, depression is different from sadness. Depression is an illness that evolves from a normal emotional reaction to a disorder typified by feelings and behaviors that last longer than a few days and are so intense that they require treatment. Mood disorders affect thought, feelings, behavior, and overall physical health. Depression can range from transient (short-term) feelings to mood disorders.

According to the National Institute for Mental Health (NIMH), an estimated 3 million adolescents aged 12 to 17 in the United States had at least one major depressive episode in the past year. This number represented 12.5% of the U.S. population aged 12 to 17. Indicators for depression could include low self-esteem, the tendency to self-blame, feelings of powerlessness and hopelessness, and loss of pleasure in living. Although, these indicators may be difficult to identify depression in children because children may not express their feelings or feel sad at all. Instead, they feel angry, irritable, aggressive, and/or hostile. Children and teens may exhibit symptoms of depression through absenteeism, various forms of acting out (aggressive and/or violent behavior) or somatic complaints (frequent stomach aches, headaches, etc.).

While mental health professionals continue to debate the exact causes of depression, onset appears to be associated with a complex mix of multiple factors including stress and emotional loss. One widely held theory suggests that there is a genetic component that may

make people (including children) biologically vulnerable to depression. In reaction to stressful situations, biologically vulnerable people are thought to experience changes in their body chemistry that may result in their becoming depressed. Poverty, divorce, death, illness, family discord, abuse, sexual identity, and neglect are examples of stressful events that may make children more vulnerable and at risk for depression. Some children are more resilient to these traumas than others. Two children who are vulnerable to depression may react differently to the same experience. For example, if both experience the death of a significant person, one's reaction may be short-lived grief, while the other may develop a major depressive episode. Another contributing factor is substance abuse. Some youth who are depressed may begin to self-medicate with drugs or alcohol. Any signs of drug or alcohol use could warrant a co-occurrence disorder assessment.

Symptoms

According to the National Alliance on Mental Illness (NAMI), a child or adolescent diagnosed with major depression typically exhibits at least five of the following symptoms, including either the first or second symptom, for at least two weeks. Look for sudden changes in behavior that are significant, last for a long time, and are apparent in all or most areas of his or her life (pervasive).

- Depressed or irritable mood for most of the day.
- Aggression toward self and others.
- Diminished interest or pleasure in almost all activities most of the day.
- Marked decline in school performance, skipping classes and opting out of school activities.
- Withdrawing from friends and social involvement.
- Significant increase or decrease in weight or appetite or failure to gain expected weight.
- Inability to sleep or excessive sleepiness.
- Slowed body movements or hyperactivity/agitation.
- Fatigue or loss of energy.
- Feelings of worthlessness or excessive or unnecessary guilt.
- Inability to concentrate or indecisiveness.
- Recurrent thoughts of death, thoughts of suicide, with or without a suicide plan.

Depression is more than the blues or the normal everyday ups and downs. When that “down” mood, along with other symptoms that lasts for more than a couple of weeks, then it may be clinical depression. Clinical depression is a serious health problem that affects all aspects of the person. It can change the way a person feels, behaves, their physical health and appearance, academic performance, social activity, and the ability to handle everyday decisions and pressures. The most common symptom is a persistent change in mood, often characterized by sadness, helplessness, and hopelessness. However, some depressed individuals have a persistent mood state characterized by anxiety and agitation. It is important to be aware that some depressed children may be identified by acting out, restlessness, and general agitation. Depression may also be cyclical in nature, characterized by both a depressed mood and agitation.

What Schools Can Do

Educator can support the mental health of all students in the classroom and school, not just individual students who may exhibit behavioral issues, including signs of depression. Here are recommendations from the U.S. Department of Health and Human Services:

- Educate staff, parents, and students on symptoms of and help for mental health problems
- Promote social and emotional competency and build resilience
- Help ensure a positive, safe school environment
- Teach and reinforce positive behaviors and decision-making
- Encourage helping others
- Encourage good physical health
- Help ensure access to school-based mental health supports
- Promote the healthy social and emotional development of all children and youth
- Recognize when young people are at risk for or are experiencing mental health problems
- Identify how to intervene early and appropriately when there are problems

Bipolar Disorder (Previously called manic-depressive illness)

Bipolar disorder is a serious form of mental illness that affects perceptions, thoughts, moods, and behavior. Bipolar Disorder affects mood more than other functions. The person may have recurrent manic episodes or manic episodes alternating with depressive episodes or primary depressive episodes. Highs may alternate with lows, or the person may feel both extremes at close to the same time.

Although less common in young children, bipolar disorder does occur in teenagers and young adults. This illness can affect anyone. However, if one or both parents have bipolar disorder, the chances are greater that their children will develop the disorder.

Bipolar disorder may begin with either manic or depressive symptoms. Mania affects thinking, judgment, and social behavior in ways that cause serious problems and embarrassment. For depressive episodes of any age group, signs are like those that occur in depressed teens. Diagnosis can only be made with careful observation of behavior patterns over an extended period.

Bipolar disorder must be diagnosed by a professional using a series of psychiatric, psychological, psychosocial, and other evaluations. Diagnosis should not be attempted by untrained school staff, the student or a family member. Diagnosis is clinically based on patient report and observation of behavior. With proper treatment, a person with bipolar disorder can live a productive life. However, this diagnosis is associated with a high mortality rate; the risk for suicide is increased for an adolescent with bipolar disorder.

Manic Episode

- Perceptual Disturbances - may see self as having special powers or abilities and others as admiring and adoring; may have auditory and/or visual hallucinations.
- Cognitive Disturbances - has increased thinking speed; may have delusions of grandeur; has difficulty concentrating; have flight of ideas and/or rapid shifting of thoughts and ideas.
- Mood Disturbances - is usually in elevated, euphoric mood; self-esteem may be extremely inflated; has decreased need for sleep.

- Behavioral Disturbances - uses loud, rapid speech that is difficult to interrupt; talks of or acts out involvement in grandiose projects; demonstrates psychomotor agitation, (pacing, twitching, gross gesturing, inability to sit still); may change appearance and dress; exhibits sexual acting out.

Depressive Episode

- Depressed or irritable mood for most of the day.
- Aggression toward self and/or others.
- Diminished interest or pleasure in almost all activities most of the day.
- Significant increase or decrease in weight or appetite or failure to gain expected weight.
- Inability to sleep or excessive sleepiness.
- Slowed body movements or hyperactivity/agitation.
- Fatigue or loss of energy.
- Feelings of worthlessness or excessive or unnecessary guilt.
- Inability to concentrate or indecisiveness.
- Recurrent thoughts of death, thoughts of suicide without a suicide plan.

What Schools Can Do

Children and adolescents who are at risk for depression or bipolar symptoms may be helped by consistent nurturing from trusted adults. People who survive traumatic childhood experiences often mention the crucial role a single caring adult played in their survival. Very often, that caring adult was an educator. The following are suggestions for school personnel to help children who are at risk:

- Someone should be identified to take time to talk with the student to explore and identify feelings. Empathic listening and validation of feelings are crucial.
- Feedback should be given in a non-judgmental fashion and should emphasize the following.
 - Unbearable pain can be survived.
 - Help is available.
 - You are not alone.
 - Talking helps.
- Triage/Psychological First Aid works best if there is a connection or relationship with the student.
 - Is there any immediate safety threat? Is the individual going to hurt/kill him/herself or others? If “yes”, see “Suicide Ideation”.
 - How long has the individual been feeling this way? Hours, days, weeks?
 - Is there anything good going on in his/her life?
 - Does the individual have anyone else to talk to?
 - How much of the time does the individual not feel depressed?
- In consultation with the student’s parents/guardians refer any student who exhibits symptoms of bipolar disorder to the school’s identified mental health professional. Ideally, these students should be assessed by a primary health provider as well as a provider with mental health expertise.
- There should be a procedure established for school personnel to obtain immediate professional help for students exhibiting symptoms of bipolar disorder, especially if the student exhibits suicidal ideation.

Disruptive Behavioral Disorders

These are serious behavioral and emotional disorders characterized by being socially disruptive and displaying annoying behavior towards others. The essential feature has been identified as a persistent pattern of conduct in which the basic rights of others and major age appropriate societal norms or rules are violated.

Disruptive behavior disorders occur in 2%-16% of children in the United States. There is no clear cause identified but it is believed that a combination of biological, genetic, and environmental factors may contribute to disruptive behavior disorders.

Biological:

Defects or injuries to specific areas in the brain can lead to behavioral problems as indicated in the results of some studies. It is also linked to abnormal levels of chemicals called neurotransmitters in the brain. The neurotransmitters assist nerve cells in the brain to communicate with one another and when this is disrupted or not working properly the messages are not delivered correctly in the brain resulting in disruptive behavior disorders or other mental illnesses. Many children and teens with disruptive behavior disorders may also suffer from other mental illnesses, such as, ADHD, learning disorders, depression, substance abuse or an anxiety disorder which may also be contributing factors to their behavior problems.

Genetics:

These children tend to have close family members that have mental illness such as mood disorders, anxiety disorders, and personality disorders. This may create a genetic predisposition for disruptive behavior disorders.

Environmental:

A dysfunctional family, a family history of mental illness and/or substance abuse, a traumatic experience and inconsistent discipline by parents can contribute to the development of behavior disorders.

Conduct Disorders

Children with conduct disorders tend to be irritable, have low self-esteem and throw frequent temper tantrums. They do not realize the negative impact of their behavior on others and have little guilt or remorse in hurting others. This disorder is more common in boys than girls. The DSM-5 lists the behaviors that are associated with conduct disorders:

A repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated, as manifested by the presence of at least 3 of the following criteria in the past 12 months from any of the categories below, with at least one criterion present in the last 6 months.

Symptoms

- Aggression to People and Animals
 - Often bullies, threatens, or intimidates others.

- Often initiates physical fights.
- Has used a weapon that can cause serious physical harm to others (e.g., a bat, brick, broken bottle, knife, gun).
- Has been physically cruel to people.
- Has been physically cruel to animals.
- Has stolen while confronting a victim (e.g., mugging, purse snatching, extortion, armed robbery).
- Has forced someone into sexual activity.
- Destruction of Property
 - Has deliberately engaged in fire setting with the intention of causing serious damage.
 - Has deliberately destroyed others' property (other than by fire setting).
- Deceitfulness or Theft
 - Has broken into someone else's house, building, or car.
 - Often lies to obtain goods or favors or to avoid obligations (i.e., "cons" others).
 - Has stolen items of nontrivial value without confronting a victim (e.g., shoplifting, but without breaking and entering; forgery).
- Serious Violations of Rules
 - Often stays out at night despite parental prohibitions, beginning before age 13 years.
 - Has run away from home overnight at least twice while living in the parental or parental surrogate home, or once without returning for a lengthy period.
 - Is often truant from school, beginning before age 13 years.
 - The disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning.
-

Oppositional Defiant Disorder (ODD)

Children with oppositional defiant disorder exhibit a pattern of uncooperative, defiant, hostile, and annoying behavior for those in authority. These behaviors disrupt normal daily activities at home, with the family and at school.

Symptoms

According to the DSM-5 the symptoms of oppositional defiant disorder include:

- Angry/Irritability Mood
- Often loses temper
- Is often touchy or easily annoyed
- Is often angry and resentful
- Argumentative/Defiant Behavior
- Often argues with authority figures or, for children and adolescents, with adults.
- Often actively defies or refuses to comply with requests from authority figures or with rules.
- Often deliberately annoys others.
- Often blames others for his or her mistakes or misbehavior.
- Vindictiveness
- Has been spiteful or vindictive at least twice within the past 6 months.

Identification of the problem is the first step in providing the child with the most appropriate support and interventions. This requires that administration supports the needs of the school staff and that teachers, parents, school nurses, mental health professionals and physicians to work together to accurately identify whether a child has conduct disorder or oppositional defiant disorder. The following are guidelines for diagnosis to be made by a mental health professional.

The DSM-5 has identified that to be diagnosed with oppositional defiant disorder an individual must:

- Exhibit defiant, hostile, negativistic behavior for at least 6 months with 4 or more of the symptoms exhibited at least once per week for individuals who are 5 years or older. For those younger than 5 years, the behavior should occur on most days for a period of at least 6 months.
- The symptoms cause distress or impair work, school or social functioning.
- Symptoms do not occur during psychotic, substance abuse, depressive, or bipolar disorder. Also, criteria are not met for disruptive mood dysregulation disorder.
- Symptoms do not fulfill criteria for Conduct Disorder.
- If over age 18, ensure the individual does not meet the criteria for Antisocial Personality Disorder.

When a behavioral health professional diagnoses a child with disruptive behavioral disorders it is important to gather information from multiple sources to make an accurate diagnosis. A pediatrician, trained psychologist, neurologist, psychiatrist or trained clinical social worker can make the diagnosis in conjunction with input from parents, other caregivers, teachers, and other school staff that know the child. The psychiatrist or clinician must determine whether other psychiatric disorders are present using a specially designed interview and assessment tools to evaluate the child before finalizing a diagnosis of conduct disorder or oppositional defiant disorder. It is important to complete a comprehensive assessment with the parents and child on the child's overall functioning and family situation.

What Schools Can Do

Educational Interventions

- Provide an environment that is structured, predictable, and conducive to learning. Seat the student where there is minimal distraction, encourage peer tutoring, and provide a quiet study area.
- Provide specialized instruction with frequent eye contact. Be clear and concise; simplify, break down and repeat instructions.
- Provide supervision and consistent consequences. Have established clearly stated consequences for misbehavior, administer consequences immediately and calmly, enforce rules consistently, and avoid ridicule and criticism.
- Be specific in naming and describing the behavior that has resulted in the consequence.
- Enhance self-esteem through frequent encouragement and praise.
-

Mental Health Interventions (licensed mental health professionals only)

- A licensed mental health professional, a psychologist, social worker or family therapist, works with the child to develop more effective ways to express and control their anger. Utilizing cognitive-behavior therapy assists the child in reshaping the way they think to improve behavior.
- Family therapy is used to improve family interactions and communication among family members.

A specialized therapy technique called Parent Management Training (PMT) teaches parents enhanced parenting skills. This technique trains parents in:

- Observing and identifying the child's behavior and the situations in which it occurs.
- Identifying the behavior that needs to be changed in a specific and concise manner.
- Focus on enhancing parenting skills.
- Behavior modification and demonstration of interventions that will be utilized (coaching the parents).
- Utilize strategies to reward positive behavior and respond to negative behaviors with taking away privileges.

- Consistency is the key to any intervention.
- Medical/Psychiatric Interventions.

Medications are not approved for specifically treating conduct disorder or oppositional defiant disorder but medications may be used to treat some of the distressing symptoms.

In-service training for school staff on symptoms of disruptive behavioral disorders, specifically conduct disorder and oppositional defiant disorder, with appropriate behavioral interventions and the importance of communicating and working with the family will support the academic success of the child. Teachers, parents, and mental health professionals coordinating and communicating with one another to teach the child healthy relationship skills and pro-social behaviors, with appropriate consequences, in a consistent manner is essential to classroom management.

Attention-Deficit / Hyperactivity Disorder

Attention-Deficit Disorder (ADD) was renamed Attention-Deficit/Hyperactivity Disorder (ADHD) in 1994. ADD is a general term frequently used to describe individuals that have attention deficit hyperactivity disorder without the hyperactive and impulsive behaviors. The terms ADD and ADHD are often used interchangeably for both those who do and those who do not have symptoms of hyperactivity and impulsiveness.

Scientific research supports the conclusion that ADHD is a biologically based disorder with a strong genetic connection, and tends to run in families. The biological research shows that children with ADHD have lower levels of the neurotransmitter dopamine in critical areas of the brain. The National Institute of Health (NIH) research observed, in PET scans, that those with ADHD had significantly lower metabolic activity in regions of the brain controlling attention, social judgment, and movement than those individuals without an ADHD diagnosis. ADHD is 3 to 4 times more common in boys than girls although it is not understood why this is the case.

The Centers for Disease Control and Prevention (CDC) claim that recent surveys show approximately 11% of children 4-17 years of age (6.4 million) have been diagnosed with ADHD as of 2011. The hallmarks of the syndrome of ADHD are inattention, hyperactivity, and impulsivity. Symptoms of this condition are expressed in multiple settings and across numerous functional domains, thus demonstrating the pervasiveness of this condition.

Symptoms

There are three different types of ADHD - predominantly inattentive, predominantly hyperactive/impulsive, and combined, each with their own set of symptoms. According to the DSM-5 the symptoms for the types of ADHD are as follows:

The predominantly inattentive type (formerly ADD):

- Often fails to give close attention to details or makes careless mistakes in schoolwork, at work, or during other activities (e.g., overlooks or misses details, work is inaccurate).

- Often has difficulties sustaining attention in tasks or play activities (e.g., has difficulty remaining focused during lectures, conversations, or lengthy reading).
- Often does not seem to listen when spoken to directly (e.g., mind seems elsewhere, even in the absence of any obvious distraction).
- Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (e.g., starts tasks but quickly loses focus and is easily sidetracked) (not due to oppositional behavior or failure to understand instructions).
- Often has difficulty organizing tasks and activities (e.g., difficulty managing sequential tasks; difficulty keeping materials and belongings in order; messy, disorganized work; has poor time management; fails to meet deadlines).
- Often avoids, dislikes or is reluctant to engage in tasks that require sustained mental efforts (e.g., schoolwork or homework; for older adolescents and adults, preparing reports, completing forms, reviewing lengthy papers).
- Often loses things necessary for tasks or activities (e.g., school materials, pencils, books, tools, wallets, keys, paperwork, eyeglasses, keys)
- Is often easily distracted by extraneous stimuli (for older adolescents and **adults this may include unrelated thoughts**).
- Is often forgetful in daily activities (e.g., doing chores, running errands, for older adolescents and adults).

The predominantly hyperactive/impulsive type:

- Often fidgets with or taps hands or feet or squirms in seat.
- Often leaves seat in classroom or in other situations in which remaining seated is expected (e.g., leaves his or her place in the classroom, in the office or other workplace, or in other situations that require remaining in place).
- Often runs about or climbs in situations in which it is inappropriate (Note: in adolescents or adults it may be limited to subjective feelings of restlessness).
- Often unable to play or engage in leisure activities quietly.
- Is often "on the go" or acts as if "driven by a motor" (e.g., is unable to be or uncomfortable being still for extended time, as in restaurants, meetings; may be experienced by others as being restless or difficult to keep up with).
- Often talks excessively.
- Often blurts out an answer before a question has been completed (e.g., completes people's sentences; cannot wait for turn in conversation).
- Often has difficulty waiting his or her turn (e.g., while waiting in line).
- Often interrupts or intrudes on others (e.g., butts into conversations, games, or activities; may start using other people's things without asking or receiving permission; for adolescents and adults, may intrude into or take over what others are doing).

The combined type (inattentive/hyperactive/impulsive):

- Those with combined type have a combination of inattentive and hyperactive/impulsive symptoms; this is the most common type of ADHD.
- The combined type of ADHD is more prevalent in elementary school-aged boys and the predominantly inattentive type is diagnosed more often in adolescent girls.

Identification of the problem is the first step in providing the child with the most appropriate support and interventions. This requires that administration supports the needs of the school staff and that teachers, parents, school nurses, mental health professionals and physician to work together to accurately identify whether a child has ADHD. The following are guidelines for diagnosis.

The DSM-5 has identified that to be diagnosed with ADHD an individual must display:

Inattention:

Six (or more) of the following symptoms have persisted for at least 6 months to a degree that is inconsistent with developmental level and that negatively impacts directly on social and academic/occupational activities.

Note: The symptoms are not solely a manifestation of oppositional behavior, defiance, hostility, or failure to understand tasks or instructions. For older adolescents and adults (age 17 and older), at least five symptoms are required.

Hyperactivity and impulsivity:

Six (or more) of the following symptoms have persisted for at least 6 months to a degree that is inconsistent with developmental level and negatively impacts directly on social and academic/occupational activities.

Note: The symptoms are not solely a manifestation of oppositional behavior, defiance, hostility, or a failure to understand tasks or instructions. For older adolescents and adults (age 17 and older), at least five symptoms are required.

When diagnosing a child with ADHD it is important to gather information from multiple sources to make an accurate diagnosis. A pediatrician, trained psychologist, neurologist, psychiatrist or trained clinical social worker can make the diagnosis in conjunction with input from parents, other caregivers, teachers and other school staff that know the child. The psychiatrist or clinician must determine whether other psychiatric disorders are present before finalizing a diagnosis of ADHD. It is important to complete a comprehensive assessment with the parents and child on the child's overall functioning and family situation. This will rule out other situations that can trigger behavior that may resemble ADHD but are symptoms in reaction to:

- A death or divorce in the family, a parent's job loss, or other sudden change.
- Undetected seizures.
- An ear infection that causes temporary hearing problems.
- Problems with schoolwork caused by a learning disability.
- Anxiety or depression.

Parents, other caregivers, teachers, and other school staff who know the child are in the best position to observe the child's behavior in various settings, i.e. home, community, and school. The parents, caregivers, teachers, and other appropriate school staff can complete a standardized rating scale to provide an accurate picture of the child's behavior in various settings. The physician can also do a complete medical examination to rule out medical problems (i.e. hearing and vision) as well as other medical issues. This information from multiple sources is pertinent to making an accurate ADHD diagnosis.

In-service training for school staff on symptoms of ADHD, appropriate behavioral interventions, and the importance of communicating and working with the family will support the academic success of the child with ADHD.

Educational Interventions

- Provide an environment that is structured, predictable and conducive to learning. Seat the student where there is a minimum of distraction, encourage peer tutoring, and provide a quiet study area.
- Provide specialized instruction with frequent eye contact. Be clear and concise; simplify, break down and repeat instruction.
- Provide supervision and consistent consequences. Have established clearly stated consequences for misbehavior, administer consequences immediately and calmly, enforce rules consistently, and avoid ridicule and criticism.
- Be specific in naming and describing the behavior that has resulted in the consequence.
- Enhance self-esteem through frequent encouragement and praise.
-

Mental Health Interventions (licensed mental health professionals ONLY):

Behavioral Management Therapy

A licensed mental health professional, a psychologist, social worker, or family therapist, works with the parents and teacher to provide training in child behavior management.

The training consists of viewing the child's behavior as a function of ADHD rather than as a negative behavior and focusing on appropriate behavior. Training includes ignoring minor inappropriate behavior.

This therapy consists of providing clear and concise directions to the child and establishing an effective incentive program such as tokens, tickets, or reward points. The management of the child's behavior is through the application of immediate and consistent consequences in the form of rewards or removal of privileges.

The main elements of behavioral management therapy are:

Goal-setting: The parent and teacher assist the child in learning to set and accomplish specific goals, such as completing a chore, finishing a classroom assignment, able to play with a peer on the playground, and being able to sit at his/her desk for an hour or more.

Rewards and consequences: The child receives rewards for good behavior and/or achieving identified goals. The child's negative behavior will get a time out or a loss of privileges.

Consistent therapy for a long period of time: Utilization of goal-setting, rewards, and consequences with the child until the child internalizes these behavioral changes on their own.

Treatment does need to be tailored to the individual needs and personal history of the child.

1. Medical/Psychiatric Interventions

The main ADHD medications include stimulants, non-stimulants and antidepressants. Some of these drugs have side effects. The most common side effects are:

- Decreased appetite/weight loss
- Sleep problems
- Headaches
- Jitteriness
- Social withdrawal
- Stomach aches
- Acne

The side effects can be managed through careful monitoring of the dosages. It is important to communicate and work closely with the child's doctor to ensure accurate administration of the medication as prescribed.

A multidisciplinary approach to treating ADHD is the most effective. Utilizing a multidisciplinary approach to treating ADHD includes:

- Educating parents and the child on their diagnosis and treatment options
- ADHD medication
- Behavior management therapy
- Involvement of teacher
- Involvement of counselor

Eating Disorders

Eating disorders are complex clinical conditions that arise from a combination of long-standing behavioral, biological, emotional, psychological, interpersonal, and social factors. They can include, but are not limited to, the following behaviors; incessant dieting, compulsive overeating, repetitive bingeing and purging and/or compulsive exercising. Scientists and researchers are still learning about the underlying causes of these emotionally and physically damaging conditions. We do know however, about some of the general issues that can contribute to the development of eating disorders.

While eating disorders may begin with preoccupations with food and weight, they are most often about much more than food. People with eating disorders often use food and the control of food to compensate for feelings and emotions that may otherwise seem overwhelming.

According to the DSM-5 here are the diagnostic criteria/symptoms that are used to identify an eating disorder:

Pica

- Persistent eating of nonnutritive, nonfood substances over a period of at least 1 month.
- The eating of nonnutritive, nonfood substances is inappropriate to the developmental **level of the individual.**
- The eating behavior is not part of a culturally supported or socially normative practice.
- If the eating behavior occurs in the context of another mental disorder (e.g., intellectual disability [intellectual developmental disorder], autism spectrum disorder, schizophrenia) or medical condition (including pregnancy), it is sufficiently severe to warrant additional clinical attention.

Rumination Disorder

- Repeated regurgitation of food over a period of at least 1 month. Regurgitated food **may be re-chewed, re-swallowed, or spit out.**
- The repeated regurgitation is not attributable to an associated gastrointestinal or other medical condition (e.g., gastro-esophageal reflux, pyloric stenosis).
- The eating disturbance does not occur exclusively during the course of anorexia nervosa, bulimia nervosa, binge-eating disorder, or avoidant/restrictive food intake disorder.

- If the symptoms occur in the context of another mental disorder (e.g., intellectual disability [Intellectual developmental disorder] or another neurodevelopmental disorder), they are sufficiently severe to warrant additional clinical attention.

Specify if: In remission- After full criteria for rumination disorder were previously met, the criteria have not been met for a sustained period of time.

Avoidant/Restrictive Food Intake Disorder

According to the DSM-5, this is an eating or feeding disturbance (e.g., apparent lack of interest in eating or food; avoidance based on the sensory characteristics of food; concern about aversive consequences of eating) as manifested by persistent failure to meet appropriate nutritional and/or energy needs associated with one (or more) of the following:

- Significant weight loss (or failure to achieve expected weight gain or faltering growth in children).
- Significant nutritional deficiency.
- Dependence on enteral feeding or oral nutritional supplements.
- Marked interference with psychosocial functioning.
- The disturbance is not better explained by lack of available food or by an associated

culturally sanctioned practice.

- The eating disturbance does not occur exclusively during the course of anorexia nervosa or bulimia nervosa, and there is no evidence of a disturbance in the way in which one's body weight or shape is experienced.
- The eating disturbance is not attributable to a concurrent medical condition or not better explained by another mental disorder. When the eating disturbance occurs in the context of another condition or disorder, the severity of the eating disturbance exceeds that routinely associated with the condition or disorder and warrants additional clinical attention.

Anorexia Nervosa

- Restriction of energy intake relative to requirements, leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health. Significantly low weight is defined as a weight that is less than minimally normal or, for children and adolescents, less than that minimally expected.
- Intense fear of gaining weight or of becoming fat or persistent behavior that interferes with weight gain, even though at a significantly low weight.
- Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.

Specify whether:

Restricting type: During the last 3 months, the individual has not engaged in recurrent episodes of binge eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas). This subtype describes presentations in which weight loss is accomplished primarily through dieting, fasting, and/or excessive exercise.

Binge-eating/purging type: During the last 3 months, the individual has engaged

in recurrent episodes of binge eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas).

Bulimia Nervosa

- Recurrent episodes of binge eating. An episode of binge eating is characterized by **both of the following:**
 - Eating, in a discrete period (e.g., within any 2-hour period), an amount of food that is larger than what most individuals would eat in a similar period of time under similar circumstances.
 - A sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating).
- Recurrent inappropriate compensatory behaviors to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, or other medications; fasting; or excessive exercise.
- The binge eating and inappropriate compensatory behaviors both occur, on average, **at least once a week for 3 months.**
- Self-evaluation is unduly influenced by body shape and weight.
- The disturbance does not occur exclusively during episodes of anorexia nervosa.

Binge-Eating Disorder

- Recurrent episodes of binge eating. An episode of binge eating is characterized **by both of the following:**
 - Eating, in a discrete period (e.g., within any 2-hour period), an amount of food that is definitely larger than what most people would eat in a similar period of time under similar circumstances.
 - A sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating).
- The binge-eating episodes are associated with three (or more) of the following:
 - Eating much more rapidly than normal.
 - Eating until feeling uncomfortably full.
 - Eating large amounts of food when not feeling physically hungry.
 - Eating alone because of feeling embarrassed by how much one is eating.
 - Feeling disgusted with oneself, depressed, or very guilty afterward.
- Marked distress regarding binge eating is present.
- The binge eating occurs, on average, at least once a week for 3 months.
- The binge eating is not associated with the recurrent use of inappropriate compensatory behavior as in bulimia nervosa and does not occur exclusively during the course of bulimia nervosa or anorexia nervosa.

Psychological Factors that can contribute to Eating Disorders:

- Low self-esteem,
- Feelings of inadequacy or lack of control in life,
- Depression, anxiety, anger, or loneliness.

Interpersonal Factors that can contribute to Eating Disorders:

- Troubled personal relationships,
- Difficulty expressing emotions and feelings,
- History of being teased or ridiculed based on size or weight,

- History of physical or sexual abuse.

Social Factors that can contribute to Eating Disorders:

- Cultural pressures that glorify “thinness” and place value on obtaining the “perfect body”.
- Narrow definitions of beauty that include only women and men of specific body weights and shapes.
- Cultural norms that value people based on physical appearance and not inner qualities and strengths.

Biological Factors that can contribute to Eating Disorders:

- Scientists are still researching possible biochemical or biological causes of eating disorders. In some individuals with eating disorders, certain chemicals in the brain that control hunger, appetite, and digestion have been found to be unbalanced. The exact meaning and implications of these imbalances remains under investigation.
- Eating disorders often run in families. Current research indicates that there are some genetic contributions to eating disorders.

A person with eating disorders may have a general mistrust of health care providers, due to her/his own secrecy and embarrassment about the problem. A teenager approached about an apparent eating disorder may react with denial of difficulties or a refusal to participate in rehabilitation. These responses reflect an overwhelming fear of letting go of the coping strategy and, thus, a return to a state of perceived weakness and helplessness.

What Schools Can Do

- Classroom education as part of the comprehensive health education curriculum should contain opportunities for learning and discussion about societal attitudes and media messages regarding weight and appearance.
- Because of the danger from eating disorders to physical health, it is important to share concerns with school health professionals including any mental health providers, who should consult with the student and parent for a referral to the student’s primary health care provider.
- Eating disorders are complex conditions that can arise from a variety of potential causes. Once started, however, they can create a self-perpetuating cycle of physical and emotional destructions. All eating disorders require professional help.
- The National Eating Disorder Association provides toolkits and more detailed information. The Toolkits available were created specifically for school personnel that include teachers, coaches, and administrators. Please go to <http://nationaleatingdisorders.org/> for more information or to access those Toolkits.

Post-Traumatic Stress Disorder (PTSD)

Post-traumatic stress disorder (PTSD) is an individual’s response to a traumatic event that exceeds one’s coping resources. All the following information is for PTSD in children over the age of six. According to the American Psychological Association (APA) as many as two thirds of adolescents’ report experiencing a traumatic event by age 16. PTSD is described in the DSM-5 as caused by the “exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:

- Directly experiencing the traumatic event(s).
- Witnessing, in person, the event(s) as it occurred to others.
- Learning that the traumatic event(s) occurred to a close family member or friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
- Experiencing repeated or extreme exposure to aversive details of the traumatic event(s).”

Examples of these events could include: sexual abuse or violence, physical abuse, disasters such as fires, hurricanes or floods, violent crimes, or motor vehicle accidents. PTSD may also occur after witnessing violence such as domestic violence, community violence, or war. It is important to note that nearly all individuals, especially children, will display some type of distress or behavioral changes immediately following a traumatic event. However, children are incredibly resilient and many will return to their prior level of functioning. It is when the symptoms last longer than one month or when the symptoms cause significant impairment in functioning that a PTSD diagnosis is warranted. Risk factors for having an increased chance of symptoms of PTSD are: exposure to multiple traumas, history of anxiety problems, or having experienced familial adversity according to the APA.

Diagnosis of PTSD should be based on the DSM-5. The following should serve as a summary of the criterion but is not exhaustive.

- Exposure to actual or threatened death, serious injury, or sexual violence (the exposure can be directly experienced or witnessed traumatic event(s), or learned of the traumatic event(s) that occurred to a close family member or friend, or by experiencing repeated or extreme exposure to aversive details of the event(s)).
- Presence of Intrusion Symptoms can be expressed through recurrent, involuntary, and intrusive distressing memories of the event(s), distressing dreams, dissociative reactions, or intense or prolonged psychological distress at the exposure to cues or symbols in which the adolescent feels as though the event(s) is recurring.
- In children older than 6 years, repetitive play may occur that includes themes or aspects of the traumatic event(s), frightening dreams may not have recognizable content and trauma-specific reenactment may occur in play.
- Persistent avoidance of stimuli associated with the traumatic event(s) beginning after the traumatic event(s) occurred. Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or associated with the traumatic event(s), i.e.: any event(s) or avoiding external reminders (people, places, conversations, activities, objects, situations).
- Negative alterations in cognitions and mood associated with the traumatic event. Inability to remember an important aspect of the traumatic event(s), expressed by exaggerated negative beliefs or expectations about oneself, others or the world, distorted cognitions about the cause of the event(s) that lead to the individual blaming himself/herself or others, persistent negative emotional state, diminished interest in significant activities, feelings of detachment or estrangement from others, and inability to experience positive emotions.
- Alterations in arousal reactivity associated with the traumatic event(s) expressed through: irritable behavior and anger outbursts, reckless or self-destructive behaviors, hypervigilance, exaggerated startle response, problems with concentration or sleep disturbances.

Symptoms

In children and adolescent's symptoms may appear as:

- The development of new fears related to the event
- Separation anxiety
- Nightmares
- Sadness
- Reduced concentration
- Decline in performance at school
- Anger
- Somatic complaints or irritability
- Avoidance.

According to the American Academy of Child and Adolescent Psychiatry (AACAP), children who experience repeated trauma may experience dissociation, or an emotional numbing that helps to block the pain and trauma. They may also become depressed, withdrawn, and detached from their feelings. In many adolescents, symptoms of a trauma may present themselves as somatic complaints such as a headache or a chronic stomachache. They may also revert to earlier behaviors such as thumb sucking or having separation anxiety. In addition, children may experience what is called “time skew,” in which the adolescent may mis-sequence the events of the trauma or not remember exact details. They may also have “omen formation” which is a belief that there were warning signs preceding the trauma. These symptoms can often take the place of visual flashbacks or amnesia which is present for adults experiencing PTSD, according to the National Center for PTSD. The symptoms should have lasted longer than 1 month, causing significant impairment in an area of functioning such as social, or school. The symptoms are not attributable to the effects of a substance.

What Schools Can Do

Early intervention following a trauma is critical, with an emphasis on creating a feeling of safety (AACAP, 2011). However, according to the DSM-5, symptoms can begin within the first 3 months following a trauma but can also be delayed by months or years. Therefore, continued support of an adolescent who has experienced a trauma is beneficial.

If the trauma is a widespread trauma that may affect multiple students, bringing in a crisis team or additional mental health resources may be warranted. Having a plan in place for crisis response is required by [New Mexico Administrative Code 6.12.6.8](#): “a plan addressing the behavioral health needs of all students in the educational process by focusing on students’ social and emotional wellbeing” with school safety plans at each school building.

For school mental health counselors, the recommended treatment for adolescents suffering from PTSD are cognitive-behavioral therapies and more specifically trauma-focused Cognitive Behavioral Therapy (CBT), play therapy has also been empirically validated but only for younger children. Psychological first aid is also a resource for school mental health personnel as it details how to help the adolescents with less severe symptoms and gives information on how to refer out the adolescents with more severe symptoms. Psychological first aid was created by the National Child Traumatic Stress Network and the National Center for PTSD. It can be found at <http://www.nctsn.org/content/psychological-first-aid-schoolspfa>

Effects of Trauma

Research has shown that today’s school communities have the potential to face many more crisis situations than ever before. In addition, the nature and severity of the types of crisis and trauma that can develop today were almost nonexistent 30 years ago. Examples

include; hostage taking, sniper attacks, adolescent suicide, high teenage rates of motor vehicle-related deaths, bomb scares, war, natural disasters, and terrorist activities. Along with the crisis situations mentioned above children are often victims/witnesses to domestic violence, experience child abuse and neglect which may include physical, emotional, or sexual abuse; experience family substance abuse issues and the loss of family members due to homicide, suicide or drug overdose or are part of the immigrant community. Trauma can happen to anyone, regardless of gender, age, socioeconomic status, or ethnicity.

Traumatic response results from exposure to drastic and tragic change in an individual's environment which has become common and familiar to them. Trauma response can also result from exposure to long term conditions that continually break down an individual's ability to cope day to day; such as poverty or neglect and abuse.

Trauma is not a new concept. However, until recently, it has largely been viewed to be applicable to only a select group of individuals, under extraordinary circumstances – for example, survivors of the above mentioned catastrophic events. There have been some notable exceptions; but for the most part, trauma has not been recognized as a part of the daily, regular, experience of many individuals, including children and adolescents. Nor has the profound linkage between trauma and child development and the disruption of physical and emotional health been fully recognized.

Implementing a Trauma Informed System

Many of the children who will arrive at school with behavioral health or substance abuse problems have experienced one or more traumas in their lives. Therefore, it is very important that school health personnel, educators, and administrators are aware of how trauma impacts the lives of their students; their behavior; their ability to form meaningful relationships and their ability to learn.

Implementing a trauma-informed system within the school setting can be challenging but can have a major impact on the school environment and has been shown to decrease many of the disruptive behavioral issues a school community deals with on a regular basis. By integrating trauma sensitivity into school policies and teaching strategies, school climates and academic achievement can greatly improve, especially in districts serving fiscally depressed communities.

Below is a Trauma Fact Sheet for Educators from the National Child Traumatic Stress Network (NCTSN). The NCTSN serves as a valuable resource for developing and disseminating evidence-based intervention, trauma-informed services, and public and professional education by combining knowledge of child development, expertise in the full range of child traumatic experiences, and attention to cultural perspectives. NCTSN offers specific information on how trauma impacts children of varying ages, important information for teachers, administrators, and parents.

Trauma Fact Sheet for Educators

One out of every four children attending school has been exposed to a traumatic event that can affect learning and/ or behavior.

FACT: Trauma can impact school performance.

- Lower GPA
- Higher rate of school absences
- Increased drop-out
- More suspensions and expulsions
- Decreased reading ability

Single exposure to traumatic events may cause jumpiness, intrusive thoughts, interrupted sleep and nightmares, anger and moodiness and /or social withdrawal – any of which can interfere with concentration and memory.

FACT: Trauma can impair learning.

- Adversely affect attention, memory, cognition
- Reduce a child’s ability to focus, organize and process information
- Interfere with effective problem solving and /or planning
- Result in overwhelming feelings of frustration and anxiety

Chronic exposure to traumatic events, especially during a child’s early years, can result in the following

FACT: Traumatized children may experience physical and emotional distress.

- Physical symptoms like headaches and stomachaches
- Poor control of emotions
- Inconsistent academic performance
- Unpredictable and/or impulsive behavior
- Over or under-reacting to bells, physical contact, doors slamming, sirens, lighting, sudden movements
- Intense reactions to reminders of their traumatic event:
 - Thinking others are violating their personal space, i.e., “What are you looking at?”
 - Blowing up when being corrected or told what to do by an authority figure
 - Fighting when criticized or teased by others
 - Resisting transition and/or change

FACT: The child who has been traumatized can be helped.

- Follow the school’s reporting procedures if abuse is suspected.
- Work with the child’s caregiver(s) to share and address school problems.
- Refer to community resources when a child show signs of being unable to cope with traumatic stress.
- Share Trauma Facts for Educators with other teachers and school personnel.

Please visit www.NCTSN.org for specific information on Psychological & Behavioral Impact of Trauma: High School Student examples and many other trauma related links.

Suicidal Ideation

Suicide attempts can be considered a symptom of depression. A suicide death is a devastating event for everyone, including the school. Therefore, it is worthwhile for educators to learn more about suicide specifically. There is some evidence that a suicide death of one student may lead to suicide attempts and/or completions by other students in the same school because of a “contagion” or copycat effect.

According to the Substance Abuse and Mental Health Services Administration’s (SAMHSA) *Preventing Suicide: A Toolkit for High Schools* guidebook “risk factors for suicide refer to personal or environmental characteristics that are associated with suicide. The environment includes the social and cultural environment as well as the physical environment. People affected by one or more of these risk factors may have a greater probability of suicidal behavior. Some risk factors cannot be changed—such as a previous suicide attempt—but they can be used to help identify someone who may be vulnerable to suicide.”

SAMHSA notes that there is no “agreed-upon” list regarding risk factors of youth suicide. However, SAMHSA does provide a list of risk factors identified by the most recent research:

Behavioral Health Issues/Disorders

- Depressive disorders
- Substance abuse or dependence (alcohol and other drugs)
- Conduct/disruptive behavior disorders
- Other disorders (e.g., anxiety disorders, personality disorders)
- Previous suicide attempts
- Self-injury (without intent to die)
- Genetic/biological vulnerability (mainly abnormalities in serotonin functioning, which can lead to some of the behavioral health problems listed above).

Note: The presence of multiple behavioral health disorders (especially the combination of mood and disruptive behavior problems or substance use) increases suicide risk.

Personal Characteristics

- Hopelessness,
- Low self-esteem,
- Loneliness,
- Social alienation and isolation, lack of belonging,
- Low stress and frustration tolerance,
- Impulsivity,
- Risk taking, recklessness,
- Poor problem-solving or coping skills,
- Perception of self as very underweight or very overweight,
- Capacity to self-injure,
- Perception of being a burden (e.g., to family and friends).

Adverse/Stressful Life Circumstances

- Interpersonal difficulties or losses (e.g., breaking up with a girlfriend or boyfriend),
- Disciplinary or legal problems,
- Bullying, either as victim or perpetrator,
- School or work problems (e.g., actual, or perceived difficulties in school or work, not attending school or work, not going to college),
- Physical, sexual, and/or psychological abuse,
- Chronic physical illness or disability,
- Exposure to suicide of peer.

Risky Behaviors

- Alcohol or drug use,
- Delinquency,
- Aggressive/violent behavior,
- Risky sexual behavior.

Family Characteristics

- Family history of suicide or suicidal behavior,
- Parental mental health problems,
- Parental divorce,
- Death of parent or other relative,
- Problems in parent-child relationship (e.g., feelings of detachment from parents, inability to talk with family members, interpersonal conflicts, family financial problems, family violence or abuse, parenting style either under protective or overprotective and highly critical).

Environmental Factors

- Negative social and emotional environment at school, including negative attitudes, beliefs, feelings, and interactions of staff and students,
- Lack of acceptance of differences,
- Expression and acts of hostility,
- Lack of respect and fair treatment,
- Lack of respect for the cultures of all students,
- Limitations in school physical environment, including lack of safety and security,
- Weapons on campus,
- Poorly lit areas conducive to bullying and violence,
- Limited access to mental health care,
- Access to lethal means, particularly in the home,
- Exposure to other suicides, leading to suicide contagion,
- Exposure to stigma and discrimination against students based on sexual orientation; gender identity; race and ethnicity; disability; or physical characteristics, such as overweight. Stigma and discrimination lead to:
 - Victimization and bullying by others, lack of support from and rejection by family and peers, dropping out of school, lack of access to work opportunities and health care,
 - Internalized homophobia, stress from being different and not accepted, and stress around disclosure of being gay, which can lead to low self-esteem, social isolation, and decreased help-seeking,
 - Stress due to the need to adapt to a different culture, especially reconciling differences between one's family and the majority culture, which can lead to family conflict and rejection.

Symptoms/Warning Signs for Suicide and Corresponding Actions

Seek immediate help from a mental health provider, 9-1-1 or the local emergency provider,

New Mexico Crisis and Access Line 1-855-662-7474 or

National Suicide Prevention Lifeline at 1-800-273-TALK (8255)

When you hear, or see any one of these behaviors:

- Someone threatening to hurt or kill themselves.
- Someone looking for ways to kill themselves: seeking access to pills, weapons, or other means.
- Someone talking or writing about death, dying, or suicide, when these actions are out of the ordinary for the person.

OR:

If you witness, hear, or see anyone exhibiting one or more of these behaviors:

- Hopelessness—expresses no reason for living, no sense of purpose in life,
- Rage, anger, seeking revenge,
- Recklessness or risky behavior, seemingly without thinking,
- Expressions of feeling trapped—like there's no way out,
- Increased alcohol or drug use,
- Withdrawal from friends, family, or society,
- Anxiety, agitation, inability to sleep, or constant sleep,
- Dramatic mood changes,
- No reason for living, no sense of purpose in life.

What Schools Can Do

No individual teacher or other school professional should feel responsible for or decide alone how to proceed with a potentially suicidal student. Every school professional should learn how to notice signs of mental distress and how to respond to a student's request for help. In addition, every school system and every school should have a crisis protocol (policy & procedures), a crisis team, and have knowledge of community resources that are available to appropriately handle students who exhibit suicidal behavior and any other crisis situations.

Every school should have a crisis protocol, a crisis team, and community resources available to deal with suicidal students and other crisis situations.

- Implement a primary suicide prevention program, teaching staff, parents and children to be aware of the seriousness of suicidal comments and how to ask for help promptly if they have such thoughts or know of someone else who is having such thoughts.
- Avoid displaying shock, judgment, or disapproval if someone discloses suicidal thoughts.
- Show any identified individual true concern that his/her disclosure is taken seriously.
- Tell the individual that suicidal intent or thoughts cannot be kept confidential and that it is necessary to seek help from others. Remind the individual that this is because he/she is cared for and that needed help is being accessed.
- If someone has talked about suicide, discuss it with a school psychologist, counselor, school nurse, principal, or other designated person so that potential risk assessment can occur immediately.
- Do not leave a suicidal individual alone. Take him/her along to get help or call/send someone else for help.

- Prepare yourself! Once a suicide crisis presents it becomes the priority and other tasks should be delegated or set aside to maintain student safety.
- Include the following in a crisis response manual:
 - A checklist of procedures to follow in the event of a crisis including responses to clear-cut or suspected suicidal thoughts or intent.
 - A list of crisis intervention team members with updated telephone numbers.
 - A list of community resources that includes addresses and telephone numbers, such as Department of Social Services, the local mental health agency, Suicide Hotline, AIDS Hotline, National Runaway Switchboard, police and fire departments, and local or regional addiction and psychiatric resources.

Developing a Youth Suicide Response Plan

Collaboration and coordination between the school district, its various schools, the School Based Health Center (if applicable), community agencies, and regional hospitals are critical and essential for a youth suicide response plan to be effective. Considering access to care issues for the plan means identifying both primary care and behavioral health care service providers, in close proximity, if these services are not provided by the school district staff or contract staff.

When developing a youth suicide response plan the following considerations should be explored by the school district:

- What resources are available within the school?
- What resources are available within the community?
- What is the existing school district’s policy on intervening with a potentially suicidal student?
- How is confidentiality of the student protected within the school district?
- Who needs to know what is going on and when?
- How do the members (school nurse, counselors, social workers, SBHC staff etc.) of the school health team(s) interface with one another?

Suicide Response Plan Components

- Communication
- Access to care
- Levels of health care provided within the school district
- Parental involvement
- Confidentiality
- Referral and assessment
- Therapeutic intervention versus disciplinary action
- Transportation policy
- Staff education/training
- Continuity of care i.e. reintegration plan for student upon returning to school
- On-going training and practice of the suicide prevention plan for entire staff

Indicators for Assessing Suicide Risk

Under no circumstance should an untrained person attempt to assess the severity of the suicide risk of an individual student; all assessments of ideation, attempts, or other risk factors must be left to the appropriate professionals. In the assessment risk tables provided below the user should keep in mind that crisis responder refers to a medical or

mental health provider trained in suicide prevention; school personnel refers any student

General Guidelines for Assessing Suicide Risk	
<p>Low or Moderate Risk Criteria</p> <ul style="list-style-type: none"> • Staff member observes behavior or warning signs that indicate student may be at risk. • Student may have verbalized suicidal thoughts. However, <ul style="list-style-type: none"> - he/she does not have a plan. - he/she does not have access to a potentially lethal weapon or other lethal means of harming him/herself. - he/she may mention a means, but verbalizes no depth of planning or commitment. 	<p>Low or Moderate Risk Response</p> <ul style="list-style-type: none"> • School personnel will contact available crisis responder (e.g. school counselor, school nurse, SBHC staff, etc.) • Crisis responder will meet with student to determine extent of crisis (suicide assessment checklist should be administered. If harm is imminent, use guidelines under topics “Severe Risk.” • If harm is not imminent, seek consent from student to contact parent/guardian. • Crisis responder will refer student and family to resources appropriate to level of risk. • Crisis responder will notify designated school personnel (e.g. counselor) about student crisis. • Crisis responder will follow up with student and family as appropriate and as agreed upon.
<p>High Risk Criteria</p> <ul style="list-style-type: none"> • Student has overtly voiced intent to engage in a suicidal act. • Student has gone beyond mere thoughts and has thought of actual actions. • Student has a suicide plan but does not have means to carry it out. 	<p>High Risk Response</p> <ul style="list-style-type: none"> • School personnel will contact SBHC or other crisis responder available (e.g. school counselor, school RN). • Crisis responder will meet with student to determine extent of crisis. A suicide assessment checklist should be administered. • If harm is imminent, student will be kept under close supervision and never left alone. If at any time the situation escalates, (e.g. student has a weapon, refuses cooperation, walks out) call 911. • Crisis responder will counsel student through crisis, help mitigate stress and develop a “safety plan” with student input. • Crisis responder will notify designated school personnel about student’s intent and suicidal behavior. • Crisis responder will refer student and family to outside resources appropriate to level of risk. • Parents should be notified of student’s behavior and expressed intent. <ul style="list-style-type: none"> - Student may only be released to parents or someone equipped to provide help. - Before student release, next steps should be determined in an intervention meeting with crisis responder, student and parent/guardian. - If parents do not appear willing to take next steps, crisis responder or designated school personnel will call Children, Youth and Family Department (CYFD) to ensure student safety. • Crisis responder will follow up with student and family periodically.

that they believe may be at risk for suicide to designated faculty crisis responder (usually school nurse or social worker).

<p>Severe Risk Criteria</p> <ul style="list-style-type: none"> • Student has concrete plan with means readily available and accessible. • Student has access to lethal means needed to carry out act. • Student is in process of carrying out suicidal act. 	<p>Severe Risk Response</p> <ul style="list-style-type: none"> • School personnel should contact first available crisis responder (i.e. school counselor, school nurse, SBHC). • Crisis responder will determine extent of crisis after meeting with student and administering a suicide assessment checklist. • Student should be kept under constant observation and within reach of a responsible adult at all times. If unsuccessful at interrupting student's suicide plan call 911. Access to any lethal means for pursuing suicide should be removed/alleviated immediately. • Parents should be notified immediately. <ul style="list-style-type: none"> - Student should only be released to parents or someone equipped to provide necessary supervision until student safety is secured (e.g. hospitalization). - Before student release, next steps should be determined in an intervention meeting with crisis responder, student and parent/guardian. - If parents do not appear willing to take next steps, crisis responder or designated school personnel will call Children, Youth and Family Department (CYFD) to ensure student safety. - Student should be entrusted to someone able to provide safe environment and accompany student to a treatment agency or hospital. • Crisis responder should counsel student through crisis and help mitigate stress until parent/guardian arrives. • Crisis responder should refer student and family to outside resources appropriate to the level of risk. Contracts and release documents for facilitating referral linkage to treatment agencies should be in place at all times. • Crisis responder should follow up with student and family periodically. Responder should confirm that treatment was initiated, is on-going and is adequately meeting the need. • Crisis responder will notify designated school personnel about student's intent and suicidal behavior or suicide attempt.
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Suicide Crisis Response

When intervening with a student who has been determined to be at risk for suicide, the following guidelines are intended for use by a mental health clinician on the school staff or attached to a School Based Health Center (SBHC).

Best Practice/Recommended Intervention

When intervention in an individual suicidal crisis is indicated, the clinician should follow these guidelines.

- Immediately intervene one-on-one to address directly and empathetically the student's self-report of stressors.
- Provide positive reinforcement to the student for seeking assistance and/or accepting assistance.
- Continue to assess the lethality of the suicide risk and assess the concreteness of plan and means of implementation of the plan.
- Inform and educate student of the need to develop a collaborative safety plan based on student's strengths, resources, and coping skills.
- Move to the safety planning process, using the information learned during the initial intervention to create an individualized safety plan.
- Do not hesitate to seek additional consultation services during or after the crisis.

Safety Plan for Low and Moderate Risk Levels

- The safety plan should follow administrative procedures regarding communication and protocols established for an individual in suicide crisis. It should include the way the parent/guardian will be notified, unless the clinician determines this would increase danger to the student. The student should be informed of the need for the clinician to act on identified information and to follow school district protocol, and the clinician should assist the student in understanding this process. If the clinician determines the suicide risk is low and referral to emergency services is not indicated, he/she should begin the next intervention with the anticipation of parent/guardian arrival.
- In collaboration with the student both informal (family, friends, clergy, etc.) and formal (doctor, other treatment providers, 24-hour crisis lines, nearest emergency room, etc.) resources should be identified as safety contacts should the risk for suicide persist or increase. Contact information for these supports should be provided to the student.
- The student should be helped to identify coping resources and personal strengths.
- The safety plan should include removing potentially lethal means of pursuing suicide and plans for formal follow up (e.g. next appointment with clinician or another provider). Lack of willingness to adhere to a safety plan would place the student at a higher risk level.
- The safety plan should be formalized into a written document ensuring 24-hour, 7-day week supervision until follow up assessment occurs.
- The safety plan should be reviewed with parent/guardian and contact information verified. Obtaining signatures from parent/guardian and student as well as clinician indicates agreement and formalizes the plan.
- If parent/guardian is unavailable or refuses to participate the clinician should attempt to verbally review the plan with an adult designated by the parent/guardian. If this proves unsuccessful, child protective services channels should be initiated.

Safety Plan for High to Severe Risk Levels

- The safety plan should follow administrative procedures regarding communication and protocols established for an individual in suicide crisis. It should include the way the parent/guardian will be notified, unless the clinician determines this would increase danger to the student. The student should be informed of the need for the clinician to act on identified information and to follow school district protocol, and the clinician should assist the student in understanding this process.
- If the clinician has determined that the student needs immediate medical or psychiatric evaluation and/or hospitalization, steps to facilitate this process should be outlined in formal agreements with acute crisis service providers for referral services.
- Transportation arrangements for the student should be guided by the school district's established and approved policies covering emergency transportation.
- A qualified adult should be identified to accompany the student to a safe environment or until care is transferred to another caregiver that is another professional or a parent/guardian.

Documentation of Intervention Events

Crisis intervention should always be documented; such documentation should include (but is not limited to):

- Risk assessment information
- Clinician's decision-making process
- Student's response to intervention
- Communication with school, parents and other providers, etc.
- Record of any consultation received
- Instructions given to student and caregivers of student
- Plans for follow up.
- Communication with School Health Officer (See Adverse Event Reporting Form Section II Resources)
- A copy of the safety plan in its entirety should be kept in the student's chart along with all other documentation.

See Resource Section of this manual for Depression Checklist for Teens and Confidential Services for Minors.

Non-Suicidal Self-Injury (NSSI)

Non-suicidal self-injury (NSSI) can also be known as self-mutilation, self-harm, or self-abuse, but it is most commonly known as cutting. NSSI is any deliberate, non-suicidal behavior or physical harm that a person self-inflicts on their body and is primarily aimed at relieving emotional distress. NSSI is a maladaptive coping mechanism used to deal with extreme stress or painful emotions. There are many different reasons for NSSI, some reasons might be to avoid feeling numb, lonely, to stay alive, or sometimes clusters of cutting behaviors form in social groups. The behavior of NSSI may be an expression of a more serious mental illness such as borderline personality disorder or dissociative disorder. NSSI is listed as one of the criteria for borderline personality disorder in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5).

Signs

Most often any type of sharp object is used for self-injurious behavior, such as (but not exclusively) a razor from a pencil sharpener, thumb tacks, knife, paper clip, scissors, disassembled shavers, or a pencil eraser. The most common NSSI behaviors are:

- Cutting
- Burning the skin
- Hitting
- Poking
- Picking
- Scratching
- Biting oneself
- Punching oneself.

Other indications to consider could be:

- Frequent or unexplained scars, cuts, bruises, or burns
- Social emotional isolation
- Disconnectedness
- Substance misuse
- Possession of sharp objects.

In addition, general signs of depression and extreme risky behaviors are other indicators to consider.

If cutting behaviors are present, the injury could be anywhere on the arms, wrists, hands, stomach, legs or in between the toes. It is not uncommon for someone to cover up their wounds by wearing long sleeved shirts or jackets when it is not appropriate for the weather. However, others might display their wounds openly. If any NSSI behaviors are observed, regardless of the severity, knowledge of the behavior requires staff to step into action by following up with the proper intervention and care to prevent further self-injury or potential wound infection due to the self-injurious behavior.

Is It a Suicide Attempt?

Non-suicidal self-injury is not always an attempt to suicide. When youth self-injure or cut themselves, they are expressing their inner pain which might be keeping them from suicide. Nevertheless, there is an increased risk for suicidal behavior for those who self-injure. It is recommended as best practice to assess and make the necessary referrals for suicide risk assessment when youth self-injure or cut themselves.

What Schools Can Do

If any signs of NSSI are visible on a student, staff should:

- Approach the student in a calm and caring matter-remember it could be easy to be shocked or in disbelief, and staff should keep their emotions under control.
- Never leave the student alone.
- Listen and be available to the student.
- Inform the student that you are required to report this.

- Emphasize to the student that they are not in trouble nor will they be punished.
- Ensure a safe transfer of the student to a school counselor, social worker, and/or nurse.
- Notify a school administrator.

Schools can appropriately manage NSSI behavior by providing annual and routine mock training to every staff member of the school. This training should include:

- Policy and procedures on NSSI.
- Identification and response to NSSI.
- Referral and follow-up to NSSI.
- Required/not required notification process (parents, staff members, CYFD, etc.)
- Linkages and coordination with community mental health resources.

It is important to incorporate best practice into your school policy and procedures when implementing NSSI interventions. Whether individual schools or entire school districts, it is recommended to identify and fully implement a crisis team. The crisis team should receive comprehensive training on how to address and manage NSSI behavior on campus and develop student safety procedures.

Preventing Social Contagion

Social contagion is the manner of behavior (i.e. self-harming) that can spread among members of a group after finding out their peer has engaged in that same behavior. To prevent social contagion in schools, school staff must:

- Reduce communication around self-injury by advising students not to explicitly talk with other students.
- Do not convene a school-wide assembly on the topic.
- Do not discuss with the students how or why the youth hurt themselves.
- Do not conduct a group setting intervention.
- Assist in the management of scars and wounds of those students who self-injure. Visible scars, wounds, and cuts should be discouraged.

Social media is another form of communication that is a perfect venue for the spread of self-injurious behavior among social groups. School staff should encourage parent(s) or guardian(s) to monitor their children’s social media accounts, and encourage them to talk with their children when self-injurious behaviors are mentioned or displayed, as well as immediately informing a responsible adult to help others stay safe.

What Schools Can Do

Best practices indicate that school staff should:

- Educate students about the signs of distress in themselves and others.
- Teach the use of positive coping skills and provide access to mental health resources.
- Keep conversations regarding self-injury amongst those who “need to know” and in a private setting.
- Focus on preventing imitative behaviors.
- Provide ongoing monitoring of students by all staff and parents.
- When self-injury is identified, provide immediate and appropriate services and referrals for the student.

Somatic Complaints

These complaints are known to occur among children and adolescents and are caused by a combination of organic and psychological factors. Persistent or frequently recurring symptoms such as headache, stomach ache, nausea, diarrhea, and palpitation are often difficult to diagnose. Some children may be predisposed to psychosomatic illness because of specific physiological and psychological vulnerabilities. It is common for an individual to experience somatic symptoms in a stressful situation.

Somatic illnesses result when an individual experience a patterned persistent exaggeration of somatic complaints. Most adults recognize that a headache is a result of being stressed and take steps to reduce or withdraw from the stress. Others, especially children, may not recognize the connection between the symptom (headache) and the cause (worry about the big test tomorrow). The headaches may persist because the student does not recognize and or seek help for an underlying problem – in this case, fear of tests or in more serious situations the fear of parental reactions, abuse/neglect.

Symptoms

According to the DSM-5 a Somatic Symptom Disorder diagnosis must meet the following criteria:

- One or more somatic symptoms that are distressing or result in significant disruption of daily life.
- Excessive thoughts, feelings, or behaviors related to the somatic symptoms or associated health concerns as manifested by at least one of the following:
 - Disproportionate and persistent thoughts about the seriousness of one’s symptoms
 - Persistently high level of anxiety about health or symptoms
 - Excessive time and energy devoted to these symptoms or health concerns.
 - Although any one somatic symptom may not be continuously present, the state of being symptomatic is persistent (typically more than 6 months)

In primary disorders, a physiological problem (such as diabetes or asthma) is already present. The psychosomatic element is the aggravation of already existing symptoms. Thus, a child with diabetes may develop recurrent bouts of metabolic imbalance triggered by emotions. A child with asthma may have severe attacks at times of extreme emotional stress. In both cases, there is a physiological illness present.

In secondary disorders, no preexisting medical problem can be found. Thus, the child with headaches due to test anxiety may undergo a battery of tests that produce no physiological evidence to explain the headaches. It should be noted, however, that it is likely that headaches and other physical symptoms are as real and painful as are those of someone with a medical diagnosis.

Following is a list of some of the most commonly seen psychosomatic complaints in children:

- Asthma - Bronchial asthma is typically caused by allergic reactions, but in some cases emotions and stress can trigger an attack.

- **Stomach Problems** - Emotions have a marked effect on the gastrointestinal system. When a child is upset, the appetite may diminish or nausea and cramping may occur. Vomiting may be induced by anxiety provoking experiences. A large proportion of complaints such as upset stomach, heartburn, stomach ache and diarrhea can be caused by reactions to emotional stress.
- **Headaches** - Simple headaches (not migraine) may be the result of tension or stress. They can also result from hunger or lack of sleep, which is why a thorough assessment/interview is needed. Migraine headaches are uncommon in children under age 12, but they may begin during adolescence and must be monitored by a health care provider.
- **Urinary Incontinence (Enuresis)** - Enuresis is common in childhood. When there are no abnormalities found in the physical examination it is likely that enuresis is caused by emotional factors. It may be a sign of anxiousness or insecurity. Unexpressed anger may manifest itself in this way, particularly in cases of abuse and neglect. Even without treatment, most children outgrow their enuresis by puberty or early adolescence.
- **Encopresis** - Encopresis may be defined as fecal holding with constipation and fecal soiling. The constipation results in overflow incontinence. Children are often unaware of their accidents and unable to control them. While the origin of encopresis is frequently physical, some factors which can lead to withholding behavior resulting in constipation and/or leaking of stool include the school environment, the school bus environment, the busy routine of the school day, lack of privacy in school bathrooms as well as abuse and neglect.
- **Cardiovascular Symptoms** - Anxious children may experience a prolonged rapid heart rate (tachycardia). The child may describe it as a “pounding heart” or “racing pulse” and may fear that a heart attack is impending. This fear of heart attack increases the anxiety that aggravates the tachycardia which can set up a vicious cycle.
- **Psychosomatic Skin Disorders** - Most cases of skin rash (urticaria) are due to disease or allergic reactions; other cases may be caused by emotional stress. Urticaria due to emotional stress usually occurs on the neck, face, and arms; although, it may appear over the entire body. It is more common in girls than boys and occurs more frequently in adolescents than younger children.
- **Diabetes** - The emotional state of a diabetic child may have a marked effect on the course of the illness. Deviations from the prescribed medication or diet may result in serious medical emergencies.

What Schools Can Do

Determine whether an ailment is a physical disorder or caused by emotional factors. If treated early, many psychosomatic complaints will not become chronic problems. It is important for school personnel to pay close attention to illnesses in children. Children who have frequently recurring episodes of the same symptoms should be referred to a primary care provider or mental health provider.

Substance Abuse

Substance or alcohol use by an adolescent should be considered abuse because the adolescent cannot legally obtain or use the substance (unless taking as prescribed by a physician). Prescription drug abuse occurs when the adolescent is either taking the substance in excess of the prescription, using another person’s prescription or using the prescription for a reason other than prescribed; for example, an adolescent sharing their Ritalin prescription with other students. Teachers and other school personnel may suspect a student of being on a substance and send them to the school health personnel per the school district policy. However, it is not the role of the school health personnel to confirm or disapprove that a student is under the influence of a substance. Each school district should have a policy in place for referring students out to an independent testing location for such

tests. Counseling for substance abuse should also be referred out as only a Licensed Alcohol and Drug Abuse Counselor (LADAC) can provide the service.

Psychotropic Medication: Use with Children and Adolescents

Ensuring Quality Care

School nurses play an integral role in promoting quality student care. When a student requires a psychopharmacological intervention, school nurses may refer to an appropriately licensed provider who can prescribe psychotropic medication. Though psychotropic medication is sometimes prescribed without behavioral health support services, it is recommended that the student be offered behavioral health resource information. If the student refuses counseling, it is important to know that the prescribing provider is responsible for monitoring the student's medication reactions per guidance set forth by the American Academy of Child and Adolescent Psychiatry (AACAP). The CDC claims that Data from the National Health and Nutrition Examination Survey shows approximately 6.0% of U.S. adolescents aged 12–19 reported psychotropic drug use in the past month.

School nurses can also promote integrated and coordinated services for students who are prescribed psychotropic medication. Integrated care can best be achieved through close coordination among the prescribing provider, the student's Primary Care Physician, the treating Behavioral Health Provider, and school health and behavioral health resources.

Also, it is important to know that several policies and state statutes guide provider prescribing practices for psychotropic medications. Among these are the guidance set forth by the Food and Drug Administration (FDA) and American Academy of Child and Adolescent Psychiatry (AACAP). Providers must also adhere to New Mexico Statutory Authority (NMSA) regarding consent for psychotropic medications, as follows:

- In accordance with NMSA 32A-6A-14, for students age 13 and younger, the informed consent of a student's legal custodian is required before providing treatment, including psychotropic medication. Custodial written consent must be included in student's medical record.
- In accordance with NMSA 32A-6A-15, for students age 14 and older, psychotropic medications may be prescribed with the informed consent of the student. When psychotropic medications are prescribed, the provider must notify the child's legal custodian of medications the student is taking and possible side effects or medication interactions. Student written consent and custodial notification must be documented in the student's medical record.

Finally, because of complex drug interactions and effects of certain medications on children and adolescents, it is highly recommended that providers consult with a child and adolescent psychiatrist for assistance with evaluation and medical management under the following circumstances:

- Student presents with complex behavioral health needs or the co-occurrence of medical and behavioral health conditions.
- Greater than three psychotropic medications are being prescribed.
- Two or more antipsychotic medications are being prescribed.
- Prescribing psychotropic medication to children 5 years of age or younger.

Divorce

It is estimated that about half of all children in the United States will spend part of their lives in a single-parent family. Given this statistic, it is likely that every school will have at least some students of divorced or divorcing families in every class. Indeed, it is not uncommon for a high proportion of students in a classroom to have divorced parents.

The divorce process is a time during which all family members must learn to achieve a new balance. It is a time of loss, growth, and change. Children may experience a wide range of emotions: anger, grief, guilt, and sadness following a divorce. Separation or divorce may be experienced as a relief for some, particularly if there has been constant conflict or abuse. Predictably, it is a time of stress. Divorce can affect children from the same family in very different ways; it is important not to presume to know how any given child will react to the situation.

There is considerable variability in how children cope with divorce and separation. In addition to causing varying degrees of disruption and stress for the entire family, divorce may also result in a change in financial status. This may necessitate relocation and/or restricted ability to participate in school programs. Students may experience behavioral or academic performance problems in school and an overall dip in self-esteem or a sense of helplessness and lack of control over life situations. There may be continuing tensions between parents over arrangements for any children. Parental work patterns may change, and children may have less contact with one or both parents.

Signs of stress after a divorce

All the following behaviors may be indicative of normal reactions to divorce if they are not extremely severe, protracted, or numerous. If these symptoms persist or become increasingly severe, then the student may need additional help from a mental health professional.

- Inability to concentrate.
- Either a drop in or perfectionist obsession with school performance and grades, often to the extreme.
- Crying for no apparent or immediate reason.
- Displays of anger or being sullen, acting-out or rebelliousness.
- Loss of enthusiasm, sense of humor or joy.
- Regression to outgrown self-comforting behaviors such as thumb sucking.
- Development of tics or nervous behaviors such as nail biting or hair pulling.
- Withdrawal or isolation of self.
- Loss of memory or inability to follow directions.
- An intense need to please.
- Pervasive sadness.
- Rejection of one parent.

What Schools Can Do

The school represents a safe environment for any child of divorcing parents. Educators can help by being supportive of all students, being alert to signs of failure to cope and by having a plan to help students having trouble. Schools should set the tone that both parents are important partners in the family-school relationship. Educators can respond in the following ways to try to help students cope:

- Offer teachers consultation on various reactions children may have to divorce.
- Keep in touch with parents about the student's school experience.
- If the parents or student self-disclose, explain that during divorce children may feel strong emotions that sometimes make it hard to pay attention in school or do school work as usual. Encourage the student to talk to a trusted adult about his/her feelings. Continue to monitor the student and offer support.
- Encourage participation in family counseling and/or a divorce support group if available. This is an optimal opportunity for prevention.
- When there is concern in any way about the severity of a child's reaction, lack of signs of recovery, (recovery may take months) or any other aspects of behavior contact the parents/guardians for referral of the child to a mental health professional immediately.
- Encourage participation in a divorce support group if appropriate and available.
- Arrange for all parents/guardians to receive information from the school and for all parents to attend conferences and other school events.
- Do not presume that there are two biological parents in the home. Sensitivity to children living in single parent families, with guardians, or in households with other relations or responsible adults is key to validating a child's sense of well-being.
- If appropriate, become familiar with the child's schedule for seeing parents. The change in routine may be confusing for the child and it may help the child to know that someone is aware of the changes.
- Never take sides or bad mouth a parent.

Grief and Loss

It is difficult to estimate the proportion of students in a school who are grieving as the result of experiencing significant loss. Perhaps the most common type of loss experienced by school-aged children is the death of a significant other. Some students lose grandparents; some may lose parents, siblings, friends, or other emotionally significant individuals. Sometimes students and school personnel are forced to deal with the death of a classmate or staff member. In addition, the death of a pet may be a traumatic event or a best friend moving away. Children whose parents divorce, who are in foster care or who have been adopted at older ages can experience multiple losses. Few teachers, school nurses, and other school personnel go through their careers without knowing a student who is grieving. It is important that school personnel take the time to become aware of a child's history of loss so they know how best to support that student.

Symptoms

It is important to recognize that grief is a normal and necessary reaction to any type of loss. Students who are grieving need to be given as much time and opportunity as they need to grieve. It is crucial that school staff **DO NOT** try to fix, deny, or overlook student's grief. Children's grief behavior may differ from that of adults; they may or may not openly mourn. There are two types of grief that children may experience – normal grief (also called

uncomplicated bereavement) and childhood traumatic grief. In both normal and traumatic grief, some of the emotions that children and adolescents experience are denial, anger, acting out, withdrawal, guilt, and depression.

Other reactions to both normal and traumatic grief may include temporary physical complaints, they may regress returning to behaviors they had previously outgrown, like bed wetting, thumb sucking or clinging to parents. Both groups may have sleep problems, loss of appetite, and decreased interest in family and friends.

Childhood Traumatic Grief (Information below is summarized from the “In Depth General Information Guide to Childhood Traumatic Grief for School Personnel” available at the link

www.NCTSN.org.

Children who develop childhood traumatic grief reactions experience the cause of that death as horrifying or terrifying, whether the death was unexpected or due to natural causes. Even if the manner of death is not objectively sudden, shocking, or frightening to others, children who perceive the death this way may develop childhood traumatic grief.

For some children and adolescents, responses to traumatic events can have a profound effect on the way they see themselves and their world. They may experience important and long-lasting changes in their ability to trust others, their sense of personal safety, their effectiveness in navigating life challenges and their belief that there is justice or fairness in life.

It is important to keep in mind that many children who encounter a shocking or horrific death of another person will recover naturally and not develop ongoing difficulties, while other children may experience such difficulties. Every child is different in their reactions to traumatic loss.

How Grief Manifests for Children and Teenagers

Although everyone grieves differently when a family member, loved one, or close friend dies, there are some common grief experiences for children and teenagers:

Feeling different from other kids or teenagers

Often, this feeling of alienation just comes over the child. He or she may not even associate it with the death or the grief, but just feels different. Other times a child or teenager is very clear that the death was a turning point that separated her from friends, peers, or family members. She may say that no one understands how she feels, or that people don't know

how to talk to her anymore. While some kids grow closer to surviving family members after the death, other children and teens feel alone with what they're going through.

A rollercoaster of emotions

Numbness, anger, fear, confusion, sadness, loneliness, happiness, fatigue, agitation, resentment, manic excitement, guilt, disappointment, worry, and so on. The feelings can come in quick succession, and be unpredictable, adding to the instability the child may already be feeling. The child may feel like a different person than he was before the death. Parents and caregivers often comment, "I don't know him anymore. He's not the same person he used to be."

Adjusting to secondary losses

Besides the death itself, there are usually other changes in a child's life caused by the death, some of which will feel like losses. Family dynamics among surviving family members may shift—sometimes quite dramatically. In many cases the family feels unstable to the child. If the surviving parent(s) or caregivers are grieving, the child may feel that she has temporarily lost those people, too, or at least that they've changed. Routines and schedules, so important to children, are often disrupted. Family finances may change. The child's identity and self-esteem undergo a significant shift when a key person is suddenly missing from her life. These are just a few examples of secondary losses.

Anger, irritability, lashing out and getting in trouble

Many grieving children and teens have sudden bursts of anger or a "short fuse." Parents, caregivers, and teachers may be startled by the child or teen lashing out, defying adults or becoming sullen and withdrawn. Some kids start to have trouble at school or start to get in trouble at school or at home as a reaction to the death and to the death-related changes in their lives.

Trying to be perfect

Many grieving children and teens try to suppress their grief or hide it from other family members. They may also try to be "perfect" (get straight A's, overachieve), both to feel in control and to compensate for the pain and turmoil the family is experiencing. Kids with this pattern of response are typically emotional caretakers for their parents or for other grieving family members. Often these behaviors are subconscious, but sometimes the child is aware of doing these things.

Can't think straight, preoccupied

Periods of not being able to pay attention, focus or complete tasks often go on for a long time after the death, and may come in waves, just as grief does. This can affect grades and relationships with teachers and adults.

Shock and delayed reaction, or grief intensifying as time goes on: Most children and teenagers look back on the time right after the death and say that they were in shock, and that it really hit them several months later. Many times, grieving children and teenagers are hitting the deepest part of their grief right when other people are expecting them to be “getting over it” or “moving on.”

Guilt and regrets

Some kids have regret and guilt about any times when they were mad at the person who died or having argued with the person. Also, they may blame themselves for the death in ways that seem to make no logical sense to others, or feel that if only they had done something different, they might have prevented it.

Processing grief through play, art, sports, tears and other non-verbal ways

Children often have a hard time putting their feelings about the death into words. If they do not say much about their grief, they may be able to process it through play, art, sports, or other physical activity, crying, or through nurturing and reassurance (being held by a person they love or snuggling with pets or stuffed animals). While this is normal, it can be challenging for parents and caregivers who wish their children would talk about it to let them know how their grief process is going.

Crying and not crying

Some children cry a lot, and others very little or not at all. It’s all normal. Children often need to be told that it’s okay to cry. On the other hand, judging a child for not crying or pressuring him to cry is not helpful. Some children are very upset but may have a hard time expressing through tears.

Cyclical grieving

Many children and teenagers are still strongly affected by the death many, many years later. Their grief may come up unexpectedly sometimes and take them by surprise. Some people say that grief is a life-long process for them.

Other Common Manifestations of Grief

- Re-grieving at life milestones

- Re-grieving at new developmental stages
- Physical symptoms like headaches, chest pains, stomachaches, dizziness, etc.
- Fear that other people will die and they will be left alone, sometimes manifesting as clinging to parents and caregivers or anxious behavior
- Anxiety and worry, sometimes panic attacks
- Nightmares
- Changes in eating and sleeping patterns; not wanting to sleep alone
- Regressing to younger behaviors
- Having unanswered questions if they were not told the whole story of the death
- If very young, unable to comprehend the finality of death
- Mixed feelings about the death, including relief, sometimes causing guilt
- Questioning beliefs
- Lower self-esteem; identity loss
- Social changes: isolating and/or not wanting to be alone
- Keeping pictures or special things that remind them of the person
- Transformation

Child Abuse and Neglect

Report suspected child abuse or neglect by calling #SAFE (#7233) from a cell phone or 1-855-333-SAFE. Child Protective Services (CPS) strives to enhance the safety, permanency, and well-being of children and families in New Mexico. We believe that a concern for children extends to all children in New Mexico, not just our own.

CPS receives reports of alleged child maltreatment 24 hours a day, seven days a week, through Statewide Central Intake at 1-855-333-SAFE (7233) or #SAFE from cell phones. CPS investigate reports of child maltreatment and intervene to keep New Mexico's children safe. CPS provides foster care to approximately 2,500 children each day and works with families to enable parents to safely and appropriately care for their children. When that cannot be accomplished, CPS workers find safe, permanent families for children through adoption or permanent guardianship.

What Schools Can Do

Child abuse and neglect are serious and widespread problems, but it can be interrupted and prevented. School personnel can play a key role in the identification and reporting of suspected child abuse.

The New Mexico Children's Code (32A-4-1 NMSA through 32A-4-34 NMSA) sometimes cited as the Abuse and Neglect Act, states that physicians, law enforcement officers, nurses, school personnel and others acting in official capacities who SUSPECT abuse must report it immediately to the local offices of the Children, Youth, and Family Department (CYFD), Social Services Division in their respective communities or appropriate tribal social services offices. All certified school personnel, including school nurses, are required to complete training in the detection and reporting of child abuse and neglect during the person's first year of employment by a school district in New Mexico (22A-10-32 NMSA).

When a child discloses indicators discussed in the following pages, it does not prove conclusively that a child is abused or neglected. He/she may tell a story that seems difficult to believe, but the story should be taken seriously and the child's concerns explored.

The presence of more than one indicator combined with other information warrants further assessment by CYFD. School employees do not need to substantiate abuse before reporting it to CYFD. They only need to SUSPECT it. In New Mexico, the CYFD or appropriate tribal social service office investigates all reports of suspected child abuse or neglect.

Reporting Child Abuse/Neglect

- CYFD maintains the NM Statewide Central Intake (SCI) system which is housed in Albuquerque for reporting suspected or known child abuse/neglect. It can be accessed state-wide through a hotline 1-855-333-SAFE (7233) or #SAFE from cell phones. Detailed information on reporting suspect abuse/neglect is available at: <https://cyfd.org/child-abuse-neglect/reporting-abuse-or-neglect>.
- Reports are more likely to result in appropriate action and/or investigation if the following information is available at the time the report is being made.
- Name of child, parent and legal guardian, address where child resides
- Age, sex, SS# of child
- Family composition, language spoken in home
- Location of the child at time of reporting
- Location where suspected abuse occurred
- Name and address of person alleged to be responsible for abuse/neglect
- Nature and extent of suspected abuse or neglect
- Names of other professionals in contact with child
- Past history of child/family
- Child's affect
- Any disability the victim may have
- History of domestic violence, substance abuse/mental illness, or criminal activity

Physical Indicators of Abuse

The following information is presented for reference for school health providers when concerns arise of child abuse (physical and sexual) and neglect. Keep in mind that some of the indicators and behaviors presented here are seen in children who are experiencing stress within their families. Family problems such as domestic violence, alcoholism, or parental absence may affect a child's physical and mental health. A key element in assessing the possibility of child abuse is checking to see if the child can offer a reasonable explanation for his/her behavior and/or physical findings. A history that is not consistent with injuries or observed behaviors is a key factor in deciding whether abuse has occurred.

Physical Abuse

When physical abuse occurs, the signs are often visually evident but may go unnoticed and/or be considered normal for an active child. Here are some signs that may trigger suspected abuse for a health care provider.

Bruises in various stages of healing

- on the face, lips, mouth, torso, back, buttocks, or thighs
- forming a pattern/imprint reflecting the shape of the article that was used to inflict the mark on the body
- on different skin surfaces of the body inconsistent with the history of the injury
- regularly appearing bruises after absence, weekend, or vacation

Burns for which the child has no explanation

- classic cigar or cigarette burns on the soles, palms, back or buttocks
- sock-like or glove-like intentional immersion burns on the extremities that may be doughnut shaped on buttocks or genitalia and spare creases of the body
- intentional burns leaving a characteristic imprint pattern on the skin surface such as curling iron, electric burner, iron, or heated objects
- infected burns as result of delay in seeking treatment

Deformities with accompanying swelling/pain suspicious of fractures/dislocations

- commonly of extremities, skull, nose, or facial structure
- multiple fractures in various stages of healing revealed on medical evaluation

Lacerations, abrasions, injuries, or hair loss/bald patches on a child with no reasonable or consistent explanation offered

- seen most often on the child's face, eyes, internal and external oral area, genitalia, buttocks, and anus
- injuries in various stages of healing
- circumferential ligature marks may be the result of "rope burns" around the ankles, wrists, and neck
- hair loss usually in patches and potentially the result of forceful pulling

Sexual Abuse

Indicators of sexual abuse are more likely to be subtle and behavioral in nature; however, physical indicators of sexual abuse may include the following signs.

- New onset of difficulty walking or sitting
- Bloody, stained, or inappropriately soiled underwear (leaves and dirt inside present on outer clothing) underwear but not
- Swelling, bruising, lacerations, or bleeding in genital or anal area
- Pregnancy
- Pain or bleeding on urination
- Vaginal/penile discharge and/or odor
- Sexually transmitted infections (STIs)
- Poor sphincter tone (poor bowel or bladder control).

Neglect and Emotional Abuse

The effects on children of neglect and emotional abuse are long term and are more likely to manifest by chronic physical and mental ill health. The health care provider may observe any or all the following neglect and emotional abuse signs and symptoms.

- Unattended physical problems and unmet medical needs of the child
- Underweight child or small stature for age with no known medical diagnosis to explain condition (failure to thrive)
- Normal intelligence but showing deficiencies in areas of intellectual and motor development
- Inappropriate care consistent with hunger, poor hygiene, and unsuitable clothes for climate

Behavioral Indicators of Abuse

Behavioral indicators of abuse are nonspecific; the child who is experiencing sexual abuse may demonstrate the same behavior as a child who is experiencing emotional abuse. For example, sexual or emotional abuse of a five-year-old child may result in a behavior change such as “wetting his/her pants”.

The observer should keep in mind that a sudden change in behavior is more concerning than observation of a behavior which has always been present in that child. The observer should be aware that many factors can influence a child’s behavior. Family difficulties such as domestic violence, drug addiction, parental loss will also result in behavioral changes in a child.

Behavior indicators seen in children who may be abused or neglected might include emotional changes, school problems, inappropriate sexual behavior, signs of neglect.

Emotional Changes

- Withdrawal, depression, or expression of suicidal thoughts (e.g., I want to die, I should just go away, I feel like killing myself)
- Child demonstrates anger by violent or self-abuse acts
- Child demonstrates unreasonable fearful reactions to normal circumstances (e.g., a child who is afraid to be alone in a room)
- Younger child demonstrates new clingy or irritable behavior (e.g., always wants to sit in the teacher’s lap or cries, becomes angry, lashes out with little provocation).

School Problems

- New onset of poor concentration or decreased attention span
- Consistently demonstrates fatigue or listlessness (e.g., falling asleep in class)
- Delinquent or anti-social behaviors (e.g., stealing, violence or threatened violence towards classmates)
- Truancy or frequent absences from class
- Dramatic change in academic achievement
- Unwillingness to change for or participate in physical education class
- Poor peer relationships/friendless (e.g., a child no one wants to play with)
- Demonstration of low self-esteem by behavior or statements
- Demonstration of regressive behavior (e.g., a 6-year-old who now sucks her thumb, refuses to eat unless fed, and talks “baby talk”)
- Demonstration of fear of a specific person or situation or new onset of withdrawal (e.g. a child who previously went gladly with a caretaker now resists vigorously)

- Extension of stay at school with early arrival and late departure (e.g. abuse occurs at home and child is fearful to return).

Inappropriate Sexual Behavior

- Inappropriate displays or seeking of “affection” (e.g., attempts French kissing with teacher, sexually provocative dress or manner for developmental level)
- Demonstration of sophisticated, precocious knowledge of sex acts by engaging others in sexual acts (e.g. attempts oral sex on other children or inserts objects in another child’s anus or vagina)
- Inappropriate compulsive masturbation to the exclusion of other enjoyable activities
- Masturbation in a manner that could cause injury (e.g. inserts objects in vagina or anus).

Evidence of Neglect

- Begging for or stealing food at school
- Lack of appropriate supervision outside of school
- Child is alone for extended periods of time inappropriate to developmental level
- Child makes statements indicating no caretaker in the home
- Untreated medical condition (e.g. untreated seizures, asthma, ADD, ADHD, or diabetes).

Follow-up on Reporting

Any verbal statement from a child that he/she has been sexually or physically assaulted in any way constitutes suspicion of abuse and must be reported.

Collaboration between the schools and social services is strongly encouraged to maintain reliability and continuity of care. The school nurse can establish a working relationship with the local social service agency by contact and follow up with the assigned social worker/case manager. Consideration should be given to regular meetings with school nurses, other school staff and social services staff to establish and maintain an ongoing rapport.

Human and Sex Trafficking Awareness

According to the National Human Trafficking Resource Center, human trafficking is a form of modern-day slavery in which traffickers use force, fraud, or coercion to control victims for engaging in commercial sex acts or labor services against his/her will. Sex trafficking has been found in a wide variety of venues within the sex industry, including residential brothels, escort services, fake massage businesses, strip clubs, and street prostitution. Labor trafficking has been found in diverse labor settings including domestic work, small businesses, large farms, and factories.

Signs a child may be involved in human trafficking/sex trafficking may be considered normal or familiar adolescent behavior. Here are some signs that may trigger suspected human/sex trafficking for a health care provider.

Behavioral Indicators of a child sex trafficking victim:

- Inability to attend school on a regular basis and/or unexplained absences
- Frequently running away from home
- References made to frequent travel to other cities
- Bruises or other signs of physical trauma, withdrawn behavior, depression, anxiety, or fear
- Lack of control over a personal schedule and/or identification or travel documents
- Hunger, malnourishment, or inappropriate dress (based on weather conditions or surroundings)
- Signs of drug addiction
- Coached or rehearsed responses to questions
- Sudden change in attire, behavior, relationships, or material possessions (e.g., expensive items)
- Uncharacteristic promiscuity and/or references to sexual situations or terminology beyond age-specific norms
- A “boyfriend” or “girlfriend” who is noticeably older and/or controlling
- Attempt to conceal scars, tattoos, or bruises
- Sudden change in attention to personal hygiene
- Tattoos (a form of branding) displaying the name or moniker of a trafficker, such as “daddy”
- Hyperarousal or symptoms of anger, panic, phobia, irritability, hyperactivity, frequent crying, temper tantrums, regressive behavior, and/or clinging behavior
- Hypoarousal or symptoms of daydreaming, inability to bond with others, inattention, forgetfulness, and/or shyness.

Behavioral indicators for labor trafficking victim:

- Being unpaid, paid very little, or paid only through tips
- Being employed but not having a school-authorized work permit
- Being employed and having a work permit but clearly working outside the permitted hours for students
- Owing a large debt and being unable to pay it off
- Not being allowed breaks at work or being subjected to excessively long work hours
- Being overly concerned with pleasing an employer and/or deferring personal or educational decisions to a boss
- Not being in control of his or her own money
- Living with an employer or having an employer listed as a student’s caregiver
- Desire to quit a job but not being allowed to do so

What Schools Can Do

To build healthy learning environments, school personnel must be knowledgeable about the signs and symptoms of child trafficking, ways to support disclosure, and the steps to take if there is a strong suspicion of trafficking. If a school staff member notices a student who shows signs of potential trafficking, the first rule is to always pay attention. Learn about the school’s policies and protocols. If the school does not have clear policies and protocols, talk to the principal about instituting them. Share this information with school staff, administrators, school boards, and members of the community.

References Resources

U.S. Department of Health and Human Services resource guide

<https://www.mentalhealth.gov/talk/educators/index.html>.

ADHD Resources

American Psychiatric Association (2013). Diagnostic and Statistical Manual of Mental Disorders (5th ed). Arlington, VA.

WebMD. ADD/ADHD symptoms: <http://www.webmd.com/add-adhd/guide/adhd-symptoms>

CDC (2011) ADD/ADHD prevalence: <https://www.cdc.gov/ncbddd/adhd/data.html>

Child Abuse & Neglect Resources

Statewide Central Intake - #SAFE (#7233) from a cell phone or 1-855-333-SAFE

<https://cyfd.org/child-abuse-neglect/reporting-abuse-or-neglect>

<https://pulltogether.org/>

<https://pulltogether.org/resources-by-county>

Child Abuse & Neglect

<https://pulltogether.org/support/keep-my-children-safe/child-abuse-neglect>

Children's Code – Chapter 32A

<http://public.nmcompcomm.us/nmpublic/gateway.dll/?f=templates&fn=default.htm>

Developmental Stages Resources

Child Development Institute: Erickson Stages of Social-Emotional Development

<https://childdevelopmentinfo.com/child-development/erickson/>

Freud's Psychosocial Developmental Stages: <https://www.verywell.com/freuds-stages-of-psychosexual-development-2795962>

Kohlberg's Moral Development: <http://www.simplypsychology.org/kohlberg.html>

New Mexico Pediatric Society: <http://www.nmaap.org/#!resources/cxwa>

WebMD: Piaget's Developmental Stages: <http://www.webmd.com/children/piaget-stages-of-development>

Eating Disorder Resources

National Institute of Mental Health (2010) Eating disorder prevalence

<https://www.nimh.nih.gov/health/statistics/prevalence/eating-disorders-among-children.shtml>

American Psychiatric Association (2013). Diagnostic and Statistical Manual of Mental Disorders (5th ed). Arlington, VA.

National Eating Disorder Association. Educator Toolkit

<http://www.nationaleatingdisorders.org/educator-toolkit>

Grief and Loss Resources

National Child Traumatic Stress Network: <http://nctsnet.org/>

Santa Fe - Gerard's House Phone (505) 424-1800: <http://gerardshouse.org/>

Albuquerque -Children's Grief Center

Phone: 505-323-0478

Address: 3001 Trellis Dr. NW

Albuquerque, NM 87107

Website: <http://www.childrensgrief.org/>

“In Depth General Information Guide to Childhood Traumatic Grief for School Personnel”
available at the link www.NCTSN.org.

Human & Sex Trafficking Awareness Resources
Pull Together.org <https://pulltogether.org/support/keep-my-children-safe/child-abuse-neglect>

National Human Trafficking Resource Center

505 Get Free Human Trafficking Safety and Support Services – The Life Link
<http://www.505getfree.org/>

505-470-0163 (office)
505-GET-FREE (text or voice hotline)<https://humantraffickinghotline.org/>

National Human Trafficking Hotline 1-888-373-7888

<https://humantraffickinghotline.org/what-human-trafficking/recognizing-signs>

Human Trafficking in American Schools Manual

<https://humantraffickinghotline.org/sites/default/files/Human%20Trafficking%20in%20Americas%20Schools%20-%20DoEd.pdf>

Video - Recognizing and Responding to Human Trafficking in a Healthcare Context

<https://humantraffickinghotline.org/resources/recognizing-and-responding-human-trafficking-healthcare-context>

Mental Health Concerns Resources

National Institute of Mental Health (2015) Major Depression among Adolescents.

<https://www.nimh.nih.gov/health/statistics/prevalence/major-depression-among-adolescents.shtml>

[U.S. Department of Health and Human Services, Mental Health.gov](http://www.mentalhealth.gov)

<https://www.mentalhealth.gov/talk/educators/index.html>

Non-Suicidal Self-Injury (NSSI) Resources

Cornell Research Program on Self-Injury and Recovery:

<http://www.selfinjury.bctr.cornell.edu/>

Self-Injury in Schools: <http://www.scar-tissue.net/schoolsipolicy.pdf>

Signs of Suicide: Middle School Program Self-Injury Packet:

http://educatorsandselfinjury.com/wp-content/uploads/2009/11/SOS-Self-injury-packet_2009.pdf

PTSD Resources

American Academy of Child and Adolescent Psychiatry. (2011). *Facts for Families:*

Posttraumatic Stress Disorder (PTSD). Washington, DC:

http://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/Facts_for_Families_Pages/Posttraumatic_Stress_Disorder_70.aspx

American Psychological Association (2008). Children and Trauma: Update for Mental Health

Professionals. Washington, DC: <http://www.apa.org/pi/families/resources/children-trauma-update.aspx>

American Psychiatric Association (2013). Diagnostic and Statistical Manual of Mental

Disorders (5th ed). Arlington, VA.

Hamblen, J., Barnett, E. (2012). *PTSD in Children and Adolescents*. Retrieved from:

<http://www.nctsn.org/content/psychological-first-aid>

National Child Traumatic Stress Network (NCTSN) is: <http://www.nctsn.org/>

New Mexico Administrative Code, Title 6 Chapter 12 Part 6

<http://ped.state.nm.us/nutrition/2014/final%20wellness%20rule%20revision%20for%208-15-14.pdf>

Psychotropic Medications Resources

Bostic, J. (2010). Evaluation of Medication Side Effects.

http://www2.massgeneral.org/schoolpsychiatry/pdfs/medications_EvalSideEffects.pdf.

Los Angeles County Department of Mental Health, Children and Family Services Bureau
(2009).

Psychotropic Medication for Children and Adolescents Quick Guide.

http://dmh.lacounty.gov/ToolsForClinicians/Reports/documents/PSYCHOTROPIC_GUIDELINES_07_01_09.pdf.

Wilens, T. (2009) Straight Talk About Psychiatric Medications for Kids. (3rd ed).

Centers for Disease Control and Prevention (CDC) (2013) Psychotropic Medication Use

Among Adolescents. <https://www.cdc.gov/nchs/products/databriefs/db135.htm>

New Mexico Law (Statutes)

<http://public.nmcompcomm.us/nmpublic/gateway.dll/?f=templates&fn=default.htm>

Somatic Complaints Resources

American Psychiatric Association (2013). Diagnostic and Statistical Manual of Mental Disorders (5th ed). Arlington, VA.

Suicide Crisis Response Resources

New Mexico Crisis and Access Line <http://www.nmcrisisline.com/> 1-855-662-7474

National Suicide Prevention Lifeline 1-800-273-8255

Substance Abuse and Mental Health Services Administration's (SAMHSA) *Preventing*

Suicide: A Toolkit for High Schools guidebook on suicide prevention

<http://store.samhsa.gov/shin/content//SMA12-4669/SMA12-4669.pdf>

<http://store.samhsa.gov/product/SMA12-4669>.

The Comprehensive School Health Manual, Massachusetts Department of Public Health

(<http://massclearinghouse.ehs.state.ma.us/SCH/SH3001R.html>)

CHAPTER FIFTEEN - STANDING ORDERS

Introduction

School nurses face new challenges daily in assuring the health of school children. To assist school nurses in meeting these challenges, Regional Health Officers in their statutory role of oversight of school Nursing provide these standing orders to direct school nurses in specific treatments and testing.

These standing orders are provided to authorize specific nursing activities in school districts where such nursing activities are in alignment with school district policy. They do not create or supersede school district policy but may be adopted as policy by school districts.

These standing orders are Issued by Regional Health Officers, Public Health Division, NM Department of Health. These standing orders will be reviewed and revised annually.

Standing Order for Administration of Naloxone by School Personnel

Authority: NMSA 1978, 24-23-1. B: Any person acting under a standing order issued by a licensed prescriber may store or distribute an opioid antagonist; and, NMSA 1978, 24-23-1.E: A person may administer an opioid antagonist to another person if the person: 1) in good faith, believes the other person is experiencing a drug overdose; and 2) acts with reasonable care in administering the drug to the other person.

Purpose: To contribute to decreasing morbidity and mortality related to opioid overdose, this standing order permits:

- School nurses to obtain, store, and administer naloxone: and,
- Non-clinical staff and volunteers of schools who have completed an overdose prevention and naloxone administration class to obtain, store, and administer naloxone.

Obtaining Naloxone:

Naloxone may be obtained from an entity which is willing to provide it to the school, whether by donation or purchase. This includes, but is not limited to: Pharmacists, pharmacies, pharmaceutical manufacturers, or pharmaceutical supply organizations, medical facilities, health organizations, or licensed prescribers. Individual or group donors may pay for medication, but it must be provided directly to the school from an entity licensed to store or distribute medications.

Naloxone storage for schools: Naloxone may be stored at any school so long as the storage location is kept secure, with entry limited to staff and individuals designated by the school nurse. Naloxone must be checked monthly for expiration. In the event, it expires, new naloxone must be obtained and the expired naloxone properly disposed.

Assessment:

Any school nurse, or designated individual who has gone through training, may administer naloxone to an individual who presents with a possible overdose so long as the person administering naloxone:

- in good faith, believes the other person is experiencing a drug overdose; and,
- acts with reasonable care in administering the naloxone to the other person.

Order:

For any individual who presents with a possible overdose:

1. Activate EMS / call 911
2. Administer intranasal naloxone by inserting the atomizer end into the nostril and pushing the plunger at the base of the device. Either of these devices may be utilized:
 - a. Naloxone 2 mg / 2 ml in prefilled syringe for intranasal use using a Mucosal Atomization Device (MAD)
OR
 - b. Naloxone 4 mg / 0.1 ml in FDA-approved intranasal administration devices.
Warning: Naloxone reversal of an opioid overdose can be rapid – following administration, the patient may regain consciousness quickly, but may be confused, agitated, irritable, and/or combative (due to precipitated withdrawal and possibly due to hypoxia). Safely restrain the patient and find a quiet place for the client to rest.
3. Provide rescue breathing / CPR as needed. If CPR is not necessary, place the patient on their side (to prevent aspiration).
4. If a comatose patient with suspected overdose fails to awaken with naloxone within 5 minutes, administer a second dose of naloxone (ampule or spray) via one of the two intranasal forms as above. Consider alternate causes for the condition (e.g., MI, hypoglycemia).
5. Stay with the individual until EMS or other medical services arrive. Naloxone may rarely cause adverse effects in individuals with contraindications, so the person must be observed during this time, either by the person who administered naloxone, another trained individual, EMS personnel, or a clinically licensed individual.
6. Naloxone wears off after 30-90 minutes – respiratory depression may re-occur with long-acting opioids. Additional doses of naloxone may be required until emergency medical assistance becomes available.
7. Documentation of the administration of naloxone on the [Adverse Event Form](#) for Schools should be completed within 72 hours of the event and submitted to the Regional School Health Advocate.
8. A copy of the [drug information sheet](#)
9. School staff, including school nurses and other staff members, may utilize the NMDOH

Administration curriculum: [Overdose Prevention and Rescue Breathing in 20 Minutes](#) or Less

education handout. This information is also available in Spanish

[Prevención de Sobredosis y Rescate de Respiración en 20 minutos o menos](#)

Guidelines for Administration of Vaccines by The School Nurse

- School nurses who choose to practice under the standing order for vaccine administration signed by the NM Public Health RHOs shall have competency in vaccine administration and perform all nursing procedures primarily under the NM Nurse Practice Act standards.
- Vaccine administration competency may be maintained by the school nurse through collaborative practice with other healthcare professionals such as a public health nurse or a healthcare professional in another setting (e.g., primary-care clinic) or by structured training such as that offered through the NM Child Health Immunization Learning Initiative (CHILI) training online or in person, Training during a Regional School Health Update, through the Centers for Disease Prevention and Control, etc.
- School Nurses administering immunizations in the school setting under RHO standing orders should follow the same protocols as public health nurses administering immunizations in public health clinics.
[NMDOH Immunization Protocol with Procedures and Standing Orders for Nurses](#)
- Any questions concerning protocols or standing orders for vaccine administration by the school nurse in the school setting should be directed to the local Public Health Regional School Health Advocate or RHO.

Standing Order for Administration of Vaccines by The School Nurse

School nurses and licensed practical nurses practicing in schools, who are under the statutory oversight of the NM Department of Health (DOH) Regional Health Officers and who have demonstrated competency* in vaccine administration may administer and/or supervise the administration of indicated vaccines (by healthcare professionals with competency) to students and to school personnel.

Such vaccines must be maintained and administered in accordance with the NM Nurse Practice Act, manufacturer's package insert, as well as DOH immunization protocols for vaccine storage and handling, immunization contraindications, injection parameters, documentation, and adverse reaction reporting. [NMDOH Immunization Protocol with Procedures and Standing Orders for Nurses](#) is available on the DOH website. Immunization clinics held in the school setting require two CPR-trained individuals in attendance and an emergency medication kit that contains, at a minimum, epinephrine (which is usually in a vial) and diphenhydramine. See attached chart for dosing information.

Standing Order Administer Influenza Vaccine for SKIIP Participants

Purpose:

To reduce the morbidity and mortality of influenza by vaccinating those children and adolescents who meet the criteria established by the Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices with priority given to high priority populations for the New Mexico Department of Health, Public Health Division (PHD).

Policy:


Under these standing orders, eligible school nurses may administer influenza vaccine to children and adolescents participating in the School Kids Influenza Immunization Program (SKIIP) that meet the criteria below.

Procedure:

- Identify children and adolescents who have not completed their influenza vaccination(s) for the current influenza season.
 - SKIIP vaccination efforts focus on achieving high influenza vaccination levels in school children.
 - Routine annual influenza vaccination is recommended for all persons aged ≥6 months who do not have contraindications.
 - For 2017-2018, only inactivated influenza vaccine (injectable) is available through SKIIP. – Because of concerns regarding low effectiveness in prior seasons, live attenuated influenza vaccine (LAIV) is not available through SKIIP.

- Screen all patients for contraindications and precautions to influenza vaccination using the 2017-2018 SKIIP Form, guidance document and SKIIP Training.

Emergency Order for Vaccine Reactions

 Epinephrine and Diphenhydramine/Benadryl				
Dose Schedule for Children & Adults (For use with vaccine reactions)				
Weight in Pounds	Weight in Kg	EPINEPHRINE dose (1:1000 = 1 mg/mL) IM		Diphenhydramine/BENADRYL dose (50 mg/mL) IM
9-15 lbs	4-7 kg	0.05 mL	U	0.1 mL (5 mg)
15-24 lbs	7-11 kg	0.10 mL		0.2 mL (10 mg)
24-31 lbs	11-14 kg	0.15 mL		0.3 mL (15 mg)
31-37 lbs	14-17 kg	0.15 mL		0.4 mL (20 mg)
37-42 lbs	17-19 kg	0.20 mL		
42-51 lbs	19-23 kg	0.20 mL		0.6 mL (30 mg)
51-77 lbs	23-35 kg	0.30 mL		
77-99 lbs	35-45 kg	0.40 mL		0.8 mL (40 mg)

>99 lbs	45+ kg	0.50 mL	1.0-2.0 mL (50-100 mg)
		May give every 5-15 minutes x 3 total doses, if necessary Max. Single Dose: 0.50 mL	Maximum Dose: Children = 30 mg Adolescent/Adult = 100 mg
		Give IM or SQ Use Tuberculin syringe	Give IM Use 1cc or 3cc syringe with 22 or 23 gauge needle, 1" or 1.5" length
		Dose is calculated by 0.01 mL (1:1000 dilution) = 0.01 mg per kg of body weight	Dose is calculated by 1.0 mg per kg of body weight

References:

“Epidemiology and Prevention of Vaccine-Preventable Diseases,” 12th Edition, May 2011, Department of Health and Human Services, Centers for Disease Control and Prevention, Appendix D-20.

Guidelines for the School Nurse to Administer Oxygen

Oxygen use in the school setting is increasing and is the standard of care for some medically challenged students. Written orders from the medically challenged student’s primary care provider for handling potential emergencies related to that student should be a part of the Individualized Health Plan (IHP). These orders should take into consideration the isolation of the school in relation to EMS and the potential need for immediate intervention in an emergency.

In the school setting, there may be times when school staff, volunteers and visitors will require the use of oxygen. Identifying these individuals prior to an emergency allows opportunity to obtain guidance from the school districts identified local emergency medical officer or an individual’s primary care provider should initiation of oxygen administration be required.

Guidelines for School Nurses

- As with any emergency, local EMS should be activated if other than routine oxygen is administered to an individual.
- Identifying medical conditions of students and staff that might require oxygen administration prior to an emergency, will assist the School Nurse in appropriately assessing potential needs and making

recommendations to the district regarding oxygen availability and usage. It also gives the nurse leverage in requesting written primary care orders for potential individual student needs.

- Distance of the school from the nearest EMS should always be considered when developing the school's policy for oxygen storage, use and maintenance.

Standing Order for the School Nurse to Administer Oxygen

IF, in the school nurse's professional opinion, an individual in the school setting is experiencing a medical emergency requiring oxygen, the nurse should immediately activate Emergency Medical Services (EMS) by CALLING 911 or directing someone else to do so.

THEN the nurse should assess the individual for respiratory distress verifying if the airway is open and noting the type and effort of breathing.

IF the airway is compromised, the nurse should reposition the head, then recheck the airway and initiate CPR as appropriate.

IF the airway is open, the nurse should elevate the head unless doing so compromises breathing or there is concern of a cervical-spine injury.

THEN the nurse should administer oxygen per the following dosage and frequency.

Dosage: 10 liters/minute by mask with titration of flow based on professional clinical judgment or per

guidance from emergency response team

Frequency: PRN until EMS arrives

IF the individual is awake and alert, a brief medical history should be obtained as well as consent to administer oxygen. Any alert individual receiving oxygen should be aware of the potential benefits and risks of receiving oxygen.

Benefits:

Provide essential nutrient (oxygen) to vital organs

Ease difficult breathing

Decrease shortness of breath

Risks:

Discomfort from nasal prongs

Compromised effort to breathe in adults with emphysema

Standing order for the School Nurse to Provide Head Lice (Pediculosis) Treatment

Refer to Chapter 10 for pertinent information on Head Lice (Pediculosis)

IF crawling lice are viewed on a student by the school nurse (usually at the nape) or eggs (nits) are present less than 1 cm from the hairline on the back of the neck and behind the ears

ONLY THEN should product treatment be initiated.

Students may be treated if they meet the following criteria:

- Children \geq 2 months old Permethrin only, (nit removal is the treatment of choice for any infant less than 2 months of age)
- Persons without allergy to chrysanthemums,
- If nit removal is also being done,
- Persons not allergic to Malathion or any of its properties.

Provide the parent/guardian information about lice control measures (e.g., washing bed linens, etc). Recommended treatment. Students who meet the above criteria for treatment of head lice who have Medicaid can obtain the medication from pharmacies with a prescription. For those students with Medicaid, determine the Medicaid provider and call in the prescription to the child's pharmacy as written above for dispensed medication. This prescription may be called in using the Regional Health Officer's name.

For students covered by Molina Medicaid, United Health Care Medicaid and Presbyterian Medicaid:

Permethrin 1% lotion, 60 cc with instructions to apply to clean, damp scalp and hair, leave on for 10 minutes, rinse thoroughly. Do not use a combination shampoo/conditioner, or conditioner before using lice medicine. Do not re-wash the hair for 1-2 days after the lice medicine is removed. Repeat in 7- 10 days if needed.

For students with Blue Cross Blue Shield Medicaid:

Malathion 0.5%, 2 fl. oz. with instructions to apply Malathion Lotion on *DRY* hair in amount just sufficient to thoroughly wet the hair and scalp. Pay attention to the back of the head and neck while applying Malathion Lotion. Wash hands after applying to scalp. Allow hair to dry naturally—use no electric heat source, and allow hair to remain uncovered. After 8 to 12 hours, the hair should be shampooed. Rinse and use a fine-toothed (nit) comb to remove dead lice and eggs. If lice are still present after 7-9 days, repeat with a second application of Malathion Lotion. Further treatment is generally not necessary. Other family members should be evaluated by a physician to determine if infested, and if so, receive treatment.

AFTER diagnosis of head lice infestation and making arrangements for treatment, the following control measures should be followed:

- Send student home at the end of the school day.
- Exclude the student from school/day care until one product treatment is completed.
- For household members, recommend treatment only for those diagnosed with head lice or who are bedmates of the student.

THEN manage control of fomites by encouraging the following:

- Clothing, towels, bed linens, etc. should be dry cleaned or machine washed in hot water and dried on the hottest setting.
- Non-washable hats, scarves, coats should be dry cleaned or sealed in a plastic bag for 14 days.
- Combs, brushes, hair ornaments, etc. may be soaked in alcohol or 1% Lysol for one hour, or sealed in a plastic bag for 14 days.

NOTES:

- Head lice are not the result of poor personal hygiene.
- Head lice do not transmit infectious disease.
- Never use environmental insecticides to control head lice—they are toxic and do not work.

Guidelines for Pregnancy Testing by the School Nurse

Pregnancy testing as a laboratory procedure in the school setting should be administered per [Clinical Laboratories Improvement Act](#) (CLIA) regulations. For an application to be CLIA Waivered complete form

[CMS-116](#) . Mail completed form to Health Facility Licensing & Certification Bureau Bank of the West Building 5301 Central Avenue NW, Suite 400 Albuquerque, NM 87108 (505) 222-8646 FAX: (505) 841-5834.

If pregnancy testing is to be performed by the school nurse, it is essential that the CLIA certified agency provide training on the test and establish standards of care for all staff regarding performing the test, counseling the student, and providing results, referral or follow-up to students who are pregnancy tested by the school nurse.

School nurse supervision should always be enforced if a home pregnancy kit is made available for a student to self-test, and the same standards of care are expected to be followed as though laboratory testing was being performed.

It should be kept in mind that every laboratory test may yield a false-positive or false-negative result. Therefore, the results of any test should be considered in the clinical context and appropriate action taken (e.g., repeat testing in two weeks if a false-negative result is suspected).

Guidelines for School Nurses

- Pregnancy testing provides an opportunity for preventive health education and counseling, *regardless of the result*. Each student requesting pregnancy testing should be informed of services available in family planning, sexually transmitted disease, mental health counseling, and social services in the community. Young and/or distraught students may need immediate emotional support and assistance getting services. Any agency unable to provide these essential services and support to every student should not perform pregnancy testing but should refer to community providers who can provide appropriate support and services.

- Each pregnant student should be informed of all her options and offered support and assistance in selecting options. It is important to explore with the student her current emotional support system (i.e., family members, other trusted adults) and to offer her help in discussing the pregnancy with identified individuals if she so desires.
- Early referral for medical care and/or other services is essential. Undecided students should be given information to allow them to access services and support later. Agency staff where pregnancy testing is performed should be knowledgeable about a wide variety of related service providers and funding resources in the community, as well as school assistance and resources for expectant parents. Follow-up with each student to assure that her physical, emotional, and educational needs have been addressed is likewise essential.

References and Resources

[Adverse Event Form](#)

CLIA Waiver Form [CMS-116](#)

Clinical Laboratory Improvement Amendments (CLIA), <https://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/index.html>.

CDC. “*Epidemiology and Prevention of Vaccine-Preventable Diseases*,” 12th Edition, May 2011, Department of Health and Human Services, Centers for Disease Control and Prevention.

[The Pink Book](#).

[Chapter 15 Standing Orders Signature Page 2017](#)

[NMDOH Immunization Protocol with Procedures and Standing Orders for Nurses](#)

NMDOH Administration curriculum: [Overdose Prevention and Rescue Breathing in 20 Minutes](#)

CHAPTER SIXTEEN – ANNUAL SCHOOL SERVICE REPORT

Definitions and Clarifications

These definitions and clarification notes are guidelines to assist the school nurse in completing the Annual School Health Services Report required annually by Public Education Department (PED). An annual report is required of each School District. However, Charter Schools should report individually and separately from the School District in which they are located; each Charter School should submit a report independently. A district may choose to collect more data than is required for the PED report; however, only information requested should be reported to PED. Tools that may be helpful to gathering data on an ongoing basis are included in the New Mexico School Health Manual Chapter 16

Contact Information

The “contact person” listed on the Annual School Health Services Report should be the person to be contacted regarding any questions about the report information, not necessarily the person submitting the report who may be administrative support staff.

Nursing Staff Data

Include the number of PED-licensed School Nurses providing services at the end of the school year in full time equivalents (FTEs). RN = Registered Nurse.

- **Total Number of RN FTEs with an assigned caseload providing direct services** - Count RNs who provide care for the general student population in FTEs. Include those nurses who provide care to both the general population *and* special education population.

(The FTE is based on a teacher FTE in the district, e.g. a teacher may work 7 hours a day (or 35 hours a week). This would be considered 1 FTE. If an RN works the same hours, the RN FTE is 1 FTE. If an RN works 5 hours a day (or 25 hours a week), the FTE would be calculated as $5/7$ or .71 FTE. Each state/district may vary in the number of hours a full-time teacher works, so it is important to follow your district definition. If school nurses work more hours per day than a teacher, the FTE still equals 1. The number should reflect every RN providing direct services. For example, if the district has 3 RNs and each works .75 FTE, it would be reported as 2.25. Another example is if a person is hired half time to be the lead nurse or nurse administrator, enter 0.5 under Nurse Administrator and 0.5 under RN with an

assigned caseload providing direct services if she/he spends the rest of the time as a school nurse.)

Direct services the nurse responsible for the care of a defined group of students in addressing their acute and chronic health conditions. It includes health screenings, health promotion and case management. Direct service also includes care provided in a health care team including LPNs or Health Assistants.

Inclusion/Exclusion

- Include long term substitute RNs (but not the substitute RN for short term needs)
 - Exclude nurses working with medically fragile students (on a 1:1, 1:2, 1:3 basis)
 - Exclude % of administrative assignment
-
- Total Number of RN FTEs providing direct services to Special Education students only
Count RNs who provide care only to special education students in FTEs.

 - Total Number of Float/Supplemental RN FTEs – Includes permanently hired/contracted RNs who provide supplemental/additional direct nursing services or specific procedures. This count is a separate category. DO NOT include RNs with an assigned caseload providing direct services, RNs working with a limited caseload providing direct services such as medically fragile students (1:1, 1:2, 1:3), or RNs providing care to special education students.

 - Total Number of RN FTEs with a special assignment (e.g. 1:1, 1:2, etc.) – Count RNs working with a limited caseload providing direct services to students such as medically fragile students (on a 1:1 basis, 1:2 basis, etc.).

 - Total number of RN FTEs providing administrative or supervisory school health services – Count RNs providing management or clinical supervision to RNs, LPNs/LVNs, health assistants, or other health extenders, or conducting other administrative health services, e.g. case management or resource nurse.

 - Certified Nurse Practitioner (CNP) – Indicate the total number in FTEs of certified nurse practitioners with an assigned caseload providing direct services to the general student population. Include those certified nurse practitioners who provide care to both the general population and special education population. Do not include those working in a school-based health center.

Assistive Personnel Data

Include in FTEs those individuals who spend a part or all their time working under the supervision of a school nurse. LPN = Licensed Practical Nurse

- Total Number of LPN FTEs with an assigned caseload providing direct services – Count LPNs who provide care for the general student population in FTEs. Include those nurses who provide care to both the general population and special education population.
- Total Number of LPN FTEs providing direct services to Special Education students only - Count LPNs who provide care only to special education students in FTEs.
- Total Number of Float/Supplemental LPN FTEs – Includes permanently hired/contracted LPNs who provide supplemental/additional direct nursing care or specific procedures. This count is a separate category. DO NOT include LPNs with an assigned caseload providing direct services, LPNs working with a limited caseload providing direct services such as medically fragile students (1:1, 1:2, 1:3, etc.), or LPNs providing care to special education students.
- Total Number of LPN FTEs with a special assignment (e.g. 1:1, 1:2, etc.) – Count LPNs working with a limited caseload providing direct care to students such as medically fragile students (1:1, 1:2, 1:3, etc.).
- Total Number of Health Assistant FTEs with an assigned caseload providing direct services – Count Health Assistants who provide care for the general student population in FTEs. Include those health assistants who provide care to both the general population and special education population.
- Total Number of Health Assistants FTEs providing direct services to Special Education students only - Count health assistants who provide care only to special education students in FTEs.
- Total number of Health Assistants FTEs with a special assignment (e.g. 1:1, 1:2, etc.) – Count Health Assistants working under the supervision of an RN with a limited caseload providing direct care to students such as medically fragile students (1:1, 1:2, etc.).
- Total Number of Assistant FTEs providing administrative support services to RNs and/or LPNs – This count includes assistants providing administrative support services to RNs and/or LPNs e.g. clerical assistance.
- Volunteer Diabetes Care Givers – Include in this count the number of individuals who perform diabetes care tasks under the direction of the school nurse. Include any school staff, family members or community members who are designated to provide

diabetes care, e.g. glucose monitoring, ketone checks, medication administration. These care givers would be trained at Level 3 of the diabetes curriculum created for use in New Mexico schools. Note Include actual number of volunteers, DO NOT prorate into FTEs.

Students with Medical Diagnoses

Medical-diagnoses refer to documentation of a diagnosis from a medical provider.

For example, if parents say their child has asthma, etc., but do NOT provide documentation from a medical provider, the child should NOT be included in this count. Choose the categories that most accurately reflect the child's health condition(s). This allows the child who has multiple diagnoses to be recorded in all those areas applicable. Count students who were enrolled at any time during the current school year even if they have withdrawn or dropped out.

For example, if a student has a cardiovascular disorder but also has asthma and diabetes, s/he would be counted in all three categories. Students with transplants should be included in the organ system that best fits. Count the student only once if she becomes pregnant more than once during the school year.

These categories include, but are not limited to, the following

ADD/ADHD

Attention deficit disorder, attention deficit hyperactive disorder

Allergic Disorders

Allergic Disorders have been broken into two groups

- **Life Threatening Allergy:** Student has a medically diagnosed severe allergy that has the potential to cause death (e.g. anaphylaxis, angioedema, or severe bronchospasm). Having a prescription for or carrying an epinephrine injector is a strong indicator of this condition.
- **Non-Life Threatening:** Student has medically diagnosed seasonal, perennial, food, chemical/drug or animal/insect allergy that is not known to have the potential to cause death (e.g. allergic rhinitis, localized itching).

Asthma

Asthma, reactive airway disease (RAD), recurrent wheezing

Cancer

Leukemia, tumors, any other form of cancer

Cardiovascular

Clinically significant cardiac murmurs, cardiac insufficiency, arrhythmias, pacemakers, hypertension, Kawasaki's disease, Raynaud's syndrome

Congenital/Genetic

Down syndrome, fragile X syndrome, Turner syndrome, Prader Willi syndrome, other syndromes

Dental/Oral

Braces, temporo-mandibular joint disorder (TMJ), cleft palate, untreated caries

Dermatologic

Eczema, psoriasis, acne, other skin disorders

Diabetes Mellitus

Type 1, Type 2

Eating Disorders

Anorexia, bulimia, Prader Willi syndrome, morbid obesity, failure to thrive

Endocrine, other than diabetes

Thyroid or parathyroid disease, Cushing's disease, Addison's disease, precocious puberty

ENT

Pressure equalizer (PE) tubes, frequent otitis media, deafness/hearing impairment, and tracheostomy

Eye

Blindness, amblyopia, and other eye diseases/conditions. Do not count basic corrective eyewear.

Gastro-Intestinal

GERD, ulcers, irritable bowel syndrome, Celiac Disease, Crohn's disease, ulcerative colitis, encopresis, lactose intolerance, colostomy

Genito-Urinary

Frequent urinary tract infections, voiding dysfunction including enuresis, bladder disease, urostomy, renal disease, fibroids, dysfunctional uterine bleeding, endometriosis

Hematology (not including cancers)

Hemophilia, anemias, sickle cell crisis, clotting dysfunction

Infectious Disease

Hepatitis B, Hepatitis C, HIV, sexually transmitted disease, vaginitis (including yeast infections), pertussis, influenza, strep throat, others

Musculo-Skeletal

Muscular dystrophy, scoliosis, skeletal dysplasia, rickets, fibromyalgia, juvenile rheumatoid arthritis, osteogenesis imperfecta, fractures, dislocations/subluxations, sprains/strains

Neurological

Has been broken in to 4 categories

- Concussions
Include any known medically diagnosed concussions in this category
- Migraines
Include any known medically diagnosed migraines in this category
- Seizure Disorders
Include any known medically diagnosed seizure disorders in this category
- Other Neurological Disorders
Such as autism, cluster headaches, spina bifida, cerebral palsy, traumatic brain injury, benign vertigo, and neurofibromatosis

Pregnancy

(Count the student only once unless she becomes pregnant more than once during the school year).

Psychiatric (other than eating disorders)

Anxiety, depression, bi-polar, obsessive compulsive disorder, suicide ideation, behavior disorders, alcohol use disorder, drug misuse (including cannabis, opiates, stimulants, etc.), tobacco abuse

Respiratory other than asthma

Chronic bronchitis, tracheostomy/ventilator-dependent

Other

Use this category **ONLY** for diagnoses that cannot be included in one of the reportable categories

Students Requiring Medically Complex Procedures

The students receiving complex procedures ordered by a medical provider should be counted for each different type of procedure one time per school year, e.g. a student who requires suctioning and is on a ventilator should be counted once under suctioning and once under ventilator.

This count is NOT the number of times a procedure has been performed, rather the number of students. Include students who were enrolled at any time during the current school year even if they have been withdrawn or dropped out.

Students requiring the following medically-complex procedures are counted

- Urinary Catheterization
- Wound Care (formerly called “dressing changes”)
- Glucose Monitoring
- IV/Heparin Flush
- Nebulizer Treatment
- Ostomy Care
- Carbohydrate Counting
- Oxygen Saturation
- Peak Flow Measurement

- Oral Suctioning
- Tracheal Suctioning/Trach Care
- Toileting (includes bowel & bladder training)
- Ventilator Care
- NG/G Tube (includes care, feeding & meds)
- Oxygen Delivery
- Other (specify)
Examples of the “Other” category include range of motion exercises, feeding assistance, etc.

Students with Prescription Medications at School

This count represents the number of students with prescription medications at school that have been ordered by a medical provider, with a school district medication authorization form on file. If a student is receiving ADHD medication as well as anti-convulsants, s/he would be counted in BOTH categories.

This count is NOT the number of doses administered. Include students who were enrolled at any time during the current school year even if they have withdrawn or dropped out.

Students with the following prescription medications ordered by a provider are counted

- ADD/ADHD meds
- Allergy meds
- Asthma meds
- Analgesics
- Antibiotics
- Anticonvulsants
- Antidipressants
- Cardiovascular meds
- Gastrointestinal meds (includes digestive aids)
- ENT meds
- Epinephrine
- Glucagon
- Insulin
- Migraine meds
- Oral Diabetes meds
- Psychotropic meds

- Oral Steroids (non-inhaled)
- Other (specify)
 - Examples of the “Other” medications might include over-the-counter medications (if ordered by a health care provider), herbal/vitamin supplements (if ordered by a health care providers), and all other prescription medications that do not fit in any of the reportable categories.

Student Deaths Occurring During the School Year

This count is the number of enrolled student deaths for any reason occurring during the school year, both on campus and off campus. These are events in which a New Mexico Department of Health [Adverse Event Form](#) should have been done. This may be an event that even occurs on the weekend or overnight.

Student Visits to Health Office

The number of student health office visits and the referrals made to healthcare providers, counselors, behavioral health, CYFD, etc. and the disposition of each visit is counted in this section. For each visit entered here under the appropriate category a selection is also required under “Disposition of Students Visiting Health Office.”

Choose the most appropriate category for each visit; do not count a single student visit more than once. This count does NOT include telephone calls, letters, etc.

*The total number of visits to the health office should equal the total number of dispositions of students visiting the health office (see below).

Acute Illnesses

All initial visits for acute illness are recorded in this category and may include acute exacerbations of chronic conditions such as an asthma attack, seizures, and anaphylactic reactions. Also, may include things like sore throat, headache, cough, stomachache, rhinitis, earache, nausea, vomiting, rash, spontaneous nosebleed, hypo/hyperglycemia, or dizziness. These students may present symptomatic at school.

Follow-up Care of Any Illness

This category includes return visits for the same illness during the same day or administration of short term medications or treatments because of an initial illness. It also includes follow-up visits for illnesses commencing outside of school.

Examples could be a child seen and referred for evaluation for strep throat. The visit is recorded under acute illness. S/he returns with antibiotics for 10 days. The administration of the antibiotics and/or other short-term medications falls under follow-up care.

Injuries Occurring at School (Initial)

This category reflects assessment of injuries incurred during school time, on the playground, & field trips.

School health office personnel are additionally asked to subcategorize as

- Injuries due to accidental trauma at school
- Injuries due to violence at school
 - # of injuries from above 2 subcategories (accidental or violent) related to head trauma

Examples could be cuts, lacerations, abrasions, contusions, burns, sprains, strains, possible fractures, dislocations, jammed fingers, eye injuries, head injuries, back injuries, nosebleed from trauma.

If the injury is life-threatening and EMS is activated, it would be recorded in this category and listed as “Referred for Immediate Follow-up” or “Transported to a Medical Facility by EMS” in the “Disposition of Students Visiting Health Office” category.

Note: This category does not include evaluation of injuries occurring at home, at after-school sports practice, or over the weekend. Injuries reported here are those evaluated by the school nurse or health assistant in the health office or on school property during school hours.

A New Mexico Department of Health [Adverse Event Form](#) may need to be completed.

Follow-up Care of Any Injury

Injuries that occur outside of school hours but are evaluated by the school nurse or health assistant are recorded in follow-up care of any injury. This would include follow-up visits after a primary school injury including wound care or ice-pack treatment.

Examples may be parental request to assess injury that occurred at home or on the way to school, additional ice-pack treatment or dressing change in the same day of injury, re-evaluation of injury, crutch use.

Care for Chronic Conditions

Capture here the number of visits to the health office for routine care of students with medically-diagnosed health conditions.

Examples could be long-term medication administration, routine peak flow measurements, glucose monitoring, routine blood pressure monitoring, any medically complex procedures.

Crisis Intervention and Mental Health

In this category include the number of visits primarily for emotional and mental health issues and crises.

Examples may include suicide ideation, uncontrolled anger or crying, depression, hyperventilating.

Suspected Child Abuse/Neglect

Guidelines for identifying possible child abuse/neglect can be found in the NM School Health Manual.

Reporting to CYFD of any suspected child abuse/neglect by nurses and certain others acting in official capacities is required under the New Mexico Children's Code.

Examples may include physical abuse symptoms, sexual abuse symptoms, behavioral indicators, evidence of neglect, child self-reporting.

Reproductive Health Counseling

Include individual student visits seeking information regarding any issue associated with the reproductive system.

Examples include pregnancy, menstrual cramps, birth control, condoms, sexually transmitted diseases, erections, growth and development, feminine hygiene issues.

General Health Counseling

From hygiene to self-care, this category is for capture of any school health office visit by a student for health counseling in areas other than reproductive health counseling.

It is Important to record the visit in this category if counseling on any general health issue is the ONLY reason for the visit or best describes the visit even if the student also presents for an illness. Count the number of student visits, NOT different areas of counseling.

Examples include questions about diseases, hygiene, nutrition, healthy life-style choices,

sun safety, dental hygiene, care of contact lenses.

Immunization Administration

This count is the number of students who received immunizations not the number of immunizations given to a student (as some students may get more than one immunization at a specific clinic). This includes those immunized at clinics sponsored by the school district and/or held on school property during school hours.

Examples include routine childhood vaccination, flu vaccination.

Other (specify)

Any other visits that do not fit in any of the above categories are recorded here.

Example include change of clothes, hand-washing, glasses repair, dental flossing issues, lost tooth, hunger, clothing repair, chapped lips treatment, safety pin needs.

Emergency Medication Administered

Enter here the number of emergency medications administered in response to an emergency at school or during a school-sponsored function.

Emergency medications that should be counted include

- Albuterol
 - Prescribed
 - Stock
- Epinephrine
 - Prescribed
 - Stock
- Glucagon
- Emergency Seizure Meds
- Other (specify)

Do NOT include routine/prophylactic doses of Albuterol (e.g. given prior to PE class). However, if used because of an Asthma Attack it would then be counted.

A NMDOH [Adverse Event Form](#) may need to be completed.

Disposition of Students Visiting Health Office

For each entry in the Student Visit to Health Office category, select the ONE best disposition of the individual visit and enter in this category. Do not enter the visit in multiple categories. The total number of entries in this category should equal the total number of entries in the “Student Visits to Health Office” category.

This category reflects the outcome/result of each visit to the school nurse’s office. When selecting a disposition for a visit, the school nurse should select the most appropriate choice that reflects the outcome when the student leaves the nurse’s office.

Disposition selections include

- Remained at School – includes students who returned to class/remained at school.
- Sent Home at School Health Office Request – includes students that are not able to remain in school and are sent home by the school nurse (or other school health personnel based on established criteria).
- Sent to SBHC – includes students that are referred to the school-based health center for immediate evaluation (whether or not they are subsequently sent home or return to class).
- Released to Go Home at Parents Request – includes students that could return to class (based on established criteria) but the parent/guardian requests that the student be released to go home.
- Transported to Medical Facility by EMS – includes those instances where EMS is called to transport the student to a medical facility (not SBHC).
- Referred to Medical Facility (Not transported by EMS) – includes those instances where a student is sent to a medical facility by a parent/guardian (or other responsible adult) using a private or agency vehicle and NOT transported by EMS.

Example includes a student given an immediate referral to the SBHC for symptoms of an ear infection, and is evaluated in the SBHC and then returns to class, the disposition of this visit is “Sent to SBHC,” NOT “Remained at School.”

**The total number of entries in this category should equal the total number of entries in the “Student Visits to Health Office” category (see above).

Student Screenings

All formal student screenings and referrals are included in this category

- Vision
- Hearing
- Dental
- Blood Pressure
- Pediculosis
- Depression/Suicide Risk
- Substance Abuse
- SPED/SAT Screening & Assessment
- BMI Surveillance
 - Do NOT count special education students in individual categories; include them only once under “SPED/SAT Assessment”.
 - Students whose height/weight are measured for BMI surveillance should also be counted here. However, since surveillance monitors population risk (rather than individual risk) referrals for BMI surveillance should not be counted.
 - Do not include any staff screenings in this category.

If a screening is not performed in any particular category, simply enter “0.”

Miscellaneous School Nursing Functions

Nursing Functions

- Health education presentations for students provided by the school RN on school property during school hours.
- IEP, 504, and SAT meetings attended by the school RN.
- IHPs, Emergency Care Plans & 504 Plans developed by the school RN.
- Home visits completed by the school RN for any reason during the school year.

Staff Encounters

- The staff immunization count is the number who received immunizations, not the number of vaccines administered.
- Referrals for additional medical care for any condition should be captured in this section under the referral category.
- Any encounter that is not for immunizations nor results in a referral for additional medical care should be included in “Other Medical Encounters” e.g. emergencies, medication issues, injuries, individual advice/education, counseling, monitoring health conditions such as hypertension and diabetes.
- Any health education presentation/training provided specifically for the school staff should be entered in that category.

References and Resources

[Annual School Health Service Report](#)

[Complex Procedure Tool](#)

[Daily Report Assist Tool](#)

[Students with Medical Diagnosis Assist Tool](#)

[Students with Prescription Medications at School Tool](#)

CHAPTER SEVENTEEN – BLOODBORNE PATHOGENS – EXPOSURE AND CONTROL

New Mexico Regulation on Bloodborne Pathogens

Occupational Safety and Health Standards (OSHA) [Regulation 29 CFR 1910.1030](#) requires that employers who have employees with potential occupational exposure develop a written Bloodborne Pathogen Exposure Control Plan. The Bloodborne Pathogen Exposure Plan is designed to eliminate or minimize employee exposure.

According to OSHA occupational exposure is defined as “reasonably anticipated skin, eye, mucous membrane, or parenteral contact with blood or other potentially infectious materials that may result from the performance of an employee’s duties.” ([Regulation 29 CFR 1910.1030](#)). OSHA has determined that some employees face a significant health risk as the result of occupational exposure. Blood and other potentially infectious materials are a significant risk because they may contain bloodborne pathogens, including hepatitis B virus (HBV) and human immunodeficiency virus (HIV). The agency further concludes that this exposure can be minimized or eliminated using a combination of engineering and work practice controls, personal protective clothing and equipment, training, medical surveillance, hepatitis B vaccination, signs and labels and other provisions.

Under New Mexico Law, [Standard number: 1952.20a](#) the state standards for occupational exposure to bloodborne pathogens and enforcement requirements meets or exceeds federal standards by being at least as effective as federal requirements.

Guidelines

- Each school district must perform an employee exposure determination to identify employees who may incur occupational exposure to blood or other potentially infectious materials. This identification must result in a list of job classifications that may be expected to incur such occupational exposure, regardless of frequency.
- As part of the federal standard, the employer is required to make available, at no cost to the employee, the hepatitis B series of vaccinations if employee is determined to be at risk for potential exposure. Furthermore, the employer must provide all appropriate personal protective equipment (PPE).
- Suggested PPE in the school setting includes gloves, face shield, apron/gown and goggles. A mouth-to-mouth shield should also be available for use by those staff properly trained and certified in its use, i.e. emergency response/CPR/first aid trained employees.
- School districts should designate administrative staff to investigate claims relating to exposures to blood and other body fluids.
- For all bloodborne pathogen exposure incidents, A [Notice of Accident](#) and an [E10-1](#) should be filed with the State Department of Education’s Worker’s Compensation Claims Adjuster who will determine if the claim is compensable under the Worker’s Compensation Law.

- Staff must be trained within 90 days of hire, then annually thereafter, be familiar with this policy and abide by its requirements.

Needlestick Safety and Prevention Act

- The Centers for Disease Control and Prevention estimate that healthcare workers in the US sustain nearly 600,000 percutaneous injuries annually involving contaminated sharps.
- An estimated 16,000 of these injuries involve sharps contaminated with blood or OPIM (Other Potentially Infectious Material) containing HIV.
- It is thought that use of safer devices could prevent about 80% of these injuries. In response to both the continuous concern over these exposures and the technological developments that may increase employee protection,
- Congress passed the [Needlestick Safety and Prevention Act of 2000](#).

Under this law, employers must:

- Document consideration and use of appropriate, commercially available and effective safer devices.
- Solicit input from non-managerial employees responsible for direct patient care regarding the identification, evaluation and selection of effective engineering controls.
- Document, in the exposure control plan, how this input was received.
- Maintain a detailed sharps injury log.

Employees are expected to:

- Not interfere with the safety features of any device.
- Report all unintentional sticks immediately, even needle sticks with a clean needle.
- Participate in the evaluation of effective engineering controls as these are introduced into their area. Share ideas and opinions concerning safer devices by communicating in writing with the appropriate safety officer, giving specific details of the device and any problems or advantages regarding the use of the device.

All reported needle sticks are confidential.

Hepatitis B Vaccination and Post-Exposure Follow-Up General Policy

-Employers will make available hepatitis B vaccination free of charge to designated high risk groups following the required training and will offer post exposure follow-up for all employees with an occupational exposure incident.

-All medical evaluations and procedures will be performed under the supervision of a licensed healthcare provider, and an accredited laboratory for all laboratory tests. All evaluations, procedures, vaccinations, and post-exposure management will be provided within a reasonable time (ASAP) and according to standard recommendations for medical care.

HBV Vaccination

-For Hepatitis B vaccination and bloodborne pathogen exposure follow-up the school district will follow procedures recommended by the New Mexico Public Schools Insurance Authority.

-Identified high risk employees will be offered the HBV series of vaccinations as a precautionary measure at the expense of the school district.

-The school district coordinator of risk management or designee will investigate claims relating to bloodborne pathogen exposure and coordinate the follow-up process.

Record Keeping

The employer shall establish and maintain an accurate record regarding bloodborne pathogen risk potential and actual exposure for each employee that will include a minimum of the following.

Exposure risk classification

-Offer of HBV vaccination as well as acceptance/declination of vaccine

-Documentation of bloodborne pathogens exposure training

-Follow-up process/procedure for any occupational exposure incidents.

Communication of Hazards to Employees

Labels and Signs

-Warning labels should be affixed to containers of regulated waste containing blood or other potentially infectious material and other containers used to store, transport or ship blood or other potentially infectious materials.

-Labels should include the BIOHAZARD symbol and be fluorescent orange or orange red with lettering or symbols in a contrasting color.

-Labels should be attached to the biohazard container by string, wire, adhesive or other method to prevent loss or unintentional removal. Red biohazard bags or containers may be substituted for labels, and they should be stored in a regulated area for pickup and disposal.



Employee Information and Training

All employees in this school district will participate annually in a bloodborne pathogen exposure training. Additional training may occur when changes such as modification of tasks or procedures may affect an employee's occupational exposure classification.

Employee Bloodborne Pathogen Exposure Training will include a minimum of the following topics.

- Universal Precautions
- Location of a copy of OSHA's Bloodborne Pathogen Standard 1910.1030
- Explanation of epidemiology, symptoms and transmission modes of bloodborne diseases.
- Explanation of this exposure control plan and location where it can be accessed
- Methods employees should use to recognize tasks involving potential occupational exposure
- Methods of operation that can prevent or reduce occupational exposure
- Selection, limitations, location, decontamination and proper disposal of PPE
- HBV Vaccine
- Response mechanism/procedures regarding exposure to potentially infectious materials
- Post exposure follow-up responsibilities for exposure
- Explanation of labels and/or biohazard color-coding system
- Opportunity for employee to ask follow-up questions and obtain answers during training
- Training records that will be maintained in the employee's personnel file

Exposure Classifications

All school district employees in the following job classifications have been identified as having occupational exposure risk to bloodborne pathogens.

- Daily Risk of Exposure
- Nurses/Health Assistants
- Security Officers
- Coaches/Athletic Director
- Special Education Teachers/Assistants
- Physical Education Teachers/Assistants
- Custodians

Occasional Risk of Exposure

- Administrators
- Classroom Teachers
- Secretaries
- Educational Assistants
- Food Service Workers
- Maintenance Workers
- Bus Drivers
- School Bus Aides

Students:

- who work with children in nursery
- who work as lab assistants
- who work in coop programs

Sample Bloodborne Pathogens Exposure Control Plan

Purpose and Policy

The purpose of the exposure control plan for this school district is to implement the requirements of the OSHA Standard [Regulation 29 CFR 1910.1030](#) Bloodborne Pathogens. The control Plan is in place to reduce the risk of employee infection with bloodborne pathogens such as, but not limited to Hepatitis B Virus (HBV), Hepatitis C (HCV) and the Human Immunodeficiency Virus (HIV) which can result in the disease commonly known as Auto Immune Deficiency Syndrome (AIDS).

The policy of this school district is that employees shall adhere to Universal Precautions. Universal Precautions is an approach to infection control. According to this concept, all human blood and human body fluids are treated as if known to be infectious for HIV, HBV and other bloodborne pathogens. The exposure control plan offers guidelines for employees to prevent exposure and for follow-up action should exposure occur.

A copy of this plan shall be maintained in each principal's office. The school health office should have a copy of the Bloodborne Pathogen Exposure Control Plan. Also, most school districts risk management department will have a copy of the control plan.

Definitions

Biological Waste - Biological waste consists of blood, excretions, exudations, secretions, suctioning's, and disposable medical supplies, which have come in contact with these substances, including but not limited to:

Medical waste – catheters, bandages, and any disposable items used in the treatment of students or employees.

Laboratory waste – cultures, specimens, slides, blood and tissue samples.

Potentially hazardous non-biological waste or trash – includes garbage waste from the preparation, cooking and serving of food in any area where biological waste may contaminate otherwise non-biological garbage or trash. Also, included in this category is combustible (e.g., plastic, wood, or paper) and non-combustible (e.g., metal or glass) materials discarded from or in an area contaminated by contact with biological waste.

Blood – Blood means human blood, human blood components and products made from human blood.

Bloodborne Pathogens – Pathogenic microorganisms that are present in human blood that can infect and cause disease in persons who are exposed to blood containing these pathogens.

Contaminated - The presence or reasonably anticipated presence of blood or other potentially infectious material on an item or surface.

Decontamination - The use of physical or chemical means to remove, inactivate, or destroy bloodborne pathogens on a surface or item to the point where they are no longer capable of transmitting infectious particles, and the surface of the item is rendered safe for handling, use, or disposal.

Engineering Controls - Controls that isolate, minimize, or remove a workplace hazard.

Exposure Incident - A specific eye, mouth, or other mucous membrane, non-intact skin, or parenteral contact with blood or other potentially infectious material that result from the performance of an employee's duties.

Handwashing Facilities – Access to an adequate supply of running water, soap and single-use towels.

Occupational Exposure - Reasonably anticipated skin, eye, mucous membrane or parenteral contact with blood or other potentially infectious materials that results from the performance of an employee's work duties.

Parenteral Exposure - The piercing of the skin barrier, including mucous membranes, by such events as needle sticks, human bites, cuts and abrasions.

Personal Protective Equipment - Specialized clothing or equipment worn by an individual to protect from a hazard. It does not permit blood or other potentially infectious materials to pass through it or reach the employee/s work clothes, street clothes, under garments, skin, eyes, mouth or other mucous membranes under normal conditions of use and for the duration of time during which the protective equipment will be used.

Regulated Waste - Any one of the following:

liquid or semi-liquid blood or other potentially infectious materials;
contaminated items that could 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 can release these materials during handling;
contaminated sharps;
pathological and microbiological wastes containing blood or other potentially infectious materials.

Universal Precautions - A method of infection control in which all human blood and certain body fluids are treated as if known to be infectious for HIV, HBV, HCV and other bloodborne pathogens.

Work Practice Controls - Controls that reduce the likelihood of exposure by altering the way a task is performed.

For definitions of other terms used in this Bloodborne Pathogens Exposure Control Plan, see [Regulation 29 CFR 1910.1030](#) Definitions.

Exposure Determination

The lists of job classifications, in the school district, for which employees have been identified as having occupational exposure risk. Exposure determination for these jobs has been made without regard to the use of personal protective equipment (PPE).

This job classification list was determined according to the potential exposure and subsequent transmission risk of certain bloodborne pathogens that employees might come in contact with during their work. These pathogens, which can transmit certain diseases, may be present in blood and other body fluids such as saliva, semen, and vaginal secretions as well as other secretions.

Bloodborne pathogens can enter and infect the human body through openings in the skin including cuts, nicks, abrasions, dermatitis, or acne. Infection can also result from punctures or cuts caused by sharp contaminated objects such as needles, broken glass, exposed ends of dental wires or any other contaminated object that can puncture or cut skin. Infection can also gain access to the body through mucous membranes of the eyes, nose, and mouth when these areas are touched with contaminated hands or implements. The HBV is particularly dangerous since it can survive on dried surfaces at room temperature for at least one (1) week (7days) ([Hepatitis B FAQs](#)).

Methods of Compliance

-Universal precautions shall be observed to minimize contact with blood or other potentially infectious materials.

-When differentiation between body fluid types is difficult or impossible, all body fluids shall be considered potentially infectious materials.

Engineering and Work Practice Controls

Gloves: Employees should wear protective gloves appropriate for risk status.

Handwashing: Employees should wash hands immediately or as soon as possible after removal of gloves or other PPE and after contact with blood or other potentially infectious materials. If hand washing facilities are not immediately available, employees should use antiseptic hand cleaner or towelettes, and then wash hands with soap and water as soon as feasible.

Procedures: All procedures involving blood or other infectious materials should be performed in such a manner as to minimize splashing, spraying, splattering and generation of droplets.

Hazardous Materials: Any container for storage, transport or shipping of potentially infectious material should be sealed and labeled or color coded.

If outside contamination of the primary container occurs, it should be placed within a second container which prevents leakage during handling/processing, storage, transport or shipping. The second container should be labeled with a biohazard sign. If the specimen could puncture the primary container, it should be placed in a puncture resistant second container meeting the characteristics as just stated.

Equipment: Equipment which may become contaminated with blood or other potentially infectious material should be decontaminated unless decontamination is not feasible.

Contaminated equipment should be enclosed in a red biohazard bag or have attached a biohazard label stating which portions remain contaminated.

It is the responsibility of the school district Safety Officer or his/her designated charge person (whoever handles the contaminated equipment) to notify all employees potentially handling the equipment, the servicing representative and/or manufacturer prior to releasing the contaminated equipment for shipping and/or decontamination.

Personal Protective Equipment (PPE)

Gloves: Gloves should be worn when it can reasonably be anticipated the hands might have contact with blood, mucous membranes, non-intact skin, other potentially infectious materials and when touching or handling contaminated items or surfaces.

Disposable (single use) gloves should be replaced as soon as possible when contaminated, torn, punctured, or when their ability/function as a barrier is compromised. Disposable gloves should not be washed or disinfected for re-use. Gloves should be worn when performing any vascular access procedures, including heel sticks and finger sticks.

Utility gloves may be decontaminated for re-use if the integrity of the glove is not compromised; However, they should be discarded if they are cracked, peeling, torn, punctured, or exhibits other signs of deterioration or when their ability to function as a barrier is compromised.

Face protection: Face protection should be worn whenever splashes, spray, spatter, droplets or aerosols of blood or other potentially bloodborne infectious materials may be present and eye, nose or mouth contamination can be anticipated.

Protective clothing: Appropriate protective clothing should be worn in occupational exposure situations. The type and characteristics of the clothing will depend upon the task and degree of exposure anticipated. This includes closed toe shoes.

Housekeeping

Cleaning and Disinfection: All equipment and environmental working surfaces should be properly cleaned and decontaminated after contact with blood or other potentially infectious materials.

Refuse containers: All bins, cans and similar receptacles intended for reuse which have a reasonable likelihood for becoming contaminated with blood or other potentially infectious materials shall be inspected and decontaminated on a regular basis and cleaned and decontaminated immediately or as soon as possible upon visible contamination.

Regulated Waste

Regulated waste should be placed in labeled containers which can be sealed and are constructed to hold the contents and prevent leakage of fluids during handling, storage, transport or shipping. If outside contamination of the regulated waste container occurs, it should be placed in a second container meeting the same requirements as the original container.

Regulated waste should be disposed of in accordance with New Mexico Environmental Department Hazardous Waste. School Districts must contract with an approved hazardous waste disposal company.



Handling Sharps

Used needles: Used needles should not be cut, bent, broken or reinserted into original sheath. They should be discarded intact immediately after use into an OSHA approved sharps disposal container.

OSHA approved sharps disposal containers: OSHA-approved containers for sharps should be easily accessible in areas where employees routinely have the greatest potential exposure for contamination by sharps.

These containers should be sealed and replaced when they are 75% full to decrease exposure by forcing contaminated objects into the container.



References and Resources

Centers for Disease Control and Prevention, (May 23, 2016). [Division of Viral Hepatitis and National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, Hepatitis B](#)

[FAQs](#)

[Confidential Exposure Incident Report Template](#)

[Employee Acceptance/Declination Template](#)

[Exposed to HIV](#)

[Information for Personnel Exposed to HCV](#)

State of New Mexico Worker's Compensation Administration, [Notice of Accident](#)

State of New Mexico Worker's Compensation Administration, [E10-1](#)

[Training Record Template](#)

United States Department of Labor, Occupational Safety and Health Administration (OSHA)

[Needlestick Safety and Prevention Act of 2000](#)

United States Department of Labor, Occupational Safety and Health Administration (OSHA)

[Regulation 29 CFR 1910.1030](#)

CHAPTER EIGHTEEN – DELEGATION
This chapter is Under Construction



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