

# **New London Public Schools Health Policies and Procedures Manual**

**Updated July 2023**



**NEW LONDON  
PUBLIC SCHOOLS**

## Table of Contents

<b>Physical Exams/General Student Health</b>	
Physical Examinations.....	3
Exemptions (Medical & Religious).....	7
Chronic Diseases and Foster Children.....	10
<b>Food Allergy Policy.....</b>	<b>11</b>
Forms.....	15
<b>Medication Administration.....</b>	<b>18</b>
Psychotropic Drug Use.....	36
Controlled Drug List.....	38
Medication Forms.....	41
Potassium Iodide.....	43
<b>Communicable Diseases</b>	
Policy and Prevention.....	44
Prevention of Disease Transmission in Schools.....	48
When to Exclude a Child from School.....	49
Varicella and Shingles.....	50
<b>Illness and First Aid</b>	
Accidents and Emergencies in School.....	58
Emergent – Category I.....	59
Urgent – Category II.....	62
Medical Attention Desirable Within an Hour – Category III.....	64
First Aid Procedures, Alphabetical Order.....	66
<b>Screenings</b>	
Vision, Hearing, Scoliosis.....	76
Forms.....	77
Tuberculosis.....	80
Pediculosis (Lice).....	86
<b>Physicians Orders.....</b>	<b>87</b>

## **PHYSICAL EXAMINATIONS**

### **Sports Physicals**

It is Policy of the Board of Education to require physicals for participation in interscholastic sports. Physicals for participation in sports shall be required within 13 months prior to the date the student is to participate in that sport. Documentation of physical must be placed in the student's health record.

The Board of Education recommends that all physicals are performed by student's own physician. Annual written parental permission will be required before physicals can be performed by the school physician.

### **Mandated Physicals**

It is the policy of the Board of Education to require periodic health assessments prior to (Pre-K) Kindergarten, during grade 6 and during grade 10, unless objected to in writing on religious grounds by the parents or guardian of the student (or by the student if age 18 or over). No record of such medical examination shall be opened to public inspection.

Failure to comply with the mandated requirement for students to have a health assessment prior to (Pre-K) Kindergarten, or during grades 6 or 10 could result in a student not being allowed to attend school until such time as a health assessment is completed or the school receives written documentation of the parents/guardians objection due to religious beliefs.

**Legal References:** Connecticut General Statute's 10 – 206, 10 – 208, and 10 – 209

## **THE ASSESSMENT REQUIREMENT**

Connecticut statute (Section 214) requires a health assessment prior to a student's enrollment in the New London School System.

It is realized that it is difficult to arrange for health assessment on such short notice. However, in order to implement this Statute, the following policy has been established for students enrolling in the New London School System:

- 1.) Upon registration, the parent/guardian and/or pupil (if an emancipated minor over 18 years of age) shall be informed in writing that a health assessment with all the required elements is required for registration in the New London School System.
- 2.) The required Health Form distributed by the State Board of Education shall be given to the parent/guardian and/or pupil (if emancipated minor or 18 years of age) to take to their physician.
- 3.) The Health Assessment Form must be returned to the school prior to enrollment of the date of registration or the pupil will be excluded until the assessment is obtained. Notice of exclusion shall be sent in writing.
- 4.) If a Connecticut enrollee has had a physical at the appropriate grade level, i.e., Pre-Kindergarten (can accept for Kindergarten if done within one year), Grade 6, or at Grade 10, and can provide documentation this shall be acceptable.
- 5.) Physicals out-of-state are accepted in Connecticut only if done by Medical Doctor (MD) or Doctor of Osteopathy (DO). State of Connecticut will not accept physicals done by Physician's Assistant's (PA's) or advanced Practice registered Nurses (APRN's) from out of state unless said provider is stationed at any U.S. military base.
- 6.) The school administrator shall send notice of exclusion to the parent/guardian and/or pupil (if an emancipated minor or 18 years of age) if this requirement is not met.

If you have questions, the school nurse is available.

**5141.21 – Pol.**

**Student Health Services (PLEASE NOTE: THE FOLLOWING SECTIONS ARE DISTRICT POLICY SO ANY CHANGES WOULD NEED BOARD CONSENT, IF NOT ALREADY OBTAINED)**

Prior to entry into school, students enrolling in the New London Public Schools shall have a complete health assessment by a legally qualified practitioner of medicine, (2) an advanced practice registered nurse, licensed pursuant to chapter 378, (3) a physician assistant, licensed pursuant to chapter 370, (4) a school medical advisor, or (5) a legally qualified practitioner of

medicine, an advanced practice registered nurse or a physician assistant stationed at any military base (A physical assessment done one year prior to entry into school will be accepted if it meets state requirements).

Health assessments are also required for students enrolled during the grade six period and again during the grade ten period. Prior to enrollment, transfer students from other towns, states, or countries must show proof that a physical assessment has been performed according to State Statute and Board policy.

All health assessments shall include:

- a. A physical examination which shall include hematocrit or hemoglobin screenings, heights, weight, blood pressure, chronic disease assessment, and tuberculosis risk assessment. High-risk students must receive a tuberculin skin test and the results recorded.
- b. An upgrading or immunizations as required under Section 10-204a.
- c. Vision, hearing, speech, and gross dental and postural screenings on health assessments prior to enrollment.
- d. Vision, hearing, postural and gross dental screenings on health assessments for students enrolled in grade six or grade ten;
- e. Such other information including a health and developmental history as the physician, advanced practice registered nurse, nurse practitioner, or physician assistant feels is necessary and appropriate.

The results of each health assessment shall be recorded on forms supplied by the State Board of Education. Such information shall be included in the cumulative health record of each student and shall be kept on file in the school such student attends. For students transferring to another school district in Connecticut, the original CHR- 1 must be sent to the new school and a true copy retained by the sending school within the local or regional board of education. For a student leaving Connecticut, a copy of the CHR-1 should be sent upon request and the original retained by the local or regional board of education.

- Upon entry into the New London Public Schools and unless exempted by law, all students shall present documentation attesting to required, adequate immunizations according to CGS Section 10-204a.
- The school district shall arrange for vision screening annually in grades kindergarten, one, and three to five inclusive under the direction and supervision of the school nurse (Section 10-204a-214).
- The school district shall provide annual audiometric screening for hearing to each student in kindergarten, one, and three to five, inclusive (Section 10-214).
- The school district shall provide postural screening for boys in grade eight or nine and girls in grade five and seven (Section 10-214).

Legal Reference: Connecticut General Statutes  
10-203 Sanitation.

10-204 Vaccination.

10-204a Required immunizations.

10-204c Immunity from liability

10-205 Appointment of school medical advisors.

10-206 Health assessments.

10-206a Free health assessments.

Policy adopted: August 11, 2005 NEW LONDON PUBLIC SCHOOLS

New London, Connecticut

# Connecticut Department of Public Health Medical Exemption Certification Statement

According to State statutes (Connecticut General Statutes Sections 19a-7f and 10-204a), no child may be admitted to a licensed childcare program or school without proof of immunization or a statement of exemption. Parents or guardians claiming a medical exemption on the basis that a given immunization is medically contraindicated should provide a signed **Student Medical Exemption Certificate for Required Immunizations**, per Public Act 21-6. ([Medical Exemption Immunizations Form.pdf \(ct.gov\)](#))

## State of Connecticut Department of Public Health Religious Exemption Statement

As of April 28, 2021, Governor Lamont signed into law Public Act 21-6, “An Act Concerning Immunizations,” which updates Connecticut’s immunization requirements for students attending pre K-12 schools, day care programs, and institutions of higher education by removing exemptions that are not medical. Religious exemptions will be observed for individuals who (1) must have been enrolled in school in Grades K-12 on or before the law’s effective date (that is, by midnight April 28, 2021); and (2) must have submitted a valid religious exemption prior to that effective date (that is, by midnight April 27, 2021). Valid Religious Exemption is “a statement . . . from the parents or guardian of [the] child” that specifies that the immunization is “contrary to the religious beliefs” of the child or parents/guardian. The law requires that the statement be properly acknowledged, as prescribed in General Statutes Sections 1-32, 1-34, and 1-35, by one of the following individuals: (1) a judge of a court of record or a family support magistrate, (2) a clerk or deputy clerk of a court having a seal, (3) a town clerk, (4) a notary public, (5) a justice of the peace, (6) an attorney admitted to the bar of this state, or (7) a school nurse. Religious exemptions will be considered valid if the student transfers schools within Connecticut (including from a public to a private school and vice versa) who was enrolled in a Connecticut school on or before April 28, 2021, and must have submitted a valid religious exemption to either school prior to that date. In order for a student to continue an existing exemption and thus be covered under the prior law allowing for religious exemptions from statutory vaccination requirements, the statement must contain all legally necessary components prior to April 28, 2021. Statements that fail to do so are legally invalid and may not be used as a basis for religious exemption.

### **CHRONIC DISEASES**

It should be the responsibility of the parents of children with chronic conditions to report such conditions to the nurse or principal. School personnel shall abide by the instructions of the private physician.

The New London Public Schools recognize that food allergies may be life threatening. For this reason, the District is committed to developing strategies and practices to minimize the risk of accidental exposure to life threatening food allergens and to ensure prompt and effective medical response should a child suffer an allergic reaction while at school. The district further recognizes the importance of collaborating with parents and appropriate medical staff in developing such practices and encourages strategies to enable the student to become increasingly proactive in the care and management of his/her food allergy, as developmentally appropriate. To this end, the New London Public Schools adopt the following guidelines related to the management of life threatening food allergies for students enrolled in district schools.

I. Identifying Students with Life-Threatening Food Allergies

Early identification of students with life-threatening food allergies is important. The district therefore encourages parents/guardians of children with a life-threatening food allergy to notify the school of the allergy, providing as much information about the extent and nature of the food allergy as is known, as well as any known effective treatment for the allergy.

II. Individualized Health Care Plans and Emergency Care Plans

1. If the District determines that a child has a life-threatening food allergy, the district shall develop an individualized health care plan (IHCP) for the child. Each IHCP should contain information relevant to the child's participation in school activities, and should attempt to strike a balance between individual, school and community needs, while fostering normal development of the child.
2. The IHCP should be developed by a group of individuals, which shall include the parents, and appropriate school personnel. Such personnel may include, but are not limited to, the school nurse, school or food service administrator(s); classroom teacher(s); and the student, if appropriate. The school may also consult with the school's medical advisor, as needed.
3. IHCPs are developed for students with special health needs or whose health needs require daily interventions. The IHCP describes how to meet the child's health and safety needs within the school environment and should address the student's needs across school settings. Information to be contained in an IHCP should include a description of the functional health issues (diagnoses); student objectives for promoting self-care and age appropriate independence; and the responsibilities of parents, school nurse and other school personnel. The IHCP may also include strategies to minimize the student's risk for exposure, such as considerations regarding:
  - a. classroom environment, including allergy free considerations;
  - b. cafeteria safety;
  - c. participation in school nutrition programs;
  - d. snacks, birthdays and other celebrations;
  - e. alternatives to food rewards or incentives;
  - f. hand-washing;
  - g. location of emergency medication;
  - h. risk management during lunch and recess times;
  - i. special events;

- j. field trips;
  - k. extracurricular activities;
  - l. school transportation;
  - m. staff notification; and
  - n. transitions to new classrooms, grades and/or buildings.
4. The IHCP should be reviewed annually, or whenever there is a change in the student's emergency care plan, changes in self-monitoring and self-care abilities of the student, or following an emergency event requiring the administration of medication or the implementation of other emergency protocols.
5. In addition to the IHCP, the district shall also develop an Emergency Care Plan (ECP) for each child identified as having a life threatening food allergy. The ECP is part of the IHCP and describes the specific directions about what to do in a medical emergency. The ECP should include the following information:
  - a. The child's name and other identifying information, such as date of birth, grade and photo;
  - b. The child's specific allergy;
  - c. The child's signs and symptoms of an allergic reaction;
  - d. The medication, if any, or other treatment to be administered in the event of exposure;
  - e. The location and storage of the medication;
  - f. Who will administer the medication (including self-administration options, as appropriate);
  - g. Other emergency procedures, such as calling 911, contacting the school nurse, and/or calling the parents or physician;
  - h. Recommendations for what to do if the child continues to experience symptoms after the administration of medication; and
  - i. Emergency contact information for the parents/family and medical provider.
6. In developing the ECP, the school nurse should obtain current health information from the parents/family and the student's health care provider, including the student's emergency plan and all medication orders. If needed, the school nurse or other appropriate school personnel, should obtain consent to consult directly with the child's health care providers to clarify medical needs, emergency medical protocol and medication orders.
7. A student identified as having a life-threatening food allergy is entitled to an IHCP and an ECP, regardless of his/her status as a child with a disability, as that term is understood under 504, or the IDEA.
8. The District shall ensure that the information contained in the IHCP and ECP is distributed to any school personnel responsible for implementing any provisions of the IHCP and/or ECP.
9. Whenever appropriate, a student with a life-threatening food allergy should be referred to a Section 504 Team for consideration if/when there is reason to believe that the student has a disability that substantially limits a major life activity, as defined by Section 504. Whenever appropriate, students with life-threatening food allergies should be referred to a PPT for consideration of eligibility for special education and related services if there is

reason to suspect that the student has a qualifying disability and requires specialized instruction.

10. When making eligibility determinations under Section 504 and/or the IDEA, schools must consider the student's needs on an individualized, case-by-case basis.

### III. Training/Education

1. The District shall provide appropriate education and training for school personnel regarding the management of students with life threatening food allergies. Such training shall include, as appropriate for each school (and depending on the specific needs of the individual students at the school) training in the administration of medication with cartridge injectors (i.e., epi-pens) and/or preventative strategies to minimize a child's risk of exposure to life-threatening allergens. School personnel will be also be educated on how to recognize symptoms of allergic reactions, and what to do in the event of an emergency. The school nurse will coordinate staff training and education. Any such training regarding the administration of medication shall be done accordance with state law and Board policy.
2. Each school within the district shall also provide age-appropriate information to students about food allergies, how to recognize symptoms of an allergic reaction and the importance of adhering to the school's policies regarding food and/snacks.

### IV. Prevention

Each school within the district will develop appropriate practices to minimize the risk of exposure to life threatening allergens. Practices, which may be considered, may include, but are not limited to:

1. Encouraging hand-washing;
2. Discouraging students from swapping food at lunch or other snack/meal times;
3. Encouraging the use of non-food items as incentives, rewards or in connection with celebrations.

### V. Communication

1. As described above, the school nurse shall be responsible for coordinating the communication between parents, a student's individual health care provider and the school regarding a student's life threatening allergic condition. School staff responsible for implementing a student's IHCP will be notified of their responsibilities and provided with appropriate information as to how to minimize risk of exposure and how to respond in the event of an emergency.
2. Each school will ensure that there are appropriate communication systems available within each school (i.e. telephones, cell phones, walkie-talkies) and for off-site activities (i.e. field trips) to ensure that school personnel are able to effectively respond in case of emergency.
3. The District shall develop standard letters to be sent home to parents, whenever appropriate, to alert them to food restrictions within their child's classroom or school.

4. All district staff are expected to follow district policy and/or federal and state law regarding the confidentiality of student information, including medical information about the student.

VI. Monitoring the District's Plan and Procedures

The District should conduct periodic assessments of its Food Allergy Management Plan and Procedures. Such assessments should occur at least annually and after each emergency event involving the administration of medication to determine the effectiveness of the process, why the incident occurred, what worked and what did not work.

**FOOD ALLERGY TREATMENT PLAN AND  
PERMISSION FOR THE ADMINISTRATION OF MEDICATIONS BY SCHOOL PERSONNEL**

PATIENT'S NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

PATIENT'S ADDRESS: \_\_\_\_\_ TELEPHONE: \_\_\_\_\_

CAAC PHYSICIAN'S NAME: \_\_\_\_\_ PATIENT'S PCP: \_\_\_\_\_

ASTHMA  YES  NO

SPECIFIC FOOD ALLERGY: \_\_\_\_\_

IF PATIENT INGESTS OR THINKS HE/SHE HAS INGESTED THE ABOVE NAMED FOOD:

- \_\_\_\_\_ Observe patient for symptoms of anaphylaxis\*\* for 2 hours
- \_\_\_\_\_ Administer **adrenaline** before symptoms occur, IM EpiPen Jr. Adult
- \_\_\_\_\_ Administer **adrenaline** if symptoms occur, IM EpiPen Jr. Adult
- \_\_\_\_\_ Administer **Benadryl** \_\_\_\_\_ tsp. or Atarax \_\_\_\_\_ tsp. Swish & Swallow
- \_\_\_\_\_ Administer \_\_\_\_\_
- \_\_\_\_\_ Call 911, transport to ER if symptoms occur for evaluation, treatment and observation for 4 hours

IF REACTION OCCURS,  
PLEASE NOTIFY THIS OFFICE! Physician's Signature \_\_\_\_\_ Today's Date \_\_\_\_\_

1. Is this a controlled drug?  Yes  No Time of administration: \_\_\_\_\_

2. Medication shall be administered from \_\_\_\_\_ to \_\_\_\_\_ (dates)

3. Relevant side effects, if any, to be observed: \_\_\_\_\_

4. Other Suggestions: Please allow child to self-administer medication if able to \_\_\_\_\_

Signature: \_\_\_\_\_ M.D. Date: \_\_\_\_\_

**\*\*SYMPTOMS OF ANAPHYLAXIS**

- Chest tightness, cough, shortness of breath, wheezing
- Tightness in throat, difficulty swallowing, hoarseness
- Swelling of lips, tongue, throat
- Itching mouth, itchy skin
- Hives or swelling
- Stomach cramps, vomiting, or diarrhea
- Dizziness or faintness

**I have received, reviewed, and understand the above information.**

\_\_\_\_\_  
Patient/parent/guardian signature  
CAAC/DMC Food Allergy Treatment Plan 01/05  
cps 3/06

\_\_\_\_\_  
Date

**Medical Statement for Children *with* Disabilities  
Requiring Special Meals in Child Nutrition Programs**

**Part I (To be filled out by School)**

Date: \_\_\_\_\_ Name of Child: \_\_\_\_\_  
School Attended by Child: \_\_\_\_\_

**Part II (To be filled out by Physician)**

Patient's Name: \_\_\_\_\_ Age: \_\_\_\_\_

Diagnosis: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Describe the patient's disability and the major life activity affected by the disability:  
\_\_\_\_\_  
\_\_\_\_\_

Does the disability restrict the individual's diet?  Yes  No  
If yes, list food(s) to be **omitted** from the diet and food(s) to be **substituted** (Diet Plan):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List foods that require a change in texture:  
  
Cut up or chopped to bite-size pieces: \_\_\_\_\_  
Finely ground: \_\_\_\_\_  
Pureed: \_\_\_\_\_

**Special Equipment Needed:**  
\_\_\_\_\_  
\_\_\_\_\_

Date \_\_\_\_\_ Signature of Physician \_\_\_\_\_

The U.S. Department of Agriculture (USDA) prohibits discrimination in all its programs and activities on the basis of race, color, national origin, gender, age, or disability. (Not all prohibited bases apply to all programs.) Persons with disabilities who require alternate means for communication of program information (Braille, large print, audiotape, etc.) should contact USDA's TARGET Center at (202) 720-2600 (voice and TDD). To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call (202)720-5964 (voice and TDD). USDA is an equal opportunity provider and employer.

**Medical Statement for Children *without* Disabilities  
Requiring Special Meals in Child Nutrition Programs**

**Part I (To be filled out by School)**

Date: \_\_\_\_\_ Name of Child: \_\_\_\_\_  
School Attended by Child: \_\_\_\_\_

**Part II (To be filled out by Medical Authority)**

Patient's Name: \_\_\_\_\_ Age: \_\_\_\_\_

Diagnosis: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Describe the medical or other special dietary needs that restrict the child's diet:  
\_\_\_\_\_  
\_\_\_\_\_

List food(s) to be omitted from the diet and food(s) to be substituted (Diet Plan):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List foods that require a change in texture:  
  
Cut up or chopped to bite-size pieces: \_\_\_\_\_  
Finely ground: \_\_\_\_\_  
Pureed: \_\_\_\_\_

**Special Equipment Needed:**  
\_\_\_\_\_  
\_\_\_\_\_

Date \_\_\_\_\_ Signature of Medical Authority \_\_\_\_\_

The U.S. Department of Agriculture (USDA) prohibits discrimination in all its programs and activities on the basis of race, color, national origin, gender, age, or disability. (Not all prohibited bases apply to all programs.) Persons with disabilities who require alternate means for communication of program information (Braille, large print, audiotape, etc.) should contact USDA's TARGET Center at (202) 720-2600 (voice and TDD). To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call (202)720-5964 (voice and TDD). USDA is an equal opportunity provider and employer.

Connecticut State Department of Education , April 2004  
cps 3/06

**Policy 5141.21**

**Administration of Medication**

The Board of Education allows students to self-administer medication and school personnel to administer medication to students in accordance with the established procedures, and applicable state regulations, sections 10-212a-1 through 10-212a-10 inclusive. In order to provide immunity afforded to school personnel who administer medication, the Board of Education, with the advice

and approval of the School Medical Advisor and the school nurse supervisor, shall review and/or revise this policy and regulation biennially concerning the administration of medications to District students by a nurse, or in the absence of a nurse, by qualified personnel for schools. The District's School Medical Advisor (or other qualified physician) shall approve this policy, its regulations and any changes prior to adoption by the Board.

### **General Policies on Administration of Medications**

1. Except as provided below in Section D, no medication, including nonprescription drugs, may be administered by any school personnel without:
  - a. the written medication order of an authorized prescriber;
  - b. the written authorization of the student's parent or guardian or eligible student; and
  - c. the written permission of a parent for the exchange of information between the prescriber and the school nurse necessary to ensure safe administration of such medication.
2. Prescribed medications shall be administered to and taken by only the person for whom the prescription has been written.
3. Except as provided in Section D, medications may be administered only by a licensed nurse; or, in the absence of a licensed nurse, by:
  - a. a full-time principal,
  - b. a full-time teacher,
  - c. or a full-time licensed physical or occupational therapist employed by the school district.

A full-time principal, teacher, licensed physical or occupational therapist employed by the school district may administer oral, topical, intranasal or inhalant medications. Such individuals may also administer injectable medications to a student with a medically diagnosed allergic condition that may require prompt treatment to protect the student against serious harm or death.

Students with chronic medical conditions, who are able to self-administer medication, provided all of the following conditions are met:

- a. an authorized prescriber provides a written medication order, including the recommendation for such self-administration;
- b. there is a written authorization for self-administration from the student's parent or guardian or eligible student;
- c. the school nurse has developed a plan for self-administration and general supervision, and has documented the plan in the student's cumulative health record;
- d. the school nurse has assessed the student's competency for self-administration and deemed it safe and appropriate, including that the student: is capable of identifying and selecting the appropriate medication by size, color, amount or other label identification; knows the frequency and time of day for which the medication is ordered; can identify the presenting symptoms that require medication; administers the medication appropriately; maintains

safe control of the medication at all times; seeks adult supervision whenever warranted; and cooperates with the established medication plan.

- e. the principal, appropriate teachers, coaches and other appropriate school personnel are informed the student is self-administering prescribed medication;
- f. such medication is transported to school and maintained under the student's control in accordance with this policy;
- g. controlled drugs, as defined in this policy, may not be self-administered by students, except in extraordinary situations, such as international field trips, with approval of the school nurse supervisor and the school medical advisor in advance and development of an appropriate plan.

Student diagnosed with asthma who is able to self-administer medication shall be permitted to retain possession of an asthmatic inhaler at all times while attending school, in order to provide for prompt treatment to protect such child against serious harm or death, provided all of the following conditions are met:

- a. an authorized prescriber provides a written order requiring the possession of an inhaler by the student at all times in order to provide for prompt treatment in order to protect the child against serious harm or death and authorizing the student's self-administration of medication, and such written order is provided to the school nurse;
- b. there is a written authorization from the student's parent or guardian regarding the possession of an inhaler by the student at all times in order to protect the child against serious harm or death and authorizing the student's self-administration of medication, and such written authorization is provided to the school nurse;
- c. the conditions set forth in subsection (b) above have been met, except that the school nurse's review of a student's competency to self-administer an inhaler for asthma in the school setting shall not be used to prevent a student from retaining and self-administering an inhaler for asthma.

Students may self-administer medication with only the written authorization of an authorized prescriber and written authorization from the student's parent or guardian or eligible student;

- a. the conditions for self-administration meet any regulations as may be imposed by the State Board of Education in consultation with the Commissioner of Public Health.

A student diagnosed with an allergic condition who is able to self-administer medication shall be permitted to retain possession of an automatic prefilled injection cartridge or similar automatic injectable equipment at all times while attending school, in order to provide for prompt treatment to protect such child against serious harm or death, provided all of the following conditions are met:

- a. an authorized prescriber provides a written order requiring the possession of an automatic prefilled injection cartridge or similar automatic injectable equipment by the student at all times in order to provide for prompt treatment in order to protect the child against serious harm or death and authorizing the student's self-administration of medication, and such written order is provided to the school nurse;
- b. there is a written authorization from the student's parent or guardian regarding the possession of an automatic prefilled injection cartridge or similar automatic injectable equipment by the student at all times in order to protect the child against serious harm or

death and authorizing the student's self-administration of medication, and such written authorization is provided to the school nurse;

- c. the conditions set forth in subsection (b) above have been met, except that the school nurse's review of a student's competency to self-administer cartridge injectors for medically diagnosed allergies in the school setting shall not be used to prevent a student from retaining and self-administering a cartridge injector for medically diagnosed allergies. Students may self-administer medication with only the written authorization of an authorized prescriber and written authorization from the student's parent or guardian or eligible student;
- d. the conditions for self-administration meet any regulations as may be imposed by the State Board of Education in consultation with the Commissioner of Public Health

A coach of intramural or interscholastic athletic events or licensed athletic trainer, who has been trained in the administration of medication, during intramural or interscholastic athletic events, may administer inhalant medications prescribed to treat respiratory conditions and/or medication administered with a cartridge injector for students with medically diagnosed allergic conditions which may require prompt treatment to protect the student against serious harm or death, provided all of the following conditions are met:

- a. the school nurse has determined that a self-administration plan is not viable;
- b. the school nurse has provided to the coach a copy of the authorized prescriber's order and parental permission form;
- c. the parent/ guardian has provided the coach or licensed athletic trainer with the medication in accordance with Section H of this policy, and such medication is separate from the medication stored in the school health office for use during the school day; and
- d. the coach or licensed athletic trainer agrees to the administration of emergency medication and implements the emergency care plan, identified in Section E of this policy, when appropriate.

An identified school paraprofessional who has been trained in the administration of medication, provided medication is administered only to a specific student in order to protect that student from harm or death due to a medically diagnosed allergic condition, except as provided in Section D below, and the following additional conditions are met:

- a. medication is administered pursuant to the written order of (A) a physician licensed under chapter 370, (B) an optometrist licensed to practice optometry under chapter 380, (C) an advanced practice registered nurse licensed to prescribe in accordance with section 20-94a of the Connecticut General Statutes, or (D) a physician assistant licensed to prescribe in accordance with section 20-12d of the Connecticut General Statutes; and
- b. medication is administered only with approval by the school nurse and school medical advisor, if any, in conjunction with the school nurse supervisor, and under the supervision of the school nurse; and
- c. the medication to be administered is limited to medications necessary for prompt treatment of an allergic reaction, including, but not limited to, a cartridge injector; and

- d. the paraprofessional shall have received proper training and supervision from the school nurse in accordance with this policy and state regulations

A principal, teacher, licensed athletic trainer, licensed physical or occupational therapist employed by the Board, coach or school paraprofessional, provided medication is antiepileptic medication, including by rectal syringe, administered only to a specific student with a medically diagnosed epileptic condition that requires prompt treatment in accordance with the student's individual seizure action plan, and the following additional conditions are met:

- a. there is written authorization from the student's parents/guardians to administer the medication; and
- b. a written order for such administration has been received from the student's physician licensed under Chapter 370 of the Connecticut General Statutes; and
- c. the principal, teacher, licensed athletic trainer, licensed physical or occupational therapist employed by the Board, coach or school paraprofessional is selected by the school nurse and school medical advisor, if any, and voluntarily agrees to administer the medication; and
- d. the principal, teacher, licensed athletic trainer, licensed physical or occupational therapist employed by the Board, coach or school paraprofessional annually completes the training program established by the Connecticut State Department of Education and the Association of School Nurses of Connecticut, and the school nurse and medical advisor, if any, have attested, in writing, that such training has been completed; and
- e. the principal, teacher, licensed athletic trainer, licensed physical or occupational therapist employed by the Board, coach or school paraprofessional receives monthly reviews by the school nurse to confirm competency to administer antiepileptic medication.
- f. a director of a school readiness program or a before or after school program, or the director's designee, provided that the medication is administered:
  - i. only to a child enrolled in such program; and
  - ii. in accordance with Section K of this policy.

A licensed practical nurse, after the school nurse has established the medication plan, provided that the licensed practical nurse may not train or delegate the administration of medication to another individual, and provided that the licensed practical nurse can demonstrate one of the following:

- a. training in administration of medications as part of their basic nursing program;
- b. successful completion of a pharmacology course and subsequent supervised experience; or
- c. supervised experience in the administration of medication while employed in a health care facility.

Medications may also be administered by a parent or guardian to his/her own child on school grounds.

Investigational drugs or research or study medications may be administered only by a licensed nurse. For FDA-approved medications being administered according to a study protocol, a copy of the study protocol shall be provided to the school nurse along with the name of the medication to be administered and the acceptable range of dose of such medication to be administered.

## Diabetic Students

1. The New London of Education permits blood glucose testing by students who have a written order from a physician stating the need and capability of such student to conduct self-testing.
2. The Board will not restrict the time or location of blood glucose testing by a student with diabetes on school grounds who has written authorization from a parent or guardian and a written order from a physician stating that such child is capable of conducting self-testing on school grounds.
3. In the absence or unavailability of the school nurse, select school employees may administer medication with injectable equipment used to administer glucagon to a student with diabetes that may require prompt treatment in order to protect the student against serious harm or death, under the following conditions:
  - a. The student's parent or guardian has provided written authorization.
  - b. A written order for such administration has been received from the student's physician licensed under Chapter 370 of the Connecticut General Statutes.
  - c. The school employee is selected by either the school nurse or principal and is a principal, teacher, licensed athletic trainer, licensed physical or occupational therapist employed by a school district, coach or school paraprofessional.
  - d. The school nurse shall provide general supervision to the selected school employee.

The selected school employee annually completes any training required by the school nurse and school medical advisor in the administration of medication with injectable equipment used to administer glucagon.

### **D. Epinephrine for Purposes of Emergency First Aid without Prior Authorization**

- a. The school nurse attested in writing that selected school employee completed the required training.
  - b. The selected school employee voluntarily agrees to serve as one who may administer medication with injectable equipment used to administer glucagon to a student with diabetes that may require prompt treatment in order to protect the student against serious harm or death.
1. For purposes of this Section D, “regular school hours” means the posted hours during which students are required to attend at the individual school on any given day.
  2. The school nurse shall maintain epinephrine in cartridge injectors for the purpose of emergency first aid to students who experience allergic reactions and do not have prior written authorization of a parent or guardian or a prior written order of a qualified medical professional for the administration of epinephrine.
    - a. The school nurse, in consultation with the school nurse supervisor, shall determine the supply of epinephrine in cartridge injectors that shall be available in the individual school.

- b. In determining the appropriate supply of epinephrine in cartridge injectors, the nurse may consider, among other things, the number of students regularly in the school building during the regular school day and the size of the physical building.
3. The school nurse or school principal shall select principal(s), teacher(s), licensed athletic trainer(s), licensed physical or occupational therapist(s) employed by the Board, coach(es) and/or school paraprofessional(s) to maintain and administer the epinephrine in cartridge injectors for the purpose of emergency first aid as described in Paragraph (1) above, in the absence of the school nurse.
  - a. More than one individual must be selected by the school nurse or school principal for such maintenance and administration in the absence of the school nurse.
  - b. The selected personnel, before conducting such administration, must annually complete the training made available by the Department of Education for the administration of epinephrine in cartridge injectors for the purpose of emergency first aid.
  - c. The selected personnel must voluntarily agree to complete the training and administer epinephrine in cartridge injectors for the purpose of emergency first aid.
4. Either the school nurse or, in the absence of the school nurse, at least one of the selected and trained personnel as described in Paragraph (2) above shall be on the grounds of each school during regular school hours.
  - a. The school principal, in consultation with the school nurse supervisor, shall determine the level of nursing services and number of selected and trained personnel necessary to ensure that a nurse or selected and trained personnel is present on the grounds of each school during regular school hours;
  - b. If the school nurse, or a substitute school nurse, is absent or must leave school grounds during regular school hours, the school nurse, school administrator or designee shall send an email to all staff indicating that the selected and trained personnel identified in Paragraph (2) above shall be responsible for the emergency administration of epinephrine.
5. The administration of epinephrine pursuant to this section must be done in accordance with this policy, including but not limited to the requirements for documentation and record keeping, errors in medication, emergency medical procedures, and the handling, storage and disposal of medication; and the Regulations adopted by the Department of Education.
6. The parent or guardian of any student may submit, in writing, to the school nurse or school medical advisor, if any, that epinephrine shall not be administered to such student pursuant to this section.
  - a. The school nurse shall notify selected and trained personnel of the students whose parents or guardians have refused emergency administration of epinephrine;
  - b. The Board shall annually notify parents or guardians of the need to provide such written notice.
7. Following the emergency administration of epinephrine by selected and trained personnel as identified in this section:

- a. Such emergency administration shall be reported immediately to:
  - i. The school nurse or school medical advisor, if any, by the personnel who administered the epinephrine; and
  - ii. The student's parent or guardian, by the school nurse or personnel who administered the epinephrine.
- b. A medication administration record shall be:
  - i. Submitted to the school nurse by the personnel who administered the epinephrine as soon as possible, but no later than the next school day; and
  - ii. filed in or summarized on the student's cumulative health record, in accordance with Section E of this policy.

### **Documentation and Record Keeping**

1. Each school or before-and-after school program and school readiness program where medications are administered shall maintain an individual medication administration record for each student who receives medication during school or program hours. This record shall include the following information:
  - a. the name of the student;
  - b. the student's state-assigned student identifier
  - c. the name of the medication;
  - d. the dosage of the medication;
  - e. the route of the administration, (i.e., oral, topical, inhalant, etc.);
  - f. the frequency of administration;
  - g. the name of the authorized prescriber;
  - h. the dates for initiating and terminating the administration of medication, including extended year programs;
  - i. the quantity received at school and verification by the adult delivering the medication of the quantity received;
  - j. the date the medication is to be reordered (if any);
  - k. any student allergies to food and/or medication(s);
  - l. the date and time of each administration or omission, including the reason for any omission;
  - m. the dose or amount of each medication administered; and,
  - n. the full written or electronic legal signature of the nurse or other authorized school personnel administering the medication;
  - o. conducted and documented at least once a week and co-signed by the assigned nurse and a witness.
2. All records are either to be made in ink and shall not be altered, or recorded electronically in a record that cannot be altered.
3. Written orders of authorized prescribers, written authorizations of parent or guardian, the written parental permission for the exchange of information by the prescriber and school nurse to ensure safe administration of such medication, and the completed medication administration record for each student shall be filed in the student's cumulative health record or, for before-and-after school programs and school readiness programs, in the child's program record.

4. Authorized prescribers may make verbal orders, including telephone orders, for a *change* in medication order. Such verbal orders may be received only by a school nurse and must be followed by a written order, which may be faxed, and must be received within three (3) school days.
5. Medication administration records will be made available to the Department of Education for review until destroyed pursuant to Section 11-8a and Section 10-212a(b) of the Connecticut General Statutes.
  - a. The completed medication administration record for no controlled medications may, at the discretion of the school district, be destroyed in accordance with Section MS of the Connecticut Record Retention Schedules for Municipalities, so long as it is superseded by a summary on the student health record.
  - b. The completed medication administration record for controlled medications shall be maintained in the same manner as the no controlled medications. In addition, a separate medication administration record needs to be maintained in the school for three (3) years pursuant to Section 10-212a(b) of the Connecticut General Statutes.
6. Documentation of any administration of medication by a coach or licensed athletic trainer shall be completed on forms provided by the school and the following procedures shall be followed:
  - a. a medication administration record for each student shall be maintained in the athletic offices;
  - b. administration of a cartridge injector medication shall be reported to the school nurse at the earliest possible time, but no later than the next school day;
  - c. all instances of medication administration, except for the administration of cartridge injector medication, shall be reported to the school nurse at least monthly, or as frequently as required by the individual student plan; and
  - d. the administration of medication record must be submitted to the school nurse at the end of each sports season and filed in the student's cumulative health record.

### **Errors in Medication Administration**

7. Whenever any error in medication administration occurs, the following procedures shall apply:
  - a. the person making the error in medication administration shall immediately implement the medication emergency procedures in this policy if necessary;
  - b. the person making the error in medication administration shall in all cases immediately notify the school nurse, principal, school nurse supervisor, and authorized prescriber. The person making the error, in conjunction with the principal, shall also immediately notify the parent or guardian, advising of the nature of the error and all steps taken or being taken to rectify the error, including contact with the authorized prescriber and/or any other medical action(s).
  - c. the principal shall notify the Superintendent or the Superintendent's designee.

8. The school nurse, along with the person making the error, shall complete a report using the authorized medication error report form. The report shall include any corrective action taken.
9. Any error in the administration of medication shall be documented in the student's cumulative health record or, for before-and-after school programs and school readiness programs, in the child's program record.
10. These same procedures shall apply to coaches and licensed athletic trainers during intramural and interscholastic events, except that if the school nurse is not available, a report must be submitted by the coach or licensed athletic trainer to the school nurse the next school day

### **Medication Emergency Procedures**

1. Whenever a student has a life-threatening reaction to administration of a medication, resolution of the reaction to protect the student's health and safety shall be the foremost priority. The school nurse and the authorized prescriber shall be notified immediately, or as soon as possible in light of any emergency medical care that must be given to the student.
2. Emergency medical care to resolve a medication emergency includes but is not limited to the following, as appropriate under the circumstances:
  - a. use of the 911 emergency response system;
  - b. application by properly trained and/or certified personnel of appropriate emergency medical care techniques, such as cardiopulmonary resuscitation;
  - c. administration of emergency medication in accordance with this policy;
  - d. contact with a poison control center; and
  - e. transporting the student to the nearest available emergency medical care facility that is capable of responding to a medication emergency.
3. As soon as possible, in light of the circumstances, the principal shall be notified of the medication emergency. The principal shall immediately thereafter contact the Superintendent or the Superintendent's designee, who shall thereafter notify the parent or guardian, advising of the existence and nature of the medication emergency and all steps taken or being taken to resolve the emergency and protect the health and safety of the student, including contact with the authorized prescriber and/or any other medical action(s) that are being or have been taken.

### **Supervision**

1. The school nurse is responsible for general supervision of administration of medications in the school(s) to which that nurse is assigned.
2. The school nurse's duty of general supervision includes, but is not limited to the following:
  - a. availability on a regularly scheduled basis to:
    - i. review orders or changes in orders, and communicate these to personnel designated to give medication for appropriate follow-up;

- ii. set up a plan and schedule to ensure medications are given properly;
  - iii. provide training to licensed nursing personnel, full-time principals, full-time teachers, full-time licensed physical or occupational therapists employed by the school district, coaches of intramural and interscholastic athletics, licensed athletic trainers and to identified paraprofessionals designated in accordance with Section B(3)(t), above, which training shall pertain to the administration of medications to students, and assess the competency of these individuals to administer medication;
  - iv. support and assist other licensed nursing personnel, fulltime principals, full-time teachers, full-time licensed physical or occupational therapists employed by the school district, coaches of intramural and/or interscholastic athletics, licensed athletic trainers and identified paraprofessionals designated in accordance with Section B(3)(t), above, to prepare for and implement their responsibilities related to the administration of specific medications during school hours and during intramural and interscholastic athletics as provided by this policy;
  - v. provide appropriate follow-up to ensure the administration of medication plan results in desired student outcomes; and
  - vi. provide consultation by telephone or other means of telecommunications, which consultation may be provided by an authorized prescriber or other nurse in the absence of the school nurse.
- b. In addition, the school nurse shall be responsible for:  
implementing policies and procedures regarding the receipt, storage, and administration of medications;
- i. reviewing, on a periodic basis, all documentation pertaining to the administration of medications for students;
  - ii. performing observations of the competency of medication administration by full-time principals, full-time teachers, full-time licensed physical or occupational therapists employed by the school district, coaches of intramural and/or interscholastic athletics and licensed athletic trainers in accordance with Section B(3)(e), above, and identified paraprofessionals designated in accordance with Section B(3)(f), above, who have been newly trained to administer medications; and
  - iii. conducting periodic reviews, as needed, with licensed nursing personnel, full-time principals, full-time teachers, full-time licensed physical or occupational therapists employed by the school district, coaches of intramural and/or interscholastic athletics and licensed athletic trainers in accordance with Section B(3)(e), above, and identified paraprofessionals designated in accordance with Section B(3)(f), above, regarding the needs of any student receiving medication.

### **Training of School Personnel**

1. Full-time principals, full-time teachers, full-time licensed physical or occupational therapists employed by the school district, coaches of intramural and/or interscholastic

- athletics and licensed athletic trainers in accordance with Section B(3)(e), above, and identified paraprofessionals designated in accordance with Section B(3)(f), above, who are designated to administer medications shall at least annually receive training in their safe administration; and only trained full-time principals, full-time teachers, full-time licensed physical or occupational therapist employed by the school district, coaches of intramural and/or interscholastic athletics and licensed athletic trainers in accordance with Section B(3)(e), above, and identified paraprofessionals designated in accordance with Section B(3)(f), above, shall be allowed to administer medications.
2. Training for full-time principals, full-time teachers, full-time licensed physical or occupational therapists employed by the school district, coaches of intramural and/or interscholastic athletics and licensed athletic trainers in accordance with Section B(3)(e), above, and identified paraprofessionals designated in accordance with Section B(3)(f), above, shall include, but is not necessarily limited to the following:
    - a. the general principles of safe administration of medication;
    - b. the procedures for administration of medications, including the safe handling and storage of medications, and the required recordkeeping;
    - c. specific information related to each student's medication plan, including the name and generic name of the medication, indications for medication dosage, routes, time and frequency of administration, therapeutic effects of the medication, potential side effects, overdose or missed doses of the medication, and when to implement emergency interventions.
  3. The principal(s), teacher(s), licensed athletic trainer(s), licensed physical or occupational therapist(s) employed by the Board, coach(es) and/or school paraprofessional(s) who administer epinephrine as emergency first aid, pursuant to Section D above, shall annually complete the training program developed by the Departments of Education and Public Health and training in cardiopulmonary resuscitation and first aid.
  4. The Board shall maintain documentation of medication administration training as follows:
    - a. dates of general and student-specific trainings;
    - b. content of the trainings;
    - c. individuals who have successfully completed general and student specific administration of medication training for the current school year; and
    - d. names and credentials of the nurse or school medical advisor, if any, trainer or trainers.
  5. Licensed practical nurses may not conduct training in the administration of medication to another individual.

### **Handling, Storage and Disposal of Medications**

1. All medications, except those approved for transporting by students for self-medication, those administered by coaches of intramural or interscholastic athletics or licensed athletic trainers in accordance with Section B(3)(e) above, and epinephrine to be used for emergency first aid in accordance with Section D above, must be delivered by the parent,

guardian, or other responsible adult to the nurse assigned to the student's school or, in the absence of such nurse, the school principal who has been trained in the appropriate administration of medication. Medications administered by coaches of intramural or interscholastic athletics or licensed athletic trainers must be delivered by the parent or guardian directly to the coach or licensed athletic trainer in accordance with Section B(3)(e) above.

2. The nurse shall examine on-site any new medication, medication order and the required authorization to administer form, and, except for epinephrine to be used, as emergency first aid in accordance with Section D above, shall develop a medication administration plan for the student before any medication is given to the student by any school personnel. No medication shall be stored at a school without a current written order from an authorized prescriber
3. The school nurse shall review all medication refills with the medication order and parent authorization prior to the administration of medication, except for epinephrine intended for emergency first aid in accordance with Section D above.
4. Emergency Medications
  - a. Except as otherwise determined by a student's emergency care plan, emergency medications shall be stored in an unlocked, clearly labeled and readily accessible cabinet or container in the health room during school hours under the general supervision of the school nurse, or in the absence of the school nurse, the principal or the principal's designee who has been trained in the administration of medication;
  - b. Emergency medication shall be locked beyond the regular school day or program hours, except as otherwise determined by a student's emergency care plan.
5. All medications, except those approved for keeping by students for self-medication, shall be kept in a designated and locked location, used exclusively for the storage of medication. Controlled substances shall be stored separately from other drugs and substances in a separate, secure, substantially constructed, locked metal or wood cabinet.
6. Access to stored medications shall be limited to persons authorized to administer medications. Each school or before-and-after school program and school readiness program shall maintain a current list of such authorized persons.
7. All medications, prescription and non-prescription, shall be delivered and stored in their original containers and in such a manner that renders them safe and effective.
8. At least two sets of keys for the medication containers or cabinets shall be maintained for each school building or before-and-after school program and school readiness program. One set of keys shall be maintained under the direct control of the school nurse or nurses and an additional set shall be under the direct control of the principal and, if necessary, the program director or lead teacher who has been trained in the general principles of the administration of medication shall also have a set of keys.
9. Medications that must be refrigerated shall be stored in a refrigerator, at no less than 36 degrees Fahrenheit and no more than 46 degrees Fahrenheit. The refrigerator must be located in the health office that is maintained for health services with limited access. Non-

controlled medication may be stored directly on the refrigerator shelf with no further protection needed. Controlled medication shall be stored in a locked box that is affixed to the refrigerator shelf.

10. All unused, discontinued or obsolete medications shall be removed from storage areas and either returned to the parent or guardian or, if the medication cannot be returned to the parent or guardian, the medication shall be destroyed in collaboration with the school nurse:
  - a. non controlled drugs shall be destroyed in the presence of at least one witness;
  - b. controlled drugs shall be destroyed in pursuant to Section 21 a-262- 3 of the Regulations of Connecticut State Agencies
  - c. accidental destruction or loss of controlled drugs must be verified in the presence of a second person, including confirmation of the presence or absence of residue and jointly documented on the student medication administration record and on a medication e1Tor form pursuant to Section 10-212a(b) of the Connecticut General Statutes. If no residue is present, notification must be made to the Department of Consumer Protection pursuant to Section 21a-262-3 of the Regulations of Connecticut State Agencies.
11. Medications to be administered by coaches of intramural or interscholastic athletic events or licensed athletic trainers shall be stored:
  - a. in containers for the exclusive use of holding medications;
  - b. in locations that preserve the integrity of the medication;
  - c. under the general supervision of the coach or licensed athletic trainer trained in the administration of medication; and
  - d. in a locked secured cabinet when not under the general supervision of the coach or licensed athletic trainer during intramural or interscholastic athletic events.
12. In no event shall a school store more than a three (3) month supply of a medication for a student.

## **School Readiness Programs and Before-and-After School Programs**

1. As determined by the school medical advisor, if any, and school nurse supervisor, the following procedures shall apply to the administration of medication during school readiness programs and before-and-after school programs run by the Board, which are exempt from licensure by the Office of Early Childhood:
  - a. Administration of medication at these programs shall be provided only when it is medically necessary for participants to access the program and maintain their health status while attending the program.
  - b. Except as provided by Section D above, no medication shall be administered in these programs without:
    - i. the written order of an authorized prescriber; and
    - ii. the written authorization of a parent or guardian or an eligible student.
  - c. A school nurse shall provide consultation to the program director, lead teacher or school administrator who has been trained in the administration of medication regarding the safe administration of medication within these programs. The school medical advisor and school nurse supervisor shall determine whether, based on the population of the school readiness program and/or before-and-afterschool program, additional nursing services are required for these programs.
  - d. Only school nurses, directors or directors' designees, lead teachers or school administrators who have been properly trained may administer medications to students as delegated by the school nurse or other registered nurse or other registered nurse. Properly trained directors or directors' designees, lead teachers or school administrators may administer oral, topical, intranasal or inhalant medications. Investigational drugs or research or study medications may not be administered in these programs.
  - e. Students attending these programs may be permitted to self-medicate only in accordance with the provisions of Section B(3) of this policy. In such a case, the school nurse must provide the program director, lead teacher or school administrator running the program with the medication order and parent permission for self-administration.
  - f. In the absence of the school nurse during program administration, the program director, lead teacher or school administrator is responsible for decision making regarding medication administration.
  - g. Cartridge injector medications may be administered by a director, lead teacher or school administrator only to a student with a medically diagnosed allergic condition, which may require prompt treatment to protect the student against serious harm or death.
2. Local poison control center information shall be readily available at these programs.
3. Procedures for medication emergencies or medication errors, as outlined in this policy, must be followed, except that in the event of a medication error a report must be submitted

by the program director, lead teacher or school administrator to the school nurse the next school day.

4. Training for directors or directors' designees, lead teachers or school administrators in the administration of medication shall be provided in accordance with Section I of this policy.
5. All medications must be handled and stored in accordance with Section H of this policy. Where possible, a separate supply of medication shall be stored at the site of the before-and-after or school readiness program. In the event that it is not possible for the parent or guardian to provide a separate supply of medication, then a plan shall be in place to ensure the timely transfer of the medication from the school to the program and back on a daily basis.
6. Documentation of any administration of medication shall be completed on forms provided by the school and the following procedures shall be followed:
  - a. a medication administration record for each student shall be maintained by the program;
  - b. administration of a cartridge injector medication shall be reported to the school nurse at the earliest possible time, but no later than the next school day;
  - c. all instances of medication administration, except for the administration of cartridge injector medication, shall be reported to the school nurse at least monthly, or as frequently as required by the individual student plan; and
  - d. the administration of medication record must be submitted to the school nurse at the end of each school year and filed in the student's cumulative health record.
7. The procedures for the administration of medication at school readiness programs and before-and-after school programs shall be reviewed annually by the school medical advisor, if any, and school nurse supervisor.

#### **L. Review and Revision of Policy**

In accordance with the provisions of Section 10-212a-2(a), the New London Board of Education shall review this policy periodically, and at least biennially, with the advice and approval of the school medical advisor, if any, or other qualified licensed physician, and the school nurse supervisor. Any proposed revisions to the policy must be made with the advice and approval of the school medical advisor, school nurse supervisor or other qualified licensed physician.

**NEW LONDON PUBLIC SCHOOLS  
New London, Connecticut  
REFUSAL TO PERMIT ADMINISTRATION  
OF EPINEPHRINE FOR EMERGENCY FIRST AID**

Name of Child: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address of Child: \_\_\_\_\_

Name of Parent(s): \_\_\_\_\_

Address of Parent(s): \_\_\_\_\_ (if different from child)

Connecticut law requires the school nurse and other qualified school personnel in all public schools to maintain epinephrine in cartridge injectors (EpiPens) for the purpose of administering emergency first aid to students who experience allergic reactions and do not have a prior written authorization of a parent or guardian or a prior written order of a qualified medical professional for the administration of epinephrine. State law permits the parent or guardian of a student to submit a written directive to the school nurse or school medical advisor that epinephrine shall not be administered to such student in emergency situations. This form is provided for those parents who refuse to have epinephrine administered to their child. The refusal is valid for only for the 20\_\_ - 20\_\_ school year.

I, the parent/guardian of \_\_\_\_\_

*Print name of student*

refuse to permit the administration of epinephrine to the above named student for purposes of emergency first aid in the case of an allergic reaction.

\_\_\_\_\_  
Signature of Parent/Guardian Date

Please return the completed original form to your child's school nurse or school medical advisor.

\_\_\_\_\_  
Name of Medical Advisor

\_\_\_\_\_  
Address of Medical Advisor

**5141.231**  
**4118.234**

### **Psychotropic Drug Use**

The Board of Education prohibits all school personnel from recommending the use of psychotropic drugs for any student enrolled within the school system. For purposes of this policy, the term "recommend" shall mean to directly or indirectly suggest that a child use psychotropic drugs.

Psychotropic drugs are defined as prescription medications for behavioral or social-emotional concerns, such as attentional deficits, impulsivity, anxiety, depression and thought disorders and includes, but is not limited to stimulant medications and anti-depressants.

However, school health or mental health personnel, including school nurses or nurse practitioners, the District's Medical Advisor, school psychologists, school social workers, and school counselors may recommend that a student be evaluated by an appropriate medical practitioner.

The District shall follow procedures for identification, evaluation, placement and delivery of services to children with disabilities or suspected disabilities provided in state and federal statutes that govern special education.

Communications between and among school health, mental health personnel and other school personnel pertaining to a child in possible need of a recommendation for a medical

evaluation shall be accomplished through the District's established child study teams and/or the planning and placement team and its procedures, in conformity with state and federal special education statutes.

### **Psychotropic Drug Use**

In order to properly implement the Board policy prohibiting school personnel from recommending the use of psychotropic drugs for any child, the following administrative regulations are hereby established:

1. Psychotropic drugs are defined as prescription medications for behavioral or social-emotional concerns, such as attention deficits, impulsivity, anxiety, depression and thought disorders.
2. Psychotropic drugs include, but are not limited to, Ritalin, Adderal, Dexedrine and other stimulant medication, and anti-depressants.
3. All school personnel, including teachers and administrators are prohibited from any communications, both oral and written, to the parents and/or guardians of a child in which the use of psychotropic drugs is recommended.
4. School health or mental health personnel which includes school nurses or nurse practitioners, the District Medical Advisor, school psychologists, school social workers, and school counselors are permitted to discuss with parents and/or guardians of a child the advisability of a medical evaluation by an appropriate medical practitioner when there are behaviors or concerns that may be indicative of medication considerations.
5. School personnel, through the Planning and Placement Team and/or Child Study Team referral process, shall communicate to the school medical staff about a child's behavior that may indicate the need for an evaluation.
6. The Planning and Placement Team (PPT) has the authority and responsibility to recommend a medical evaluation as part of an initial evaluation or reevaluation as needed to determine a child's eligibility for special education and related services, or educational needs for a child's individualized education program (IEP).
7. As required, the District may seek remedy through the due process provisions allowed under the Individuals with Disabilities Educational Act (IDEA) if a parent and/or guardian refuses consent for a reevaluation.
8. Appropriate medical practitioners, such as a psychiatric consultant or physician, with whom the District contracts for services to students or to whom the District makes a referral for an evaluation may recommend such medications.
9. School personnel may consult with the medical practitioner performing the evaluation with the informed consent of the parent or guardian of the child. The purposes of such communication include the following:
  - a. Conveying concerns or observations of a child, both prior to and following a medical evaluation;
  - b. Requesting health records and other educationally relevant medical evaluations;

- c. Providing school records to medical practitioners upon request;
  - d. Providing information on school performance to help a medical practitioner monitor and evaluate the effectiveness of psychotropic drugs and/or other medical interventions and/or treatment;
  - e. Discussing with medical practitioners appropriate and necessary nursing or health care in schools to ensure student safety;
  - f. Disclosure of educationally relevant information by the medical practitioner to school personnel.
10. The Department of Children and Families (DCF) is prohibited by state law from taking a child into custody solely on the refusal of a parent or guardian to administer or consent to the administration of any psychotropic drug. However, a PPT meeting may be convened if the child is eligible or may be eligible for special education or making a referral to the Department of Children and Families if there are concerns about a child's safety and possible abuse or neglect.

**Medication Error or Incident Report**

Date of Report: \_\_\_\_\_ School: \_\_\_\_\_ Prepared by: \_\_\_\_\_

Name of Student: \_\_\_\_\_ Grade: \_\_\_\_\_

Home Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**Date Error Occurred:** \_\_\_\_\_ **Time Noted:** \_\_\_\_\_

Person Administering Medication: \_\_\_\_\_

Prescribing Practitioner: \_\_\_\_\_

Reason medication was prescribed: \_\_\_\_\_

Date of Order: \_\_\_\_\_ Instructions for Administration: \_\_\_\_\_

Medication(s)	Dose	Route	Scheduled Time	Dispensing Pharmacy	Prescription #

**Describe the error and how it occurred (use reverse side if necessary):** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Action Taken:**

Prescribing practitioner notified: YES \_\_\_\_\_ NO \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Parent Notified: YES \_\_\_\_\_ NO \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

**Outcome:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Print or Type

Title: \_\_\_\_\_ Date: \_\_\_\_\_

*Record of Education/Supervision for Principal/Teachers in Medication Administration*

**FOR INDIVIDUAL STUDENTS**

**School Year:** \_\_\_\_\_ **School Building:** \_\_\_\_\_ **Responsible School Nurse:** \_\_\_\_\_

<b>Principal/Teacher</b>	<b>Students</b>	<b>Date of Education</b>	<b>Medications</b>	<b>Idiosyncrasies</b>	<b>Desired Effects</b>	<b>Untoward Effects</b>	<b>Contra-indication</b>	<b>Dates of Return Demo</b>	<b>Dates Direct Supervision</b>

**POTASSIUM IODIDE (KI) FACT SHEET AND PERMISSION FORM**

The State of Connecticut is making Potassium Iodide tablets (KI) available to child care facilities and youth camps within the 10-mile emergency –planning zone around Millstone Power Station in Waterford, CT. KI is a form of iodine. It helps to protect the thyroid gland when there is a chance that you might be exposed to a harmful amount of radioactive iodine. In the rare event of a nuclear emergency, your child care provider will be directed when to administer KI through the Emergency Alert System (EAS). Children in child care and youth camps are of the age most likely to suffer the effects of radioactive iodine. Your childcare program or youth camp must obtain your written consent in order to administer KI pills to your child/children. Please remember that the administration of KI to your child under these emergency conditions is voluntary.

**Contraindications:**

- \*Your child should not take Potassium Iodide if he/she is allergic to iodine.
- \*Your child should not take Potassium Iodide if he/she has chronic hives.
- \*Although a single tablet of KI should be tolerated by most people, some (particularly adults), with a number of rare diseases and conditions should discuss this issue with their physicians. These conditions include:
  - \*Hypocomplementemic vasculitis, possibly as a component of lupus or chronic hives,
  - \*Autoimmune thyroid disease, such as Graves disease.

**Potential side Effects:**

Please consult with your pediatrician if your child experiences any of these side effects:

- \*Minor upset stomach
- \*Rash

**POTASSIUM IODIDE (KI) CHILD MEDICATION AUTHORIZATION FORM**

Name of Child: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Street \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Please indicate your authorization or refusal by marking the appropriate line below:

\_\_\_\_\_ YES, I want my above named child to be administered KI by my provider when:  
 The Governor declares a nuclear emergency, AND individuals in specified area, that includes this child care facility/youth camp, are advised by the Emergency Alert System (AES) to take the Potassium Iodide (KI) tablets AND I understand that the ingestion of Potassium Iodide (KI) under these circumstances is voluntary.

\_\_\_\_\_ NO, I do NOT want my above named child to be given Potassium Iodide (KI) by my provider in the event of a nuclear emergency. I have been advised in writing by the facility about the contraindications and the potential side effects of taking Potassium Iodide. I understand that it is my responsibility to notify my provider in writing if I desire to change my authorization as indicated above.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

**Communicable/Infectious Diseases Policy**

The New London Board of Education recognizes that all children have a constitutional right to a free, suitable program of educational experiences. The Board also recognizes that it has a responsibility to assure that the New London Public Schools provide a safe environment for all of its students and employees.

To that end, the Board adopts the following policy for educating students known to have a chronic infectious disease, such as AIDS/HIV infection, Cytomegalovirus (CMV), Hepatitis B or C, or Herpes Simplex, and for ensuring a safe and healthy environment for all students.

1. As a general rule and with the approval of the child's physician, a child with a chronic infectious disease will be allowed to attend school in a regular classroom setting and will be considered eligible for all rights, privileges, and services provided by law and existing policy of the New London Board of Education.
2. With the written permission of a parent or guardian, the school nurse will function as the:
  - a. Liaison with the child's physician,
  - b. Child's advocate in the school by assisting in problem resolution, answering questions, and by performing similar functions, and
  - c. Coordinator of services provided by other staff.
3. Each school will respect the right to privacy of the child and maintain strict confidentiality of any records containing health information. Therefore, knowledge that a child has a chronic infectious disease shall be confined to those persons authorized by the parent or guardian and with a direct need to know. Those persons will be provided with appropriate information concerning the child's needs and such precautions as may be necessary.
4. Based upon individual circumstances, special programming may be warranted. Special education may be provided if a Planning and Placement Team (PPT) determines it necessary.
5. Under certain circumstances a child with a chronic infectious disease might pose a risk of transmission to others. If any such circumstances exist, the school Medical Advisor, in consultation with the school nurse and the child's physician, must determine whether a risk of transmission exists in the school. If the school Medical Advisor determines that a risk exists, the student shall be removed from the classroom.
6. A child with a chronic infectious disease may be temporarily removed from the classroom for the reasons stated in #5 until an appropriate school program adjustment can be made, an appropriate alternative educational program can be established, or the Medical Advisor determines that the risk has abated and the child can return to the classroom.
  - a. Removal from the classroom will not be construed to be the only response to reduce risk of transmission. School personnel should be flexible in developing alternatives and should attempt to use the least restrictive means to accommodate the child's needs.
  - b. In any case of temporary removal of the student from the school setting, regulations of the State of Connecticut and school practice regarding home-bound instruction shall apply.
7. Each removal of a child with chronic infectious disease from normal school attendance will be reviewed by the school medical advisor in consultation with the parent or guardian and the student's physician and supervising school nurse at least once every month to determine whether the condition precipitating the removal has changed.

8. A child with a chronic infectious disease may need to be removed from the classroom for his or her own protection when other communicable diseases, such as measles or chicken pox, are occurring in the school population. This decision will be made by the child's physician and the parent or guardian in consultation with the school nurse and/or the school Medical Advisor.
9. In accordance with Board policy and as mandated by Federal law and regulations of the Occupational Safety Health Administration (OSHA), routine and standard procedures will be used to clean up after a child has an accident or injury at school. The following procedures shall be followed:
  - a. Blood or other body fluids emanating from any child, including ones known to have a chronic infectious disease, should be treated cautiously.
  - b. Gloves should be worn when cleaning up blood spills. These spills should be disinfected with either bleach or another disinfectant, and persons coming into contact with them should wash their hands afterwards.
  - c. Blood-soaked items would be placed in labeled and leak proof bags for washing or further disposition.
  - d. Similar procedures have been adopted for dealing with vomitus and fecal or urinary incontinence in any child.
  - e. Hand washing after contact with a school child is not routinely recommended unless physical contact has been made with the child's blood or body fluids, including saliva.
  - f. Exposure incidents are reported, documented and treated according to OSHA regulations.

A child with an infectious disease may be considered handicapped, if the child presents such physical impairment that limits one or more major life activities. Therefore, Section 504 of the Rehabilitation Act may apply. The parent or guardian or the school administration may make a referral for a determination whether the student is handicapped and entitled to protection under Section 504. The Planning and Placement Team will conduct an Individual Placement Program (IPP) to determine whether the student is handicapped or is "otherwise qualified" within the meaning of Section 504. The student will be educated in the least restrictive environment.

**NEW LONDON PUBLIC SCHOOLS**

<b>COMMON COMMUNICABLE DISEASES DISEASE</b>	<b>EXCLUSION FROM SCHOOL POLICY</b>
<b>Chicken pox</b>	until lesions are crusted
<b>Conjunctivitis</b>	Children with bacterial infections of the eye may return 24 hours after antibiotic therapy and has permission from the physician to return to school
<b>COVID - 19</b>	Those who test positive should isolate for 5 days with the day of the positive test or symptom onset being Day 0. After the 5 day isolation period, students and staff are allowed to return to school if they have been fever free for 24 hours. Individuals returning from a positive COVID case must wear a mask from day 6 to day 10.
<b>Elevated Temperature (100 degrees or over)</b>	A full 24 hours after the child is afebrile (99.9 degrees or lower) without the need for antipyretics.
<b>German Measles (Rubella)</b>	<b>6</b> days after onset of rash
<b>Impetigo</b>	Has received appropriate medically prescribed therapy for 24 hrs. and has permission from the physician to return to school
<b>Hepatitis</b>	Has physician's permission to return to school
<b>Infectious Mononucleosis</b>	No set time – only while illness lasts, has permission from physician to return to school
<b>Measles</b>	5 days after appearance of rash

<b>Meningitis</b>	No set time – only while illness lasts, has permission from physician to return to school
<b>Mumps</b>	Until swelling has subsided or not less than 9 days after onset of parotid swelling
<b>Ringworm of Scalp</b>	None, if under proper treatment
<b>Scabies</b>	Has received appropriate medically prescribed treatment for 24 hrs. and has permission from physician to return to school
<b>Streptococcal Infection</b>	Has received appropriate therapy for <b>12</b> hours and has permission from physician to return to school
<b>Fifth Disease</b>	Excluding children from school is not recommended as a public health measure

Children excluded from school with any of the above health problems must be evaluated by the school nurse before returning to the classroom.

**PREVENTION OF DISEASE TRANSMISSION IN SCHOOLS:**

Routine and standard procedures should be used to clean up after a child or adult has an accident or injury at school. Blood, vomitus, stool, urine, or other body fluids from any child or adult, should be treated cautiously. Gloves should be worn when cleaning up all spills whenever possible. These spills should be disinfected with either bleach or another disinfectant, and persons coming in contact with them should wash their hands immediately afterwards. Hand washing after contact with a school child or adult is routinely recommended.

Whenever possible, direct skin contact with body fluids should be avoided. Disposable gloves should be available in at least the office of the custodian, nurse, or principal. Gloves are recommended when direct with body fluids is anticipated (i.e. treating bloody noses, handling clothes soiled in incontinence, cleaning small spills by hand). If extensive contact is made with body fluids, hands should be washed afterwards. Gloves used for this purpose should be put in a plastic bag or lined trashcan, secured, and disposed of daily. Custodians will clean up large spills.

## **WHEN TO EXCLUDE A CHILD FROM SCHOOL**

1. Temperature of 100 or over.
2. Temperature of 99 with symptoms.
3. Sore throat that is accompanied by fatigue, body aches and fever.
4. Persistent/disruptive cough lasting for more than a few days.
5. Any skin eruption suggestive of a communicable disease.
6. Any possible eye infection.
7. Vomiting and/or diarrhea

## **REQUIREMENTS FOR READMISSION TO SCHOOL**

- Children who are fever free for 24 hours without the need for antipyretics.
- Children who have COVID may return after 5 days of isolation and fever free for 24 hours without the need for antipyretics.
- Children may return after vomiting or diarrhea have resolved provided, they are fever free without antipyretics and able to tolerate fluids and solid foods.
- Children who have had chicken pox, mumps, or scabies must be checked by the school nurse, school health aide, principal, or principal's designee.
- Children with impetigo may return to school 24 hours after starting antibiotic therapy provided there is no discharge from blisters and exposed lesions are covered.
- Children with bacterial infections of the eye may return-24 hours after antibiotic therapy has begun.
- Children may return to school following the chicken pox once the rash has scabbed and no new lesions have appeared within a 24 hour period.
- Children with mumps may return to school-five days after the onset of symptoms.
- Children with streptococcal infections may return 12 hours after antibiotic therapy has begun.
- Child with scabies may return after treatment with a scabicide. No time limit – may come back after treatment.
- A note from the physician stating the child is free from communicable disease will be accepted in all cases.



## **Guidelines for Chickenpox Prevention and Control in School and Childcare Settings**

### **Background**

The varicella zoster virus (VZV) causes chickenpox (varicella), a vaccine preventable, generalized rash illness. VZV can also cause shingles (herpes zoster), a localized rash in a person who has already had chickenpox. People who have never had chickenpox can develop chickenpox after being exposed to a person with chickenpox or shingles. A person is considered to have immunity to chickenpox if he or she has had the disease or received the varicella (chickenpox) vaccine.

One dose of vaccine is not fully protective in all people and immunity induced by a single dose of varicella vaccine has been shown to wane over time. As of June 2006, it has been recommended that all persons who have only been vaccinated once receive a second dose of varicella vaccine. As of 2016-2017, 2 doses of varicella are required for enrollment in Connecticut schools for most grades (only 1 dose is required for grade 6, but 2 doses are still recommended for adequate protection).

### **Management of Symptomatic Persons:**

#### ***Disease Notification***

Chickenpox is a reportable condition in Connecticut. Schools are required to report all cases of chickenpox that they are aware of to the Connecticut Department of Public Health (CTDPH) Immunization Program. Cases should be reported using the [Varicella Case Report Form](#).

Completed case report forms should be faxed directly to the Immunization Program at 860-509-7945. Cases of shingles are not reportable; questions about the control and management of shingles cases may be directed to the Immunization Program at 860-509-7929.

#### ***Exclusion of Symptomatic Children***

Children and staff with chickenpox should be excluded from school or childcare. Individuals with uncomplicated chickenpox may return to school or childcare once their rash has scabbed. This may take several days in mild cases or several weeks in severe cases and in immunocompromised individuals. Immunocompromised children or those with a prolonged course should be excluded for the duration of the vesicular eruption. Some vaccinated children may develop mild “breakthrough varicella”—these children must still be excluded.

Immunocompetent persons with shingles can remain at school as long as the lesions can be completely covered. Persons with shingles should be careful about personal hygiene, wash their hands after touching their lesions and also avoid close contact with others.

Please see the [“Guidelines for Healthcare Personnel in Evaluating Chickenpox-like Rash in Recipients of Varicella Vaccine in Daycare and School Settings”](#) for additional information about evaluating chickenpox-like rash illnesses.



## **Management of Exposed Persons:**

For control purposes, a person is deemed exposed if they have spent at least 4 hours in the vicinity (e.g. classroom, cafeteria) of an infected person. This does not mean, however, that there is no risk for persons with less exposure to an infected individual.

An outbreak of varicella is defined as 3 or more cases of chickenpox in one facility within a three-week period. The number of varicella outbreaks in Connecticut has drastically decreased since the recommendation for 2 doses of varicella vaccine, from 20-40 outbreaks per year to less than 5 outbreaks per year. Implementing appropriate control measures can further reduce the risk of chickenpox transmission in school and childcare settings.

### ***Disease Notification***

An [exposure letter](#) should be distributed to all exposed immunocompromised and/or unvaccinated children and staff upon recognition of a single case of chickenpox. An exposure letter does not need to be sent if all exposed children and staff have documented immunity to varicella.

An [outbreak letter](#) should be distributed to all students and staff, regardless of vaccination status, upon recognition of an outbreak of varicella.

### ***Exclusion of Exposed Persons***

The following recommendations should be implemented **during varicella outbreaks:**

1. Exclude susceptible immunocompromised persons:
  - a. An immunocompromised person may return to school or daycare as per written directions from their physician.
  - b. Unvaccinated women who are pregnant
2. Exclude all non-compliant (unvaccinated) children required to have chickenpox (varicella) immunity according to regulations.
3. Exclude exposed children with signed medical or religious exemptions, and infants <1 year or >1 year but not yet vaccinated from day 8 of initial exposure until 21 days after the last case.

Unvaccinated individuals may return immediately upon receiving 1 dose of varicella-containing vaccine. ***There are no specific public health recommendations for exclusion in non-outbreak settings, however, these control measures may be considered in consultation with the school or child care program medical advisor.***

**Additional information about VZV and forms referenced in this document can be found on the CTDPH website: <http://www.ct.gov/dph/immunizations>**

**CTDPH Immunization Program**

**Phone: 860-509-7929**

**Fax: 860-509-7945**



## Guidelines for Evaluating Chickenpox-like Rash in Recipients of Varicella Vaccine

Varicella (chickenpox) vaccine has been available for use in the United States since March 1995. The Connecticut Department of Public Health (CTDPH) distributes vaccine to health care providers to administer to all children through 18 years of age.

Varicella vaccine is a live virus vaccine that can cause a mild case of chickenpox in 1-5% of vaccine recipients. Distinguishing a rash induced by varicella vaccine virus from a rash caused by wild-type virus in a vaccine recipient is critical to making appropriate community infection control decisions and patient management decisions, particularly regarding individuals at risk for serious complications of varicella. The two most important features to consider when evaluating a chickenpox-like rash in a vaccine recipient are: 1) the time interval since receipt of varicella vaccine; and 2) the severity of the chickenpox-like illness. The following guidance is provided to assist in making clinical and public health decisions.

There are three possible categories of chickenpox-like rash in vaccine recipients:

**1. Wild-type chickenpox** - This illness usually presents as typical chickenpox with a generalized rash averaging 200-400 lesions with many vesicles, fever, and cough. The patient should be considered infectious and excluded until the lesions dry and crust over, usually 5 days after rash onset. This typically occurs during two time frames:

- a) <1 week post-vaccination - In this case, exposure to wild-type virus happens prior to or immediately following vaccination. Wild-type chickenpox can occur in this scenario because there has been insufficient time for immunity to develop prior to exposure.
- b) >6 weeks post-vaccination - In this case, exposure to wild-type virus happens well after vaccination and the vaccine recipient did not respond to the vaccine prior to exposure ("vaccine failure"). Total vaccine failures are unusual.

**2. Vaccine-associated rash ("side effect" from vaccine)** - This occurs in 1% to 5% of vaccine recipients and typically occurs 1- 3 weeks, but is possible up to 6 weeks, post vaccination. It usually presents as a generalized rash, usually more maculopapular than vesicular, consisting of <20 lesions (but can be up to 50 lesions) and a few vesicles at the site of injection (median = 2). Patients are afebrile and otherwise asymptomatic. This type of rash is caused by attenuated vaccine virus, and is much less infectious than disease caused by wild-type virus. If transmission of vaccine virus does occur, infection has been found to be mild or asymptomatic. ***Such patients do NOT need to be considered infectious for public health purposes***, and if local day care/school policy permits, do NOT need to be excluded. However, day care and school programs will need to develop their own policies on this issue.

**3. "Breakthrough chickenpox"** (also known as vaccine-modified chickenpox) - This is a form of wild-type chickenpox that is less severe due to the development of "partial immunity" that was not sufficient to prevent disease, but was able to attenuate symptoms. Typically, it occurs > 6 weeks post-vaccination. Breakthrough chickenpox usually presents as a generalized rash consisting of <50 lesions, usually more maculopapular, with a few vesicles. Patients are often afebrile and minimally symptomatic. Although individuals with breakthrough varicella are usually much less infectious than those with typical wild-type disease, such patients should still be considered infectious and excluded until any vesicular lesions dry and crust over, usually a much shorter time period (1-4 days) than for wild-type chickenpox.

CTDPH Immunizations Program  
Phone: 860-509-7929



These guidelines can be used to assist with the evaluation of chickenpox-like rash in vaccine recipients, to help decide whether or not they are infectious, and if they need to be excluded from day care or school settings. The two most important features to consider in making these determinations are: 1) the time interval since receipt of varicella vaccine; and 2) the severity of the chickenpox-like illness.

<b>Timing Post Vaccination</b>	<i>If rash occurs at &lt; 1 week</i>	<i>If rash occurs at 1-3 weeks (typically) but can occur up to 6 weeks</i>	<i>If rash occurs at &gt; 6 weeks</i>	
<b>Symptoms</b>	-Generalized rash (typically 200-400 lesions with many vesicles) -Fever -Cough (if "partial" immunity has developed, symptoms may be attenuated)	-Generalized rash, more maculopapular than vesicular (usually <20 but can be up to 50 lesions [median=5]) -Some localized vesicles at the site of injection (median=2) -Afebrile -Asymptomatic	-Generalized rash, more maculopapular than vesicular (usually <50 lesions) -Often afebrile -Minimally symptomatic	-Generalized rash (typically 200-400 lesions with many vesicles) -Fever -Cough
<b>Type of Disease</b>	Wild-type chickenpox	-Vaccine-related chickenpox -Side effect of vaccine (occurs in 1-5% of vaccinees)	"Breakthrough" chickenpox with wild-type chickenpox virus	Wild-type chickenpox (vaccine failure) (complete vaccine failures are very unusual)
<b>Infectious?</b>	Highly infectious	-Rarely infectious -If transmission occurs, infection may be asymptomatic or very mild	-Infectious -Usually much less infectious than wild-type disease	Highly infectious
<b>Exclude?</b>	Exclude from school until all lesions have dried and crusted over, or until no new lesions appear, usually by the 5th day after rash onset	<i>No need to exclude from school or day care.</i> The child may attend school or day care if local policy permits	Exclude as for wild-type chickenpox: with fewer lesions and more rapid clearing, usually only 1-4 days.	Exclude as for wild-type chickenpox

Varicella (Chickenpox) (ct.gov)



Connecticut Department of Public Health  
Immunization Program  
**Varicella Case Report Form**

(revised August 3, 2018)

Person reporting: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Reporting site/clinic: \_\_\_\_\_ City: \_\_\_\_\_

Date reported: \_\_\_\_/\_\_\_\_/\_\_\_\_ Reporting site type:  School  Day care  Physician  Health department

Patient's healthcare provider (if not the person reporting): \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Demographic information**

Patient name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_

Street address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Parent/Guardian name (optional): \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Sex:  Male  Female  Other Country of birth:  USA  Other \_\_\_\_\_  Unknown

Ethnicity:  Hispanic  Non-Hispanic  Unknown

Race:  White  Black  Asian  Hawaiian/Pacific Islander  
 American Indian/Alaska Native  Unknown  Other (specify) \_\_\_\_\_

Attends:  School  Day care  Work  College  Other \_\_\_\_\_

Name of institution: \_\_\_\_\_ City: \_\_\_\_\_

**Clinical data**

Rash onset: \_\_\_\_/\_\_\_\_/\_\_\_\_ Fever?  Yes, temperature \_\_\_\_\_ °F  No  Unknown Fever onset: \_\_\_\_/\_\_\_\_/\_\_\_\_

Number of lesions:  <50  50-249  250-499  >500

Rash description:  Generalized  Local  Unknown

Did the rash crust?  Yes, rash lasted \_\_\_\_\_ days before all crusted  No, rash lasted \_\_\_\_\_ days  Unknown

Diagnosed by:  Physician/nurse  Parent/guardian  School  Self  Other \_\_\_\_\_

Laboratory tests				
	Date	Positive	Negative	Not done
DFA		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PCR		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Culture		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
IgM		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
IgG		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Medical history
Is the patient pregnant? <input type="checkbox"/> Yes, due date: ____/____/____ <input type="checkbox"/> No <input type="checkbox"/> Unknown
Has the patient been diagnosed with varicella in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Varicella vaccine dates: #1 ____/____/____ #2 ____/____/____

For patients born after the year 2000, is the patient up to date with varicella-containing vaccine (at least one dose by 16 months, at least 2 doses by 7 years)?

Yes  Unknown

No, reason:  MD diagnosis of previous disease at age \_\_\_\_\_ or date (if known) \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Lab evidence of previous disease  Born outside the U.S.  Medical contraindication  
 Never offered vaccine  Parent/patient refusal  Parent/patient forgot to vaccinate  
 Religious exemption  Too young to vaccinate  Parent/patient report of previous disease  
 Other \_\_\_\_\_  Unknown

Did the patient develop any complications that were diagnosed by a healthcare provider? [Check all that apply]			
	Yes	No	Unknown
Skin/soft tissue infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cerebellitis/ataxia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Encephalitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dehydration/hypovolemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hemorrhagic condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia (diagnosed by <input type="checkbox"/> X-ray <input type="checkbox"/> MD <input type="checkbox"/> unknown)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Meningitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other complications (Specify: _____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Was the patient treated with antivirals?  Yes, name: \_\_\_\_\_ Started on \_\_\_\_/\_\_\_\_/\_\_\_\_  
 No or N/A  Unknown

Is the patient immunocompromised due to a medical condition or treatment?  
 Yes, specify \_\_\_\_\_  
 No  Unknown

Does the patient have any co-morbid medical conditions?  
 Yes, specify \_\_\_\_\_  
 No  Unknown

Did the patient die from varicella or complications (including secondary infection) associated with varicella?  
 No  Unknown  
 Yes, date of death: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Autopsy performed?  Yes  No  Unknown  
Cause of death: \_\_\_\_\_

Was the patient hospitalized?  No  Unknown  
 Yes, name of hospital \_\_\_\_\_  
Admit date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Discharge date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Primary reason for hospitalization (Specify chief complaint and/or admission diagnosis): \_\_\_\_\_

- Severe varicella presentation  Unknown
- Varicella-related complication  Observation
- Administration of IV treatment  Isolation
- Non-varicella hospitalization with coincident varicella
- Other \_\_\_\_\_

Return form to: Connecticut Department of Public Health  
Immunization Program  
410 Capitol Ave, MS #11MUN  
Hartford, CT 06134

or fax form to (860) 707-1905

Questions? Call (860) 509-7929

<b>DPH use only</b>	CTEDSS ID: _____
Case status: <input type="checkbox"/> Confirmed <input type="checkbox"/> Probable <input type="checkbox"/> Suspect <input type="checkbox"/> Not a case	
Epi-linked to another case? <input type="checkbox"/> Yes, case ID _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Outbreak linked? <input type="checkbox"/> Yes, name of outbreak: _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown	

## Draft Letter #1

### School's Letterhead

#### Sample Exposure Letter

From School Principal, Nurse or Medical Advisor to Parents and Staff re:

## VARICELLA IN SCHOOL

Date

Dear Parent/Guardian:

**A child/children** at our school *has/have* contracted *chickenpox/shingles* and your child may have been exposed. Because this virus spreads easily, most children who have never had chickenpox and come into contact with someone who has either of these illnesses will become ill with chickenpox. A relatively mild illness can result in the loss of a week or more of class time for a child. Although chickenpox is not usually a serious illness, it can cause serious complications and can even result in death.

There is a varicella (chickenpox) vaccine available to help prevent chickenpox and it is recommended for persons older than 12 months of age who have never had the disease. If your child has already had this vaccine, it should be on his or her shot record as "varicella", "VZV", or "chickenpox". Our records indicate that your child has never had chickenpox nor been vaccinated against it.

Studies have shown that children who have been exposed to chickenpox/shingles and are vaccinated within 5 days of exposure are less likely to become sick. **If your child has not had chickenpox or has not been vaccinated**, we suggest that you contact your child's regular health-care provider as soon as possible to discuss the use of varicella (chickenpox) vaccine for your child. Children who do not have protection against chickenpox may be excluded from school as part of the CT Department of Public Health outbreak control guidelines.

It is vital that parents of immunocompromised children (i.e., HIV, cancer, leukemia, organ transplant, etc.) contact their child's physician immediately. For their own protection, immunocompromised children will be excluded until the school nurse receives written instructions from the physician whether they can return to school.

If your child does develop chickenpox, he/she should be kept from attending school until the rash has scabbed over. This is true even if your child was previously vaccinated. Please help us to protect your child and stop the spread of chickenpox in our school.

## **Draft Letter #2**

### **School's Letterhead**

#### Sample Exposure Letter

*From School Principal, Nurse or Medical Advisor to Parents and Staff re:*  
**VARICELLA IN SCHOOL**

#### **Date**

#### **Dear Parent or Guardian:**

This letter is to notify you that we are currently experiencing a chickenpox outbreak at our school and that your child may have been exposed. The number of chickenpox cases at our school is now at least 3. The Connecticut Department of Public Health and we recommend you protect your child and the school community from chickenpox.

Although chickenpox is not usually a serious illness, it can cause serious complications and can even result in death. Some children who are vaccinated will still develop varicella. These cases, also called "breakthrough," are usually mild. Nonetheless they are still contagious. Because they are mild, they may not be recognized or excluded, therefore leaving more opportunities to infect others, especially those who are at high risk for severe disease and have contraindications for vaccination (e.g., susceptible pregnant women, immunocompromised persons).

The Connecticut Department of Public Health recommends that children who have already received one dose of varicella vaccine receive a second dose of vaccine during an outbreak. If your child has only had one dose of varicella vaccine, please contact your health-care provider about getting a second dose of varicella vaccine for your child as soon as possible. While one dose protects more than 80% of children who got it against getting chickenpox and protects against serious disease, it is insufficient to stop the circulation of chickenpox in the school community. Since there are susceptible people who either have not or cannot be vaccinated and who are at high risk of severe complications from chickenpox, stopping outbreaks among vaccinated school children is important.

If your child does develop chickenpox, he/she should be kept from attending school until the rash has scabbed over. This is true even if your child was previously vaccinated. Please help us to protect your child and stop the spread of chickenpox in our school.

## ILLNESS AND FIRST AID Guidelines

### **Accidents in the Home or Off School Property**

Responsibility for such accidents rests with the family and the family physician. When accidents or illnesses occur outside, the school nurse and the teacher should have the family assume the responsibility for medical attention. If necessary, the child should be sent home and the family advised to obtain medical care. The school should give only emergency or first aid nursing care.

### **Emergency Care in School for Students**

The school is responsible for the immediate care given to a pupil whose sickness or injury occurs on the school premises during school hours or in school-sponsored and supervised activities. An emergency is defined as an occurrence which is similar to those outlined in the following Categories I through IV. Category V will be considered an emergency at the discretion of the school nurse in charge of the child at the time of the incident.

These categories will overlap and the school nurse will use her professional judgment and assessment.

The school shall maintain a file of Emergency Information for each pupil, which shall be updated annually and as needed.

If the child's injury requires immediate care, the parent or guardian will be called by telephone and advised of the pupil's condition. This call is the building Principal's (or their designee's) responsibility. If parents or guardian cannot be reached and immediate medical or dental attention is indicated, the family physician/dentist or Medical Advisor cannot be reached, the student will be transported to the local hospital by EMS.

**Legal Reference:** Connecticut General Statutes  
10-205 Appointment of school medical advisers  
10-212 School nurses and nurse practitioners  
52-557b "Good Samaritan Law" Immunity from liability for emergency medical assistance, first aid or medication by injection.  
School personnel not required to administer or render.

## CATEGORY I

**EMERGENT** – NEEDS IMMEDIATE TREATMENT AND MOBILIZATION OF EMERGENCY MEDICAL SERVICES WHILE INITIATING APPROPRIATE FIRST AID. DIRECT OTHERS TO IMMEDIATELY CALL FOR AN AMBULLANCE AND TRANSFER RESPONSIBILITY FOR CARE WHEN PROFESSIONAL HELP

ARRIVES. NOTIFY PARENT OR GUARDIAN AS SOON AS POSSIBLE. DO NOT LEAVE INDIVIDUAL ALONE.

## **IMMEDIATE TREATMENT and TRANSFER TO MEDICAL FACILITY**

The first aider must be aware of the correct sequence of maneuvers and that the victim's condition (conscious or unconscious) determines the sequence. In the case of an unconscious victim, the first priority is to insure an open airway. Mouth to mouth resuscitation or if no pulse, Cardiopulmonary Resuscitation (CPR), should be instituted if the victim can be ventilated.

### **ACUTE AIRWAY OBSTRUCTION – (e.g. foreign body in throat)**

If victim is conscious and unable to expel obstructing object, and complete airway obstruction is recognized perform abdominal thrusts (or chest thrusts, if applicable).

If ineffective and victim becomes unconscious, begin CPR.

### **ANAPHYLAXIS** - (insect sting, drug allergy, rarely food allergy)

The victim is in shock and color is mottled. The respirations are wheezy and may cease. Heart rate is increased at first, and blood pressure is low or unobtainable. Victim may be covered with hives. Monitor airway. Then follow standing orders for administration of EpiPen.

### **CARDIAC OR RESPIRATORY ARREST**

Perform cardiopulmonary resuscitation (CPR) as taught by a certified instructor.

### **CESSATION OF BREATHING** – See “Unconscious State”

### **CHEMICAL BURNS IN THE EYE**

Immediately irrigate the eye (s) copiously with most available source of water (shower, drinking fountain spigot), retain name of chemical with victim and transfer directly to ophthalmologic care. Caution: Certain chemicals in laboratories react violently with water. Check with knowledgeable person.

### **COMA**

Observe symptoms and ascertain possible contributory causes (trauma, drugs, alcohol, and diabetes) for immediate report to physician. Loosen clothing to facilitate breathing. Call for an ambulance.

### **HEAT STROKE**

If body temperature reaches 105 degrees F, apply cold compresses and /or use fan or air conditioner to promote cooling of skin.

### **HEMMORRAGE - MASSIVE**

**External Hemorrhage** (e.g. severed limb, lacerated blood vessel).

Apply firm and constant pressure with a gauze pad or clean cloth to the site of bleeding. In severe cases of massive hemorrhage such as a severed limb, the application of a tourniquet, as a last resort, may be life saving. Material with the broadest width should be used and the time of application noted. Tourniquet should be used only as instructed in certified course with attention given to dangers of improper use. Protect severed part with a sterile or clean dressing and pack in ice. Send the part with the victim for emergency care.

**Internal Hemorrhage** (e.g. abdominal trauma, fracture).

Immobilize immediately and do not move until medical aid arrives. Position victim with abdominal trauma on back or side and observe carefully for vomiting and cardio respiratory arrest (initiate CPR). Victim may exhibit sign of shock and if so, should be treated accordingly. It is most important that the victim should lie comfortably and quietly. If a limb is fractured, it should be immobilized

**NEAR DROWNING**

Consider the possibility of neck or back injury. Carefully remove victim from water using a aboard or other back support keeping neck in line with spine. Perform Cardiopulmonary Resuscitation (CPR), watching carefully for vomiting (turn to side and evacuate throat). Keep patient warm, continue CPR (as needed) and transfer immediately to medical facility.

**NECK OR BACK INJURY**

Carefully assess the victim's neurological status (alertness, speech, voluntary and involuntary movements, ability to respond) before moving at the site of the accident. Do not attempt to move the victim if he complains of pain in the neck or back or has tingling of feet or hands or inability to move an extremity. Cover and keep warm. Await medical aid.

The victim may also suffer a cardio respiratory arrest. Using at least two (2) people, carefully move victim on his back to a firm board or surface (being very careful not to move the neck from straight line of the body) and initiate CPR.

**PENETRATING/CRUSHING CHEST WOUNDS OR PNEUMOTHORAX**

Victim will complain of chest pain and shortness of breath. May require CPR. If there is a penetrating injury, there will be hemorrhage at the site of penetration, and the wound may gurgle air with each respiration. Place or tape a clean cloth over the penetration site and apply firm but constant pressure until medical aid can be obtained. If the penetrating object is in place and intact, leave it and do not apply pressure. If the victim suddenly and without warning complains of shortness of breath, prop in a sitting position.

**THE DECISION TO USE A TOURNIQUET IS A DECISION TO RISK SACRIFICE OF THE LIMB IN ORDER TO SAVE A LIFE.**

**POISONING** – Save sample of poison

**External** – (e.g. insecticide spray, aniline dye)

Treat for shock or initiate CPR as indicated. Loosen or remove clothing, rinse-affected area of victim with large volume of water being careful not to spread poison to unaffected areas of body. Send victim and sample of poison to medical facility.

**Internal** – (accidental or intentional ingestion).

Note victim's respiratory and cardiac status. Note size of pupils and degree of alertness (e.g. narcotics cause pinpoint pupils, atropine drugs cause dilated pupils). Smell breath, monitor airway, save container, if available, and treat as indicated. Call the Connecticut Poison Information Center. Be prepared to call 911 if advised by Poison Control.

## **CATEGORY II**

**URGENT** - IMMEDIATE EVALUATION AND REFERRAL TO TREATMENT FACILITY. CALL AMBULANCE IMMEDIATELY FOR TRANSFER. NOTIFY PARENT/GUARDIAN OF SUSPECTED EXTENT OF INJURY AND LOCATION OF TREATMENT FACILITY.

### **DO NOT LEAVE VICTIM ALONE**

#### **CORONARY OCCLUSION**

Victim may complain of chest pain, difficult breathing and become weak, sweaty, pale or blue. Loosen clothing, place victim in a position of comfort, usually sitting upright, and observe for cardio respiratory arrest.

#### **DISLOCATIONS AND FRACTURES**

DO NOT MOVE if neck or back injury is suspected (See Category I Item G). Splint or immobilize affected extremity and refer or transport to medical facility as soon as possible.

**DRUG OVERDOSE** – See “Poisoning”

#### **HEAD INJURY WITH LOSS OF CONSCIOUSNESS**

Keep victim lying flat, immobilize neck, observe vital signs and transfer to medical facility.

#### **HEAT PROBLEMS**

**Heat Cramps.** Often an early sign of approaching heat exhaustion, if there is a deficiency in both water and salt. Usually affects the muscles of the victim's legs and abdomen first. Give the victim sips of water over a period of about one hour and exert pressure with hands on the cramped muscles to help relieve spasm.

**Heat Exhaustion.** Symptoms may include profuse sweating, cool clammy skin, nausea and dizziness, and the victim may be in shock. Have victim lie down in a cool place, loosen clothing, elevate the feet and give sips of water, as above, if no nausea.

### **INTERNAL BLEEDING**

Victim may exhibit signs of shock and if so, should be treated accordingly. It is most important that the victim should lie comfortably and quietly. If a limb is fractured it should be immobilized.

### **MAJOR BURNS**

Assess consciousness and respiratory status. Burned extremities or small burned areas of body (15%) should be cooled with cold water to prevent further tissue damage. Cover lightly with clean gauze or cloth and transfer to medical facility.

### **PENETRATING EYE INJURY AND THERMAL BURN TO EYE**

For penetrating eye injury do not remove object. Cover both eyes loosely with sterile or clean dressing. Avoid pressure on eyes, keep victim quiet, and transport by stretcher.

### **SEIZURE – CAUSE UNKNOWN**

May occur following head injury or other unknown causes in a person not previously epileptic. Turn victim on side to prevent occlusion by tongue or aspiration of vomitus: Take measures to prevent further injury to victim. Refer to medical facility.

### **UNCONSCIOUS STATES**

If the victim is breathing and the heart is beating, try to ascertain cause of unconsciousness (head injury, seizure, drug, etc.). Assess pupil size. Observe for vomiting. Loosen clothing, position lying on right side except in cases of suspected neck injury (be careful not to hyperextend neck). Keep airway open. Perform CPR if necessary.

### **CATEGORY III**

**MEDICAL ATTENTION DESIRABLE WITHIN AN HOUR - CONTACT NURSE FOR EVALUATION AND NOTIFY PARENT/GUARDIAN**

#### **ACUTE EMOTIONAL STATE**

Calm victim by speaking in a quiet voice. If hyperventilating have them breathe into a paper bag. Try to understand what is upsetting the person. Be kind, gentle, and sympathetic. Seek professional assistance from trained personnel (e.g. psychologist, social worker, nurse or counselor). Notify parents and possibly refer to physician.

#### **ASTHMA/WHEEZING**

Place victim in comfortable sitting position. Encourage fluids. Authorized person should be called to administer any medication ordered for student. Call parents and refer to medical facility or physician as condition requires.

#### **BITES AND STINGS**

##### **Animal bites**

Cleanse wound with soap and water. Assess child's tetanus status by school record, and refer to doctor for immunization and follow-up. Refer to medical facility for possible rabies prophylaxis if bite was by raccoon, skink, bat, or fox (in Connecticut).

##### **Insect and Spider Bites (without anaphylaxis)**

Remove stinger, if present. Apply ice to reduce swelling and pain. Refer to medical facility if more than minor local inflammation. Check records and ask for history of allergy.

##### **Snake Bite**

Poisonous snake (mostly copperhead in this area) leaves two (2) deep fang marks about 2 cm apart, and causes immediate swelling and pain of extremity. Nonpoisonous snakebite is a ring of teeth in a semi-circle and essentially no immediate local reaction. If bite is in a limb, immobilize the arm or leg in a lower position, keeping the involved area below the level of the victim's heart. Transfer to medical facility.

#### **BURNS WITH BLISTERS**

Blisters form quickly. Apply cold, wet compresses gently and lightly to reduce tissue damage. Do not break blisters. Cover loosely with gauze and refer to medical facility.

**HIGH FEVER** (Greater than 103 degrees)

Have victim lie comfortably. Notify parent and advise consultation with a medical facility or family physician.

**LACERATION**

Apply direct pressure over site to stop bleeding. Wash area with soap and water and assess depth of wound. Cover with dry sterile bandage.

**MODERATE REACTION TO DRUGS** (Rash, Dizziness, etc.)

Have victim lie comfortably. Loosen clothing. Notify parent/guardian and/or contact physician.

**NON-PENETRATING EYE INJURIES**

Gently close the eye, and apply clean loose dressing and refer for ophthalmologic care.

**TOOTH – ACCIDENTAL LOSS OR BROKEN**

If the tooth is completely avulsed, it should be picked up and no attempt made to clean it.

**--DO NOT SCRAPE THE TOOTH**

**--HANDLE THE TOOTH BY CROWN SECTION ONLY**

**--DO NOT TOUCH THE ROOT STRUCTURE**

**First** - if the tooth is clean, try to put it back in the socket.

**Second** - if you cannot put the tooth in the socket, place the tooth in the cheek pouch or under the tongue.

**Third** - if the tooth is dirty or the child is too young or upset to have the tooth in the month, place the tooth in milk.

**Fourth** - if there is no milk available, place the tooth in water.

**Following the above steps, send the child to his dentist as soon as possible.**

## **FIRST AID GUIDELINES, ALPHABETICAL**

### **ABDOMINAL PAIN**

Place victim in comfortable position. Take Temperature. Elicit recent diet history plus history of vomiting, stool pattern, menstrual cycle. Notify parent/guardian. Advise medical consultation if pain is unusually severe or persists beyond one (1) hour. Do not give anything by mouth.

**ACUTE AIRWAY OBSTRUCTION** - See “Foreign Body in Throat”

### **ABRASIONS, MINOR CUTS, LACERATIONS**

Cleanse with soap and water or hydrogen peroxide. Apply sterile dressing.

### **ACUTE EMOTIONAL STATE**

Calm, by speaking in quiet voice. If hyperventilating, have them breathe into a paper bag. Try to understand what is upsetting the person. Be kind, gentle, and sympathetic. Seek professional assistance from trained personnel (e.g., psychologist, social worker, nurse, or counselor).

**ANAPHYLACTIC SHOCK** - See “Anaphylaxis”

### **ANAPHYLAXIS:**

The victim is in shock, and color is mottled. The respirations are wheezing and may cease. Heart rate is increased at first, and blood pressure is low or unobtainable. Victim may be covered with hives. Monitor airway. Then give the first dose of epinephrine (0.3) if 35 lbs or over, from a pre-loaded bee sting emergency kit. EpiPen is injected intramuscularly. The EpiPen automatically injects 0.3 cc when pressed against the skin. Look for the stinger if insect bit is suspected, and carefully scrape out (do not use tweezers). Repeat; see Medical Doctor’s orders (Dr. Sikand), medical adviser, or current physician.

### **ASTHMA/WHEEZING:**

Place person comfortable sitting position. Encourage fluids. Refer to physician’s orders. Call parents and refer to medical facility or physician, as condition requires.

## **BLEEDING**

### **Nosebleed**

Press the bleeding nostril firmly against the middle partition of the nose for 10 minutes to allow clots to form. Keep the child or adult in a sitting position; tilt the head forward to avoid swallowing blood. Try to prevent child or adult from blowing through nose for several hours so clot will not be dislodged. If bleeding persists, contact parents and advise medical care. In an adult, in addition to above efforts, check blood pressure and refer to medical care when indicated.

### **Cuts**

Wash with antibacterial soap and water, apply bacitracin ointment if necessary, and apply sterile dressing. Apply direct pressure over cut.

### **Small Wound**

Cleanse with antibacterial soap and water. Apply band-aid or sterile gauze dressing. If bleeding cannot be effectively controlled by applying pressure with sterile gauze and fingers at the site of the wound, notify parents and recommend medical attention.

### **Large Wound**

Apply direct pressure with a clean dressing or any cloth and fingers over site of bleeding until medical aid may be secured.

### **Puncture Wounds**

Wash gently but thoroughly with antibacterial soap and water. Cover with sterile dressing.

### **Laceration**

Wash with antibacterial soap and water or hydrogen peroxide, if needed. Apply pressure dressing if necessary and arrange for patient to see his own physician or go to emergency room at hospital. If as a result of laceration or injury careful examination of the wound reveals that there has been an amputation of a part, the part is to be sent as cleanly and moistly as possible with the patient, to the physician or hospital.

Massive Hemorrhage

### **External hemorrhage** (e.g., severed limb, lacerated artery, nosebleed in hemophilia).

Control bleeding by placing a clean covering, such as a sterile dressing, over the wound and applying pressure. Seek medical attention. (Call 911) In the case of a severed limb, protect severed part and transport with victim. Wash hand immediately after completing care.

### **BLISTERS**

If open, wash with soap and water or Hydrogen peroxide. Apply sterile dressing.

### **BRUISES**

If skin is unbroken, apply cold compress or ice

### **BURNS-MINOR**

Cool burned area in cold water. Cover loosely with gauze or leave open if very minor

### **CHOKING** - See "Foreign Body in Throat"

### **CONVULSION IN KNOWN EPILEPTIC**

Turn victim on side to prevent aspiration of vomitus and obstruction from tongue. Observe safety precautions. Have victim lie down to rest after seizure. Notify parent/guardian. **DO NOT LEAVE VICTIM ALONE DURING SEIZURE.**

### **DENTAL EMERGENCIES** – See also "Tooth/Accidental Loss or Broken – Category III"

### **Toothache**

Rinse the mouth vigorously with warm water to clean out debris. Use dental floss to remove any food that might be trapped within the cavity (especially between teeth). If swelling is present, place cold compresses to the out side of the cheek. (DO NOT USE HEAT) Do not place aspirin on gum tissue or aching tooth. If the pain is severe, contact student's parent.

### **Knocked out Tooth**

Follow New London policy – place tooth in a container of cool water or milk.

### **Bitten Tongue**

Apply direct pressure to bleeding areas with a sterile or clean cloth. If swelling is present, apply cold compresses. If bleeding doesn't stop readily or the bite is severe, refer the individual to his/her dentist or to the hospital emergency room.

### **Orthodontic Problem (Braces and Retainers)**

If a wire is causing irritation, cover the end of the wire with a wax ball. Refer individual to his/her orthodontist.

If a wire is imbedded in the cheek, tongue, or gum tissue, **DO NOT** attempt to remove it. Refer individual to orthodontist immediately.

If there is a loose or broken appliance, refer the individual to the orthodontist

### **EYE IRRITATION**

**Flush eye with clear water.**

### **Chemical Burns Of The Eye**

Immediately irrigate the eye(s) copiously with most available source of water (shower, drinking fountain spigot), bandage eye loosely, retain name of chemical with victim and transfer directly to ophthalmologic care certain chemical in laboratories react violently with water. Check with knowledgeable person.

### **Eye Injuries**

For non-penetrating eye injuries gently close the eye, and apply clean, loose dressing, and refer for ophthalmologic care.

For penetrating eye injury, do not remove object. Cover both eyes loosely with sterile or clean dressing. Avoid pressure on eyes, keep victim quiet, and transport by stretcher. To transfer patient with bleeding eye, have patient in sitting position.

**Foreign Body in the Eye** - See "Foreign Bodies."

### **FEVER 100 DEGREES OR HIGHER**

Notify parents and exclude child from school.

## **FOREIGN BODY**

### **Foreign Body in the Eye**

Remove object if possible with clean handkerchief or tissue. If unable to remove, gently close eye and cover with dressing. Notify parent and recommend medical attention.

### **Foreign Body in the Ear**

Tilt head to affected side. IF the object does not come out, do not attempt to remove it. Notify parents and recommend medical attention.

### **Foreign Body in Nose**

If foreign body does not dislodge itself spontaneously, do not attempt to remove. Call parent and advise medical attention. Do not advise to blow nose forcefully.

### **Foreign Body In Throat**

Let patient attempt to expel object by coughing if he can. If the object can be seen, attempt to remove it with your finger. Use protocol for choking conscious or unconscious.

Grab the victim and stand behind him or her. Wrap your arms around waist. Make a fist with one hand and grasp it with the other, placing both hands against the victim's abdomen with a quick, forceful upward thrust, expelling the air in the lungs. Repeat six-eight (6-8) times if necessary or until object is expelled or victim becomes unconscious.

If the victim is prone or unconscious, begin CPR.

## **FRACTURES – DISLOCATIONS – SPRAINS**

If sprain or dislocation is suspected, apply cold pack for 30 minutes and keep extremity elevated if possible.

Carefully assess the patient's neurological statute (alertness, speech, voluntary and involuntary movement, ability to respond) at the site of the accident. Do not move the patient if he complains of pain in neck or back, or has tingling of feet or hands, or inability to move an extremity. Cover and keep warm. Call for an ambulance.

Assess for asymmetry, deformity, swelling, skin discoloration, point tenderness, altered range of motion, loss of function, and absence of pulse above and below injury site.

### **For suspected dislocation/fracture:**

- Determine site and mechanism of injury.
- Cover protruding bones with sterile/clean bandage.
- DO NOT probe or wash such wounds.
- Assist student to relax and keep affected area still.
- Use sling to support hand and wrist with elbow slightly lower than forearms.
- Monitor pulse and respirations and check for shock every 15 minutes until transported.
- Inform parent. Transfer to medical facility if appropriate.

### **For suspected sprains/strains:**

- Determine site and mechanism of injury.

- Assist student to keep calm and keep affected area still.
- Elevated affected part if possible with support of pillow or sling.
- Apply ice to affected area for 30 minutes, protecting skin with cloth.
- Buddy-tape jammed fingers.

**Refer for prompt medical assessment if:**

- Limping severely/unable to bear weight
- Unable to move associated joint without severe pain

**May ace wrap observing the following limitations:**

- For applying compression to mild sprain (defined as having mild pain, minimal swelling, not pint of tenderness, and if ankle is involved, able to walk with pain)
- For holding ice on an injured limb
- For holding splint on an injured limb
- Do-wrap from distal to proximal to promote venous return:
- Use spiral turns covering one-third of one-half of each previous wrap:
- Avoid excessive pressure to avoid interference with circulation and nerve function;
- Check distal pulses and capillary refill;
- Instruct student and parent to elevate and rest bandaged extremity and to consult health care provider immediately for numbness/blue or purplish colorations;
- When dismissing student from health room with ace wrap, advise student and parent of need for prompt medical assessment when symptoms of mild sprain persists beyond 48 hours and of need to re-wrap ace if too tight or too loose.

**FAINTING**

When symptoms first occur, place head between knees and if necessary place the patient in a horizontal position and elevate legs. May use ammonia inhalant if needed.

**FEVER**

For fever of 100 degrees, notify parent or guardian for dismissal.

**FROSTBITE**

Protect frozen area from further injury. Handle gently and do not massage. Warm affected area rapidly by immersing in warm water (102-105 degrees), or wrap part gently in a sheet or blanket. Separate affected skin areas with non stick sterile gauze, such as between fingers and toes. Notify parent or guardian. Advise “urgent” medical consultation. Do not allow the victim to walk if feet are involved. Keep injured parts elevated during transportation.

**HEADACHE**

Check temperature. If necessary, have child rest quietly for up to ½ hour. If pain persists, notify parents and recommend medical care.

**HEAD LICE PROCEDURE – See Head Lice Section of Manual**

**HEAD INJURY**

Complete rest, lying flat and level. Check for broken bones. Observe for headache, vomiting, nystagmus, drowsiness, loss of equilibrium. Advise medical attention for any of these symptoms.

No head injury should be regarded lightly. Parents should be notified of a child's head injury, and child should be sent home if any doubt regarding seriousness.

**HEAT EXHAUSTION** (weakness, dizziness, nausea, headache, skin cold and clammy, body temperature usually normal)

Remove to cool or shaded area, give fluids, loosen clothing. If condition worsens or victim becomes disoriented, seek medical attention immediately.

**HEART ATTACK** (CORONARY OCCULSION)

Patient may have complained of chest pain and have become weak, sweaty, pale, and blue. May complain of difficult breathing. Loosen clothing, place victim in a position of comfort and do not leave patient alone. Call for an ambulance immediately. CPR to be implemented if appropriate.

**INFECTIONS** - See "Skin and Hair."

**INSULIN REACTION IN DIABETIC**

Victim may complain of dizziness, light-headedness or headache; may appear pale or sweaty; speech may be incoherent. If able to react and swallow, give sugar, sugar solution, or candy. Notify parent/guardian, physician, and if necessary, refer to medical facility. If non-responsive, treat as Category IID, unconscious state. Refer to individual health care plan.

**INSULIN SHOCK** - See "Insulin Reaction in Diabetic"

**NECK OR BACK INJURY**

Carefully assess the victims' neurologic status (alertness, speech, voluntary and involuntary movements, ability to respond) before moving at the site of the accident. Do not move the victim if he complains of pain in the neck or back or has tingling of feet or hands, or inability to move an extremity. Cover and keep warm. Await medical aid.

**NOSEBLEEDS** - See "Bleeding."

**PEDICULOSIS (Infection of Head Lice)** – See "Head Lice" and "Skin and Hair"

**PENETRATING/CRUSHING CHEST WOUNDS OR PNEUMOTHORAX**

Victim will complain of chest pain and shortness of breath. May require CPR. If there is a penetrating injury, there will be hemorrhage at the site of penetration, and the wound may gurgle air with each respiration. Place or tape a clean cloth over the penetration of site apply firm but constant pressure until medical aid can be obtained. If the penetration object is in place and intact, leave it, and do not apply pressure, If the victim suddenly and without warning complains of shortness of breath, prop in a sitting position.

**POISON IVY, POISON SUMAC OR POISON OAK** – See "Skin and Hair"

Wash skin with soap and water after exposure. May apply Calamine Lotion to soothe skin.

**POISONS**

Save sample of poison.

A. **External** – (e.g., insecticide spray, aniline dye)

Treat for shock or initiate CPR as indicated. Loosen or remove clothing, rinse affected area of victim with a large volume of water. Send victim and sample of poison to medical facility.

B. **Internal** – (accidental or intentional drug ingestion)

Note patient's respiratory and cardiac status. Note size of pupils and degree of alertness (e.g., narcotics cause pinpoint pupils, atropine drugs cause dilated pupils). Smell breath, monitor airway, save container if available, and treat as indicated. Call the State Poison Information Center.

Connecticut Poison Information Center  
Farmington Ave  
Farmington, Connecticut 06302  
Telephone: 1-800-222-1222

With certain poisons, such as strong alkalines, strong acids or petroleum products (e.g., gasoline, pine, oil, lye), vomiting should not be induced because of the danger of aspiration. The poison Control Center will advise you. If the person vomits, save specimen.

## **SKIN AND HAIR**

### **Impetigo**

Send home until the condition is clear or is under medical treatment.

**Pediculosis (infection of head lice)** Follow procedure in Head Lice Section of Manual

### **Poison Ivy**

Wash area well with soap and water. For itching, may apply Calamine Lotion.

### **Ringworm**

Send child home until condition is under medical treatment.

### **Scabies**

Send child home until condition is under medical treatment, and physician's readmission slip is obtained.

### **Sunburn**

May apply Calamine Lotion, any other lotion, or sunburn spray.

## **SLIVERS AND SPLINTERS**

Wash with antibacterial soap and water. If slight and protruding, remove with tweezers. Wash again with soap and water. Apply sterile dressing. If the sliver or splinter is large or deep,

consult physician. Check health record date of tetanus injection. If it is outdated, advise that a booster be given.

### **SORE THROAT**

Check temperature – if 100 degrees or more, child should be dismissed from school.

### **SPLINTERS**

Wash area with soap and water or hydrogen peroxide. If small and protruding, remove with tweezers. A sterile needle may be used to remove superficial splinter. Deep or large splinters should be removed by a physician. Notify the parent of the possible need for tetanus inoculation

### **SPRAINS**

Rest affected area. Apply ice packs, elevate (if possible) and compress area. The ice should not be in direct contact with the skin. Notify parents. If extreme pain; refer rapidly.

### **SEIZURE**

May occur following head injury or other unknown causes in a person not previously epileptic. Turn victim on side to prevent occlusion by tongue or aspiration of vomitus. Take measures to prevent further injury to victim. Refer to medical facility.

### **SHOCK**

Keep patient lying down with head lower than body. Lower extremities can be slightly elevated: Maintain body heat, ascertain and control contributory causes such as bleeding and extreme pain. Check pulse and blood pressure. Call 911/ EMS as needed.

### **TICK BITE**

Remove tick by grasping with tweezers where mouth parts enter the skin. Tug gently, but firmly until it releases. Cleanse area with soap and water. The health worker is to remove the tick as quickly as possible to reduce the possibility of the tick transmitting the bacterium that causes Lyme disease and other tick borne diseases. At the earliest possible time advise parents to observe area of bite for signs of infection.

1. **Do not handle the tick with bare hands.** Use tweezers to remove the tick.
2. Grasp the tick as close to the skin surface as possible and pull upward with steady even pressure. Do not twist or jerk the tick as this may cause the mouthparts to break off and stay in the skin.
3. Do not squeeze, crush, or puncture the tick. Its fluids may contain infective agents.
4. After removing the tick, thoroughly wash with antibacterial soap and wash hands with antibacterial soap and water.

**Never** remove the tick by using fingernail polish, alcohol or hot matches

**TOOTHACHE** - See “Accidental Loss of Tooth/Broken Tooth” Category III

**VOMITING**

Allow child to lie down on side. When vomiting, have face down and head low. Reassure child and keep him quiet. Advise rest, nothing by mouth. If persistent, advise parent to contact a physician. Notify parents and advise medical attention.

**SCREENINGS**

Visions, hearing and scoliosis screening shall meet current state law requirements and regulations and will follow guidelines and procedures to the definition, standards, implementation, environment, equipment, referral and personnel qualifications as per the current edition of the Connecticut State Department of Education manual “Guidelines for Health Screenings”. The school nurse/designee is responsible for conducting these screenings and recordings results in the health record.

Students failing these screenings will be referred for professional examination and parent/guardian will be notified. Screenings will be performed at any time at parent or professional request.





**Vision Screening**

**Student:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Grade:** \_\_\_\_\_  
**To:** \_\_\_\_\_ **Address:** \_\_\_\_\_  
**From:** \_\_\_\_\_ (School Nurse)

Recently we have administered vision-screening tests to all of the children in our schools. On the basis of these test results, we think it would be desirable for your child to have a thorough eye examination. Therefore, we suggest that you take him/her to an eye specialist (Oculist, Ophthalmologist, Optometrist) for further examination or that you follow the recommendations of your family physician.

**Date of Test:** \_\_\_\_\_ **Test Used:** \_\_\_\_\_ **Other Symptoms (please describe):** \_\_\_\_\_  
**School:** \_\_\_\_\_

**Report of Eye Examination**

**Student's Name:** \_\_\_\_\_

**Measurements:** (See back of form for preferred notation for recording visual acuity.)

**A. Visual Acuity:**

	Distant Vision		Near Vision	
	Without Correction	With Best Correction With Ordinary Lenses	Without Correction	With Best Correction With Ordinary Lens
<b>Right eye (O.D.)</b>				
<b>Left Eye (O.S.)</b>				
<b>Both Eyes (O.U.)</b>				

**B. If glasses are to be worn, were safety lenses prescribed in:** \_\_\_ Plastic \_\_\_ Tempered Glass

**II. Prognosis and Recommendations:**

Is a student's vision impaired considered to be: \_\_\_ Stable Deteriorating \_\_\_ Capable of improvement \_\_\_ Uncertain

What treatment is recommended, if any? \_\_\_\_\_

Is re-examination advised? \_\_\_\_\_ If so, after what interval? \_\_\_\_\_

Glasses: \_\_\_ Not needed: \_\_\_ To be worn consistently \_\_\_ For close work only \_\_\_ Other (Specify) \_\_\_\_\_

Lighting requirements: \_\_\_ Average: \_\_\_ Better than Average: \_\_\_ Less than Average

Use of eyes: \_\_\_ Unlimited: Limited as Follows: \_\_\_\_\_

Physical Activity: \_\_\_ Unrestricted: \_\_\_\_\_ Restricted as Follows: \_\_\_\_\_

Other Recommendations: \_\_\_\_\_

To be forwarded by Examiner: \_\_\_\_\_ To: \_\_\_\_\_

To be forwarded by Examiner: \_\_\_\_\_ To: \_\_\_\_\_

Date of the exams: \_\_\_\_\_

**Office Report of Hearing Tests**

**School:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Nurse:** \_\_\_\_\_

NAME	Grade	Defect	Home Visit	Plan For Follow-Up	Results
------	-------	--------	------------	--------------------	---------





## Connecticut Tuberculosis (TB) Risk Assessment User Guide

### Avoid testing persons at low risk

Routine testing of persons without risk factors is not recommended and may result in unnecessary evaluations and treatment because of falsely positive test results.

### If necessary, prioritize persons with risks for progression

If health system resources do not allow for testing of all non-U.S. born persons from a country with an elevated TB rate, prioritize patients with at least one of the following medical risks for progression:

- diabetes mellitus
- smoker within past 1 year
- end stage renal disease
- leukemia or lymphoma
- silicosis
- cancer of head or neck
- intestinal bypass/gastrectomy
- chronic malabsorption
- body mass index  $\leq 20$
- immunosuppression (see TB Risk Assessment)
- Upper lobe fibrotic lesion that has not shown at least one year of stability on two chest radiographs, after evaluation to ensure not active

### United States Preventive Services Task Force (USPSTF)

The USPSTF has recommended testing persons born in, or former residents of, a country with an elevated TB rate (regardless of length of time in the U.S.) and persons who live in or have lived in high-risk congregate settings such as homeless shelters and correctional facilities. Because the increased risk of exposure to TB in congregate settings varies substantially by facility and local health jurisdiction, clinicians are encouraged to follow local recommendations when considering testing among persons from these congregate settings. The USPSTF did not review data supporting testing among close contacts to persons with infectious TB or among persons who are immunosuppressed because these persons are recommended to be screened by public health programs or by clinical standard of care.

### Local recommendations, mandated testing and other risk factors

Several risk factors for TB that have been used to select patients for TB screening historically or in mandated programs are not included among the components of this risk assessment. This is purposeful in order to focus testing on patients at highest risk. However, certain populations may be mandated for testing by statute, regulation, or policy. This risk assessment does not supersede any mandated testing. Examples of these populations might include: primary and secondary school students, healthcare workers, residents or employees of correctional institutions, substance abuse treatment facilities, homeless shelters, and others.

For public schools, [Connecticut General Statutes Section 10-206](#) (b) and (c) mandate that each student have a health assessment at three time periods during his/her primary and secondary school education: "prior to public school enrollment," during Grade 6 or 7, and during Grade 9 or 10. [Connecticut General Statutes Section 10-206](#) (c) states that: "The assessment shall also include tests for tuberculosis...where the local or regional board of education, in consultation with the school medical advisor and the local health department, or in the case of a regional board of education, each local health department, determines that said screening or test is necessary..." The results of the risk assessment and testing, when done, should be recorded on the Connecticut State Department of Education (CSDE) [Health Assessment Record](#) (HAR-3); or on the CSDE [Early Childhood Health Assessment Record](#); and in the student's Cumulative Health Record (CHR-1).

Public school personnel (e.g. teachers) are not required to be tested for TB by any Connecticut state statute or regulation.



## Connecticut Tuberculosis (TB) Risk Assessment

See *the Connecticut TB Risk Assessment User Guide* for more information about using this tool.

- Use this tool to identify asymptomatic **adults and children** for latent TB infection (LTBI) testing.
- This tool can be used for school-aged children to determine if a student should have a TB test.
- This risk assessment does not supersede any TB testing mandated by statute, regulation or policy.
- **Do not repeat testing** unless there are **new risk factors** since the last test.  
*If initial negative screening test occurred prior to 6 months of age, repeat testing should occur at age 6 months or older.*
- Do not treat for LTBI until active TB disease has been excluded:  
*For persons with TB symptoms or an abnormal chest x-ray, evaluate for active TB disease with a chest x-ray, symptom screen, and if indicated, sputum acid-fast bacilli (AFB) smears, cultures and nucleic acid amplification testing (NAAT). A negative tuberculin skin test (TST) or interferon gamma release assay (IGRA) does not rule out active TB disease.*

**LTBI testing is recommended if any of the boxes below are checked.**

**Birth, travel, or residence** for at least 1 month in a country with an elevated TB rate

- Includes any country other than the United States, Canada, Australia, New Zealand, or a country in western or northern Europe
- If resources require prioritization within this group, prioritize patients with at least one medical risk for progression (see the Connecticut Tuberculosis Risk Assessment User Guide for this list).
- IGRA is preferred over TST for non-U.S.-born persons  $\geq 2$  years old

**Immunosuppression, current or planned**

- HIV infection, organ transplant recipient, treated with TNF-alpha antagonist (e.g., infliximab, etanercept, others), steroids (equivalent of prednisone  $\geq 2$  mg/kg/day, or  $\geq 15$  mg/day for  $\geq 1$  month) or other immunosuppressive medication

**Close contact** to someone with infectious TB disease

- Should test if patient has never been tested for this exposure

**Treat for LTBI if TB test result is positive and active TB disease is ruled out.**

**None of the above:** No TB testing is indicated **at this time.\***

**Please complete all information below:**

Patient/Student

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_



## Connecticut Tuberculosis (TB) Risk Assessment User Guide

### Avoid testing persons at low risk

Routine testing of persons without risk factors is not recommended and may result in unnecessary evaluations and treatment because of falsely positive test results.

### If necessary, prioritize persons with risks for progression

If health system resources do not allow for testing of all non-U.S. born persons from a country with an elevated TB rate, prioritize patients with at least one of the following medical risks for progression:

- diabetes mellitus
- smoker within past 1 year
- end stage renal disease
- leukemia or lymphoma
- silicosis
- cancer of head or neck
- intestinal bypass/gastrectomy
- chronic malabsorption
- body mass index  $\leq 20$
- immunosuppression (see TB Risk Assessment)
- Upper lobe fibrotic lesion that has not shown at least one year of stability on two chest radiographs, after evaluation to ensure not active

### United States Preventive Services Task Force (USPSTF)

The USPSTF has recommended testing persons born in, or former residents of, a country with an elevated TB rate (regardless of length of time in the U.S.) and persons who live in or have lived in high-risk congregate settings such as homeless shelters and correctional facilities. Because the increased risk of exposure to TB in congregate settings varies substantially by facility and local health jurisdiction, clinicians are encouraged to follow local recommendations when considering testing among persons from these congregate settings. The USPSTF did not review data supporting testing among close contacts to persons with infectious TB or among persons who are immunosuppressed because these persons are recommended to be screened by public health programs or by clinical standard of care.

### Local recommendations, mandated testing and other risk factors

Several risk factors for TB that have been used to select patients for TB screening historically or in mandated programs are not included among the components of this risk assessment. This is purposeful in order to focus testing on patients at highest risk. However, certain populations may be mandated for testing by statute, regulation, or policy. This risk assessment does not supersede any mandated testing. Examples of these populations might include: primary and secondary school students, healthcare workers, residents or employees of correctional institutions, substance abuse treatment facilities, homeless shelters, and others.

For public schools, [Connecticut General Statutes Section 10-206](#) (b) and (c) mandate that each student have a health assessment at three time periods during his/her primary and secondary school education: "prior to public school enrollment," during Grade 6 or 7, and during Grade 9 or 10. [Connecticut General Statutes Section 10-206](#) (c) states that: "The assessment shall also include tests for tuberculosis...where the local or regional board of education, in consultation with the school medical advisor and the local health department, or in the case of a regional board of education, each local health department, determines that said screening or test is necessary..." The results of the risk assessment and testing, when done, should be recorded on the Connecticut State Department of Education (CSDE) [Health Assessment Record](#) (HAR-3); or on the CSDE [Early Childhood Health Assessment Record](#); and in the student's Cumulative Health Record (CHR-1).

Public school personnel (e.g. teachers) are not required to be tested for TB by any Connecticut state statute or regulation.

#### **Age as a factor**

Age is not considered in this risk assessment. However, children and younger adults have more years of expected life during which progression from latent infection to active TB disease could develop. Some programs or clinicians may additionally prioritize testing of younger non-U.S.-born persons where all non-U.S.-born are not tested. An upper age limit for testing has not been established but could be appropriate depending on individual patient TB risks, comorbidities, and life expectancy. This risk assessment tool is valid for both adults and children.

#### **When to repeat a risk assessment and testing**

Risk assessments should be completed for new patients, patients thought to have new potential exposures to TB since last assessment, and during routine pediatric well-child visits. Repeat risk assessments should be based on the activities and risk factors specific to the person. Persons who volunteer or work in health care settings might require annual testing and should be considered separately. Re-testing should only be done in persons who previously tested negative and have new risk factors since the last assessment (unless they were <6 months of age at the time of testing). In general, new risk factors would include new close contact with an infectious TB case or new immunosuppression, but could also include foreign travel.

#### **Immunosuppression**

The exact level of immunosuppression that predisposes to increased risk for TB progression is unknown. The threshold of steroid dose and duration used in the Connecticut TB Risk Assessment are based on data in adults and in accordance with ACIP recommendations for live vaccines in children receiving immunosuppression.

#### **Foreign travel or residence**

Travel or residence in countries with an elevated TB rate may be a risk for TB exposure in certain circumstances (e.g., extended duration, likely contact with persons with infectious TB, high prevalence of TB in travel location, non-tourist travel). The one month duration of travel or

residence used in this risk assessment is intended to identify travel most likely to involve TB exposure. TB screening tests can be falsely negative within the 8 weeks after exposure, so are best obtained 8 weeks after a person's return.

#### **IGRA preference in non-U.S.-born persons ≥2 years old**

Because IGRAs has increased specificity for TB infection in persons vaccinated with *Bacillus Calmette-Guérin* (BCG), IGRA is preferred over the TST for non-U.S.-born persons ≥2 years of age. IGRAs can be used in persons <2 years of age, however, there is an overall lack of data in this age group, which complicates interpretation of test results. In BCG vaccinated immunocompetent persons with a positive TST, it may be appropriate to confirm a positive TST with an IGRA. If IGRA is not done the TST result should be considered the definitive result.

#### **Negative test for LTBI does not rule out active TB**

It is important to remember that a negative TST or IGRA result does not rule out active TB disease. A negative TST or IGRA in a patient with active TB disease can be a sign of extensive disease. Any suspicion for active TB disease or extensive exposure to TB should prompt an evaluation for active TB disease, including physical exam, symptom review, and 2-view chest x-ray.

#### **Most patients with LTBI should be treated**

Persons with risk factors who test positive for LTBI should generally be treated once active TB disease has been ruled out with a physical exam, chest radiograph and, if indicated, sputum AFB smears, cultures, and NAAT. However, clinicians should not feel compelled to treat a person with a positive TB test who does not have identified TB risk factors, especially if at higher risk of adverse reactions.

### Emphasis on short course regimens for LTBI treatment

Shorter regimens for treating LTBI have been shown to be as effective as 9 months of Isoniazid, and are more likely to be completed. Use of these shorter regimens is preferred in most patients, although the 12 week regimen is not recommended for children <2 years of age. It is under study in pregnancy. Drug-drug interactions and contact to drug resistant TB are other contra-indications for shorter regimens.

Medication	Frequency	Duration
Rifampin	Daily	4 months
Isoniazid + Rifapentine	Weekly	12 weeks**

\*\*11-12 doses in 16 weeks required for completion.

### Refusal of recommended LTBI treatment

Refusal should be documented. Recommendations for treatment should be made at future encounters with medical services. If treatment is later accepted, TB disease should be excluded and chest x-ray repeated if it has been more than 6 months from the initial evaluation for children or adults 5 years or older and 3 months for children less than 5 years of age.

### Persons with a history of LTBI, with or without treatment

A person with a history of a documented positive TB test does not need to have a TB test repeated at any interval. If a person with a history of LTBI has a new TB exposure, they should have a symptom assessment to ensure they are well; for persons with a negative symptom assessment, repeat chest radiographs are rarely indicated. Persons with LTBI who completed treatment do not need to be treated again, except in rare circumstances (e.g. exposure to a drug resistant strain of TB).

### Symptoms that should trigger evaluation for active TB

Patients with any of the following symptoms that are otherwise unexplained should be evaluated for active TB disease: cough for more than 2-3 weeks, fevers, night sweats, weight loss, lymphadenopathy, hemoptysis or excessive fatigue.

### Resources

Connecticut State Department of Public Health: Tuberculosis Control Program  
<https://portal.ct.gov/en/DPH/Infectious-Diseases/Tuberculosis/Tuberculosis-Control-Program>

Connecticut State Department of Education: School Nursing  
[www.ct.gov/sde/schoolnurse](http://www.ct.gov/sde/schoolnurse)

Centers for Disease Control and Prevention (CDC) Basic Information and Facts about Tuberculosis  
<https://www.cdc.gov/tb/topic/basics/default.htm>

CDC: Fact Sheets for LTBI Regimens, Isoniazid+Rifapentine, Rifampin, and Isoniazid are available at the following URL:  
<https://www.cdc.gov/tb/publications/factsheets/treatment.htm>

National Tuberculosis Controller's Association Provider Guidance: *Using the Isoniazid/Rifapentine to Treat Latent Tuberculosis Infection (LTBI)*  
<https://www.surveygizmo.com/s3/4592623/2018-3HP-Provider-Guidance-Download>

American Academy of Pediatrics, Red Book Online, Tuberculosis are available at the following URL:  
<https://redbook.solutions.aap.org/chapter.aspx?sectionid=189640207&bookid=2205>

### Abbreviations

AFB= acid-fast bacilli  
BCG= Bacillus Calmette-Guérin  
IGRA= interferon gamma release assay  
LTBI= latent TB infection  
NAAT= nucleic acid amplification testing  
TB= tuberculosis  
TNF= tumor necrosis factor inhibitors (?)  
TST= tuberculin skin test

**Authorization for the Administration of Medication by School, Child Care, and Youth Camp Personnel**

In Connecticut schools, licensed Child Day Care Centers and Group Day Care Homes, licensed Family Day Care Homes, and licensed Youth Camps administering medications to children shall comply with all requirements regarding the Administration of Medications described in the State Statutes and Regulations. Parents/guardians requesting medication administration to their child shall provide the program with appropriate written authorization(s) and the medication before any medications are administered. Medications must be in the original container and labeled with child's name, name of medication, directions for medication's administration, and date of the prescription.

**Authorized Prescriber's Order (Physician, Dentist, Optometrist, Physician Assistant, Advanced Practice Registered Nurse or Podiatrist):**

Name of Child/Student \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_ Today's Date \_\_\_/\_\_\_/\_\_\_

Address of Child/Student \_\_\_\_\_ Town \_\_\_\_\_

Medication Name/Generic Name of Drug \_\_\_\_\_ Controlled Drug?  YES  NO

Condition for which drug is being administered: \_\_\_\_\_

Specific Instructions for Medication Administration \_\_\_\_\_

Dosage \_\_\_\_\_ Method/Route \_\_\_\_\_

Time of Administration \_\_\_\_\_ If PRN, frequency \_\_\_\_\_

Medication shall be administered: Start Date: \_\_\_/\_\_\_/\_\_\_ End Date: \_\_\_/\_\_\_/\_\_\_

Relevant Side Effects of Medication \_\_\_\_\_  None Expected

Explain any allergies, reaction to/negative interaction with food or drugs \_\_\_\_\_

Plan of Management for Side Effects \_\_\_\_\_

Prescriber's Name/Title \_\_\_\_\_ Phone Number (\_\_\_\_) \_\_\_\_\_

Prescriber's Address \_\_\_\_\_ Town \_\_\_\_\_

Prescriber's Signature \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

School Nurse Signature (if applicable) \_\_\_\_\_

**Parent/Guardian Authorization:**

- I request that medication be administered to my child/student as described and directed above
- I hereby request that the above ordered medication be administered by school, child care and youth camp personnel and I give permission for the exchange of information between the prescriber and the school nurse, child care nurse or camp nurse necessary to ensure the safe administration of this medication. I understand that I must supply the school with no more than a three (3) month supply of medication (school only.)
- I have administered at least one dose of the medication to my child/student without adverse effects. (For child care only)

Parent/Guardian Signature \_\_\_\_\_ Relationship \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

Parent /Guardian's Address \_\_\_\_\_ Town \_\_\_\_\_ State \_\_\_\_\_

E-mail: \_\_\_\_\_ Cell Phone # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Other Phone # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

SELF ADMINISTRATION AND /OR POSSESSION OF MEDICATION AUTHORIZATION/APPROVAL

Self-administration of medication may be authorized by the prescriber (when applicable) and school nurse (when applicable) and must be authorized by parent/guardian in accordance with board policy. In a school: 1. inhalers for asthma and cartridge injectors for life-threatening allergies require authorization by the prescriber and parent/guardian only; 2. students may possess, self-administer or possess and self-administer medications for medically-diagnosed life-threatening allergies; and 3. students who are six years of age or older may possess and self-apply an over-the-counter sunscreen product with only the parent/guardian written authorization.

- 1. Student to self-administer medication specified on this form: \_\_\_\_\_ YES \_\_\_\_\_ NO
- 2. Student to possess medication specified on this form: \_\_\_\_\_ YES \_\_\_\_\_ NO

Prescriber's Authorization and Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Authorization and Signature: \_\_\_\_\_ Date: \_\_\_\_\_

School nurse (RN) Approval of self-administration (if applicable): \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name of Individual Receiving Written Authorization and Medication \_\_\_\_\_

Title/Position/ \_\_\_\_\_ Date: \_\_\_\_\_