Immunization Manual

For Schools, Preschools, and Child Care Centers

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Washington State Department of Health

John Wiesman, Secretary of Health

This manual is available online at www.doh.wa.gov/Portals/1/Documents/Pubs/348-124_ImmunizationSchoolManual.pdf

If you have a disability and need this document in another format, please call 1-800-525-0127 (TDD/TTY 711).

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Manual Overview

The *Immunization Manual for Schools, Preschools, and Child Cares*[1] is a reference guide for staff members who process Certificates of Immunization Status (CIS), complete immunization status reports, and answer questions from parents and guardians about immunization requirements for children. Many of you deal with immunizations every day and are expected to know a lot about them. This manual will help you.

Find the manual on the Department of Health's Office of Immunization and Child Profile Web site at www.doh.wa.gov/Portals/1/Documents/Pubs/348-124_ImmunizationSchoolManual.pdf. While you may want to download and print the manual and place it in a three-ring binder, we suggest you access it electronically so that you get the latest versions of the information, forms, and letters.

The manual can help you:

- Understand Washington State immunization requirements for children attending school, preschool, and child care.
- Work successfully with parents, school administrators, and healthcare providers regarding immunization regulations.
- Answer questions about the immunizations a child needs for school, preschool and child care.
- Prepare the required school and child care Annual Immunization Status Reports.
- Report communicable diseases at your school, preschool, or child care to local public health officials.
- Work with public health officials to get susceptible children immunized during a disease outbreak.
- Understand vaccine-preventable diseases, their causes and symptoms, and how they spread.
- Find immunization resources.

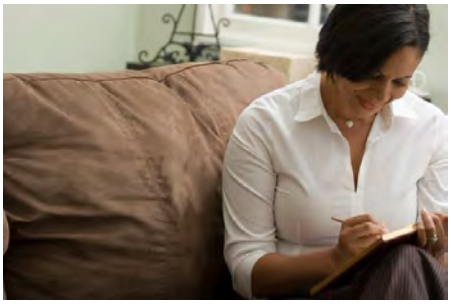
[1] "Preschools and child cares" in this manual include: preschools and child care centers associated with public and private schools, Head Start/ECEAP programs, licensed in-home child care, licensed child care centers, and children's group homes.

Responsibilities

Many organizations and individuals have responsibilities for immunizing children and students in Washington State. See below for specific responsibilities.

Parents/Guardians

The responsibility for a child meeting immunization regulations falls to parents, including foster parents and guardians. Parents should keep accurate and up-to-date immunization records for their children. Parents must submit a complete Certificate of Immunization Status (CIS) which is required for their children to attend school, preschool, or child care.



Healthcare Providers

These licensed healthcare providers can prescribe or give (administer) vaccines:

- Licensed medical doctors (MD),
- Doctors of osteopathy (DO),
- Naturopathic doctors (ND),
- Licensed Physician's Assistants (PA),
- Nurse Practitioners (ARNP) with prescriptive authority,
- Pharmacists, and
- Registered Nurses

Healthcare providers immunize patients according to the most current Recommended Immunization Schedules. By law, healthcare providers must:

- Educate parents and guardians about communicable diseases and immunizations by giving them a current Vaccine Information Statement (VIS) for each vaccine.
- Give information on the benefits and risks of immunization to parents or guardians wanting to exempt (excuse) their child from immunization requirements. Healthcare providers licensed in Washington, including physicians (M.D.), physician assistants (P.A.), osteopaths (D.O.), naturopaths (N.D.), and advanced registered nurse practitioners (A.R.N.P.), can either sign the official Certificate of Exemption or write and sign a letter about the exemption. Military personnel who are state-licensed physicians, naturopaths, or advanced registered nurses can also sign the exemption form or write a letter, if this is within the scope of their official duties.

In addition, healthcare providers should give parents up-to-date records of their child's immunization history. Providers can print the Certificate of Immunization Status (CIS) with the child's immunization history already filled out from the Washington State Immunization Information System. If a healthcare provider doesn't participate in the Immunization Information System, nurses and medical assistants can help parents fill out the CIS.

We received recent guidance from our Assistant Attorney General (AAG) clarifying that parent consent may be required before health care providers can release immunization records to a school nurse. It is ultimately up to the provider acting under HIPAA privacy rules if they will require parent consent before sharing immunization records with a school nurse. Nothing in law compels or allows providers to release immunization information to schools without parent consent. It is up to the discretion of the provider to provide this information or not.

School, Preschool, and Child Care Staff

Administrators in these facilities have final responsibility when it comes to immunizations. The administrator, by law, excludes children from school, preschool, or child care if they do not meet immunization requirements.

Administrators may give other staff members immunization tasks, which makes them 'designees.'

Designees include nurses, health assistants, secretaries, clerks, or volunteers. All designees must sign a Confidentiality Agreement in order to work with immunization information. The following tasks are the responsibility of schools, preschools, and child cares:

- Gather, check, and assess the Certificate of Immunization Status (CIS) to ensure correct and complete records.
- Create a filing system for the required CIS to make it easier to update records, including alphabetizing by grade level, name, or other system. Identify students who need more doses.
- Contact parents for follow-up.
- Identify and keep a list of susceptible students to use in the event of a disease outbreak.
- Teach staff and parents about the importance of getting immunized, keeping CIS information up to date, and following state immunization laws and school requirements.

Local Health Jurisdictions

Many local health jurisdictions (LHJs) give immunizations. Some also give out Certificates of Immunization Status (CIS) and other forms, as well as materials about communicable disease and immunization rules. Public health officials have the responsibility to work with schools, preschools, and child cares to prevent and control outbreaks of diseases that vaccines can prevent, and to study them when they occur. They also work with local healthcare providers to increase low or maintain high immunization levels in their communities.

State Agencies

Department of Health

The Office of Immunization and Child Profile at the Washington State Department of Health tracks immunization levels in the whole state as part of a federal requirement. The Office works closely with others including:

- Office of the Superintendent of Public Instruction
- Department of Social and Health Services
- Local health jurisdictions
- Department of Early Learning
- Healthcare providers

The Office helps by answering questions, making referrals, and serving as an information clearinghouse about vaccines and vaccine-preventable diseases. Public health staff may review school, preschool, and child care facility records to ensure they comply with state regulations.

State Board of Health

The State Board of Health (SBOH) has the authority to make immunization rules, including which immunizations children must have in order to enter school or child care, procedures for starting and complying with a schedule to achieve full immunization, and how to keep track of

proof of immunization status.

Department of Early Learning

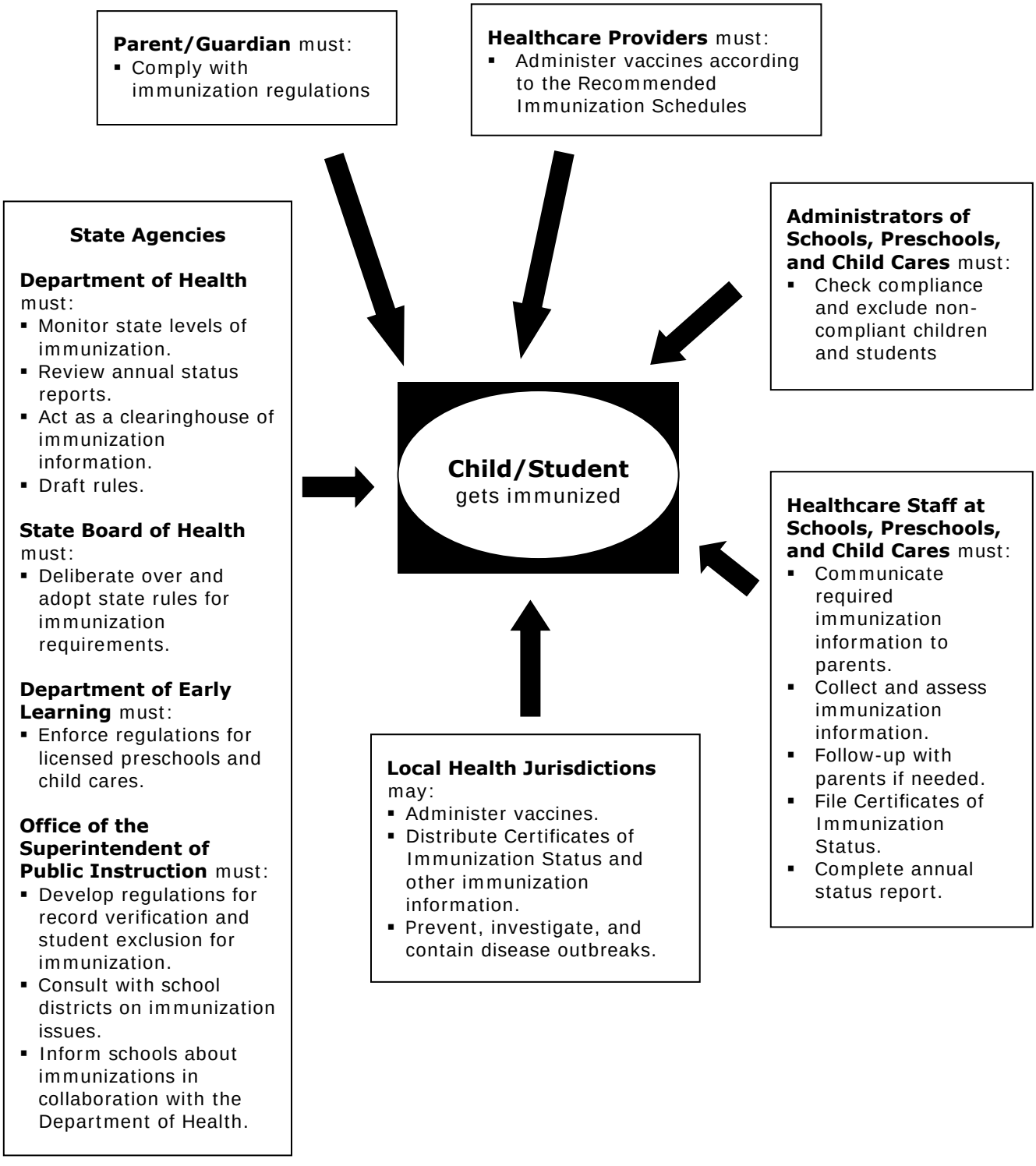
The Department of Early Learning enforces immunization rules for licensed preschools and child cares.

Office of the Superintendent of Public Instruction

The Office of the Superintendent of Public Instruction (OSPI) works with schools by:

- Providing information about immunization requirements and how to properly contain contagious diseases at schools.
- Adopting rules giving procedures for schools to check immunization records of transferring students.
- Working with the State Board of Health to adopt rules that establish procedures to exclude students from school who do not meet immunization requirements.
- Consulting with the Department of Health to prepare information for schools to comply with the law. For example, information on meningococcal and human papillomavirus which the law requires schools to send to parents/guardians.
- Consulting with school districts on immunization issues.

See below a picture of this network of players involved in the immunization of our children.



Vaccine Requirements

School, preschool, and child care staff can help to protect children against serious diseases by encouraging full and timely immunization. Help parents understand that:

- Each child must have a record of his or her immunizations on a Certificate of Immunization Status (CIS).
- Immunizing on time gives children the best protection.
- Immunization requirements in schools, preschools, and child cares have been shown to increase immunization coverage.
- Communicable diseases still exist and international travel can bring diseases common in other parts of the world to our communities.
- Keeping up-to-date records at home and school is vital.
- Children can get free or low-cost immunizations in our state.

Required Versus Recommended Immunizations

The difference between immunization requirements and recommendations can get confusing. Staff should understand the difference so parents and guardians get the necessary information to their child's school, preschool, or child care. These definitions can help:

- **Requirements:** children are required by state law (RCW or Revised Code of Washington) to get certain vaccines to enter school, preschool, and child care. The Washington Administrative Code (WAC) or rule further explains the law by determining immunization requirements using the Recommended Immunization Schedules. The schedule gets updated yearly by a national group, but the most current schedule may not be referenced in the WAC.
- **Recommendations:** the national Advisory Committee on Immunization Practices (ACIP) makes vaccine recommendations that providers follow as the "best practice" to get the best protection from diseases that vaccines prevent. Not all of the vaccines recommended by the ACIP are required in our state.

According to the Washington Administrative Code (WAC) 246-105-030:

Any child attending school, preschool, or child care in Washington State is required by law to be fully immunized at the ages and intervals consistent with the national immunization guidelines for their age/grade against the following diseases:

(A) Diphtheria
(B) Tetanus
(C) Pertussis (whooping cough)
(D) Poliomyelitis (polio)
(E) Measles (rubeola)
(F) Mumps
(G) Rubella (German measles)
(H) Hepatitis B
(I) *Haemophilus influenzae* type b (Hib disease)
(J) Pneumococcal
(K) Varicella

The students at your school, preschool, or child care must meet the immunization **requirements** for entry into school, preschool, or child care. Use the links to the Vaccines Required Charts to find the vaccines required for school or child care/preschool.

- **Vaccines Required for School Attendance, Grades K-12**
  English:
  www.doh.wa.gov/CommunityandEnvironment/Schools/Immunization/VaccineRequirements.aspx
  Español:
  www.doh.wa.gov/CommunityandEnvironment/Schools/Immunization/VaccineRequirements.aspx
  Parent version:
  www.doh.wa.gov/CommunityandEnvironment/Schools/Immunization/VaccineRequirements.aspx

- **Vaccines Required for Child Care/Preschool Attendance**
  English:
  www.doh.wa.gov/CommunityandEnvironment/Schools/Immunization/VaccineRequirements

  Español:
  www.doh.wa.gov/CommunityandEnvironment/Schools/Immunization/VaccineRequirements

  Parent version:
  www.doh.wa.gov/CommunityandEnvironment/Schools/Immunization/VaccineRequirements

- **Individual Vaccine Requirements Summary** (companion to the Vaccines Required charts and provides detailed rules and exceptions to the rules for each of the requirements)
  English only:
  www.doh.wa.gov/CommunityandEnvironment/Schools/Immunization/VaccineRequirements

Currently, schools and child cares must reference the 2013 ACIP Immunization Schedule:

- **2013 Recommended Immunization Schedule Ages Birth – 18 Years**
  English only www.cdc.gov/vaccines/schedules/hcp/child-adolescent.html
  This includes a catch-up schedule with minimum age and intervals.

Certificate of Immunization Status

All children entering school, preschool or child care must submit a Certificate of Immunization Status (CIS). **WAC 246-105-050** defines the CIS and its requirements in the box below:

Schools, preschools and child care facilities must require proof of the child or student's immunization status on the Certificate of Immunization Status (CIS).

Certificate of Immunization (CIS) means:

- Department of Health approved certificate
- Legible copy of the Department of Health approved certificate
- Certificate printed from the Washington State Immunization Information System

Do not accept an unapproved certificate.

CIS must include:

- Name of child or student
- Birth date of child or student
- Type of vaccine(s) received
- Month, day, and year of each dose of vaccine received
- Parent Signature

A completed CIS must be signed and on file at the site. Staff must immediately follow-up with the parent or guardian if the CIS is not signed, dated, or not filled out completely. Every school, preschool, and child care must review the immunizations listed on the CIS and determine a child's immunization status as complete, conditional, out of compliance, or exempt.

Status of Immunizations (WAC 246-105-020)

- **Complete**
  A child has an immunization status of "complete" as described in WAC 246-105-020 if he or she:

  - has been fully immunized for his or her age against each of the vaccine–preventable diseases listed in WAC 246-105-030 according to the national immunization guidelines described in WAC 246-105-040 or
  - has provided proof of acquired immunity

- **Conditional**
  The State Board of Health designed "conditional" status as a ***temporary*** solution for children lacking immunization against one or more of the required vaccine-preventable diseases (WAC 246-105-040). This status allows children to stay in school while parents arrange for their children to get the missing immunizations. Schools also have time to get their records in order to avoid excluding a student.

  A child in this status can attend school or child care if he or she makes satisfactory progress toward full immunization. "Satisfactory progress" (for conditional status or an expired temporary medical exemption) means the child must start, or continue, getting missed immunizations while following national immunization guidelines described in WAC 246-105-

040. Children must comply within these timeframes:

- Get any missing immunizations within 30 days after the first day of attendance or after a temporary medical exemption becomes invalid, unless getting the vaccine within such time creates an inconsistency with the immunization schedule.
- Get missing immunization doses in a vaccine series at recommended intervals and no later than 30 days past the recommended date per the immunization schedule.

After children catch up on missing immunizations, their "conditional" status changes to "complete."

- **Out of Compliance**
  A child has an immunization status of "out of compliance" as described in WAC 246-105-020 if he or she:

  - has not gotten fully immunized,
  - does not have a temporary conditional status, and
  - has no exemption(s) on file

  Any child with "out of compliance" status **must, by law,** be excluded from attending school, preschool, or child care until he or she meets the legal requirements of the law.

- **Exempt**
  A child may be exempt (excused) from immunization requirements for medical, personal/philosophical, or religious reasons. The Certificate of Exemption must be signed and dated by the parent and a licensed healthcare provider and be on file at the school, preschool, or child care.

How Parents Can Get Help with a CIS

The law requires parents/guardians to submit a completed, signed and dated CIS to meet the immunization requirements. Parents/guardians can get help in these ways:

- The healthcare provider, school, or Head Start/ECEAP program can print a CIS from the Washington State Immunization Information System with the child's immunizations already filled in.
- Get a printed immunization history from the provider's electronic health record and get help from the provider to fill out the CIS.
- If the provider does not have electronic records, get a copy of the paper immunization record.
- Get help from a healthcare provider to transfer the immunization history from the **Lifetime Immunization Record** card, which most Washington babies get at birth.
- Some schools may choose to help parents to fill out the CIS.

Note: an immunization history cannot be attached to the CIS with only a parent signature. The CIS must be filled out with the dates of vaccination and submitted to the school, preschool, or child care.

Making Changes to an Existing CIS

Schools, preschools, and child cares may accept one CIS per child for the duration of his or her stay at the school, preschool, or child care. State law does NOT require the CIS to be resubmitted nor reviewed annually or at any other interval. School staff can update an existing CIS by:

- **Phone, email, or in-person updates from a parent.** If school personnel get updated or additional immunization information (such as Tdap immunization required for 6th grade) that needs to be changed on the CIS, staff can handwrite the change, initial the change, and document the date the change was made.
- **Immunization Information System.** If school staff searches and finds updated information in the Immunization Information System, staff can make the change, note that the information came from the system, and document the date of the change.

Parent approval is NOT required if staff obtains missing immunizations in the IIS or another immunization record. Parent approval is NOT required when staff updates the CIS or a student information system with additional immunizations.

Retaining Records

Washington State law (RCW 28A.210.110) requires that schools, preschools, and child cares keep proof of immunization for each child. This means you must keep the CIS for as long as the child attends the school, preschool, or child care.

Manual Record Keeping – CIS

To enter school, preschool, or child care, every child must, by law, have a completed Certificate of Immunization Status (CIS) on file. Consider the following when setting up a filing system:

- Keep the CIS within the student's cumulative education record (which may make it easier to include the CIS in transfer records, if needed) or keep completed CISs together in a folder, arranged alphabetically by grade level or organized in a way that works for your site. Keep a separate list of not-fully immunized students. It is helpful to have this list alphabetized or organized in a way that works for your site.

A systematic filing system makes it easier to:

- Update your records.
- Identify students who have skipped immunizations or are due for more.
- Identify and keep a list of susceptible students, to be used in the event of a vaccine-preventable disease outbreak.
- Compile the required annual status report for the Department of Health (DOH).

Computerized Record Keeping – CIS

If using immunization-tracking software, be sure the software will:

- Separate immunization records into "complete," "conditional," "exempt" and "out-of–compliance" categories.
- List which immunizations a student needs and the due date for each.
- Provide information easily for the required annual status reports you send to Department of Health.

To get a blank CIS from the Department of Health:

English www.doh.wa.gov/Portals/1/Documents/Pubs/348-013_CertificateImmunizationStatusForm.pdf
Español www.doh.wa.gov/Portals/1/Documents/Pubs/348-013_CertificateImmunizationStatusFormSpanish.pdf

For other languages:
www.doh.wa.gov/YouandYourFamily/Immunization/FormsandPublications/OtherLanguage.aspx

How to Print a Completed CIS from the Immunization Information System

English only www.doh.wa.gov/Portals/1/Documents/Pubs/348-389-CIS-PrintingInstructions.pdf

Other CIS Resources

- **Frequently Asked Questions: Certificate of Immunization Status (CIS) and Certificate of Exemption (COE)**
  English Only www.doh.wa.gov/Portals/1/Documents/Pubs/348-267_FAQsCertificateImmunizationStatus-CertificateExemption.pdf

- **Certificate of Immunization Status (CIS) Child Care/Preschool Overlay** (for a quick review of required immunizations)
  For Child Care/Preschool Entry Only (print out in color on transparency paper):
  www.doh.wa.gov/Portals/1/Documents/Pubs/348-274_CertificateImmunizationStatusChildCarePreschoolOverlay.pdf

- **Certificate of Immunization Status (CIS) Kindergarten Overlay** (for a quick review of required immunizations)
  For Kindergarten Entry Only (print out in color on transparency paper):
  www.doh.wa.gov/Portals/1/Documents/Pubs/348-275_CertificateImmunizationStatusKinderOverlay.pdf

- **Certificate of Immunization Status (CIS) Middle School Overlay** (for a quick review of required immunizations)
  For middle school students (print out in color on transparency paper):
  www.doh.wa.gov/Portals/1/Documents/Pubs/348-275-CIS-MiddleSchoolOverlay.pdf

- **Certificate of Immunization Status (CIS) High School Overlay** (for a quick review of required immunizations)
  For high school students (print out in color on transparency paper):
  www.doh.wa.gov/Portals/1/Documents/Pubs/348-275-CIS-HighSchoolOverlay.pdf

Certificate of Exemption

WAC 246-105-050 allows four different types of exemptions (shown below). To file an exemption, a parent/guardian must claim at least one of the types for a child or student on the Certificate of Exemption (COE). A parent/guardian must also sign and date the COE for all exemptions.

Also, as of July 22, 2011, a licensed healthcare provider must sign the COE to verify that the parent/guardian got benefit and risk information about immunizations. The provider may also write and sign a letter stating the parent/guardian got the information about risks and benefits of immunizations. This signature is required for all exemptions, except the Religious Membership Exemption.

The Religious Membership Exemption is only for families who demonstrate membership in a church or religious body that does not believe in medical treatment. If the parent/guardian requests a religious membership exemption, no licensed healthcare provider signature is required.

Parents/guardians of exempt children or students MUST receive notification that the child/student may get excluded from school, preschool, or child care if an outbreak of a disease occurs that they have not been fully immunized against, for the duration of the outbreak.

- **Medical Exemption:**
  - Licensed healthcare providers in WA may grant a medical exemption if there is a medical contraindication to immunization as determined by the Advisory Committee on Immunization Practices: www.cdc.gov/vaccines/recs/vac-admin/contraindications.htm
  - Permanent medical exemption: A child may have a medical reason to permanently exempt an immunization. Healthcare providers must write in "permanent" for this type of exemption.
  - Temporary medical exemption: A child may have a medical reason to temporarily delay an immunization with the intent to be immunized later. Healthcare providers must give an expected date that the temporary exemption ends. Staff at a school, preschool, or child care should monitor temporary exemptions.
- **Philosophical/Personal Exemption:** Parent/guardian must indicate which vaccine(s). Healthcare provider must sign.
- **Religious Exemption**: Parent/guardian must indicate which vaccine(s). Healthcare provider must sign.

Retaining Records

Washington State law (RCW 28A.210.110) requires that schools, preschools, and child cares keep proof of immunization for each child. This means you must:

- Keep the COE for as long as the child attends the school, preschool, or child care.
- Keep information about each child excluded due to a lack of immunization. Keep the child's name, address, and date of exclusion for at least three years from date of exclusion.

Manual Record Keeping – COE

If a parent exempts a child from any immunization(s) required for school, preschool, or child

care, that child must, by law, have a completed and signed Certificate of Exemption (COE) on file for at school, preschool, or child care. Consider the following when setting up a filing system:

- Either keep completed COEs together in a folder, arranged alphabetically by grade level or organized in a way that works for your site OR keep the COE within the student's cumulative education record (which may make it easier to include the COE in transfer records, if needed).
- Keep a separate list of students exempt from immunizations. It is helpful to have this list alphabetized or organized in a way that works for your site.

A systematic filing system makes it easier to:

- Update your records.
- Give the list to your local health jurisdiction in the event of an outbreak or exposure of a vaccine-preventable disease.
- Complete the exemption portion of the annual status report.

Additional COE resources:

- **Certificate of Exemption (COE)**
  English www.doh.wa.gov/Portals/1/Documents/Pubs/348-106_CertificateofExemption.pdf
  Español www.doh.wa.gov/Portals/1/Documents/Pubs/348-106_CertificateofExemptionSP.pdf
- **Changes to the School and Child Care Immunization Exemption Law**
  www.doh.wa.gov/CommunityandEnvironment/Schools/Immunization/Exemptions.aspx

Requirements for Special Types of Students

There are additional special school populations for which there are responsibilities regarding immunizations. They are outlined below.

Alternative School Programs

Home-Schooled, Vocational Technical, Running Start, and Virtual School Students
Because many diseases spread through the air, the principle of "sharing air space" is fitting for students in alternative programs. Such programs include home-schooling, vocational technical, Running Start, and virtual schools. If the student is "sharing air space" with other students, he or she must follow school immunization requirements. "Sharing air space" includes riding the school bus or going into the school building for any activity, such as music, drama, or sports.

These students in alternative programs must have a signed Certificate of Immunization Status (CIS) on file at the enrolling school district. The student must show:

- Full immunization for his or her age or grade, or
- Satisfactory progress toward full immunization, or
- A signed Certificate of Exemption (COE).

Foster Care Students

Students in foster care must follow the same rules as all other students and have a completed CIS on file at the school they attend. Foster children can get routine medical services with their foster parent's permission. Medical services include getting immunized and getting a copy of the Certificate of Immunization Status (CIS). By law, foster parents have to tell the social worker of all known health information specific to that child (WAC 388-148-0350).

Exemptions can be claimed for foster children. To do this, the foster parent must get approval from a judge or get a COE signed by a licensed healthcare provider.

Graduating Students

Colleges may require immunization records as do various jobs, especially those in health-related fields. When students graduate, they should get their most recent and accurate CIS. The information can be given to the student's parent. Schools may want to keep a copy on file, but do not need to do this.

We recommend that schools give a letter with information about additional adolescent vaccine recommendations to graduating students with their CIS. Here is a sample letter: www.doh.wa.gov/Portals/1/Documents/Pubs/348-270_GraduatingSeniorSampleLetter.doc

Homeless Students

The McKinney-Vento Act requires immediate enrollment, even if students do not have immunization records. Families and homeless youth are often not able to get and keep copies of records. 42 U.S.C. §11432(g)(3)(C). According to the McKinney-Vento Act, schools must allow homeless students to enroll, attend classes, and participate fully in school activities, even if students lack immunization or other records. Schools cannot delay enrollment or keep homeless students out of school because they lack immunization records and school districts should have policies and procedures in place to help students get immunization records as soon as possible. If

a child or youth needs to get immunizations or immunization records, the enrolling school must immediately refer the parent or guardian to the local school district homeless liaison, who must assist in getting the immunizations or the records.

Homeless students who lack immunizations or immunization records should be placed in conditional status until they get immunizations or until their immunization records have been received at the enrolling school. If, after 30 days, the students are not showing satisfactory progress toward getting immunized, or the school has not made progress in getting immunization records, then the student will be marked out of compliance. Homeless students cannot be excluded from school while they are marked out of compliance and the homeless liaison should continue to help homeless students get immunizations, their immunization records, or an exemption.

A student is homeless if he or she meets the definition as explained in the McKinney-Vento* law.

***Who is homeless (Sec. 725 McKinney-Vento Act; USC 11432)**

(2) The term homeless children and youths' —

(A) Means individuals who lack a fixed, regular, and adequate nighttime residence (within the meaning of section 103(a)(1)); and

(B) Includes —

(i) children and youths who are sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, trailer parks, or camping grounds due to the lack of alternative adequate accommodations; are living in emergency or transitional shelters; are abandoned in hospitals; or are awaiting foster care placement;

(ii) children and youths who have a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings (within the meaning of section 103(a)(2)(C));

(iii) children and youths who are living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings; and

(iv) migratory children (as such term is defined in section 1309 of the Elementary and Secondary Education Act of 1965) who qualify as homeless for the purposes of this subtitle because the children are living in circumstances described in clauses (i) through (iii).

International Students

International students or foreign exchange students must follow the same rules as all other students and have a completed CIS on file at the school they attend. This includes short-term visitors. The school must have the CIS before the student's first day of school. Host parents of international students act as legal guardians and may sign a CIS. However, by law they cannot take the student to get immunized unless they have notarized permission from the student's parents to do so, or the student is 18 years or older.

We strongly recommend the CIS be filled out as part of pre-registration for all international students. Schools should also give copies of the CIS to agencies that sponsor international students. The agency can then include the CIS when they arrange student visits. In other words, completing the CIS should become a regular part of the application process for international students. Then school districts can know if an international student is in compliance with immunization requirements when he or she arrives in Washington State to start school.

Special Education Students

Students should generally follow immunization requirements for their grade. For example, a student who is 10 years old but is held back a grade should follow the immunization requirements for that grade. Developmentally delayed students in special education programs should follow requirements for whichever grade they are in. If these students are not associated with a specific grade, they should follow the requirements for students who are about the same age. For example, students over 18 years of age in a special education program should follow the requirements for 12th graders. Special education students who are 12 years of age should follow the 6th grade requirements since many 6th graders are 12 years old.

Summer School Students

All students enrolled in a Washington State public or private summer school must have a completed and signed CIS on file. If students attending summer school in a building other than the school they regularly attend but within the same school district and they have a CIS on file at their regular school, they are in compliance with the immunization law. This policy also applies to vocational technical skill centers and off campus and alternative schools. However, the records must be accessible to the summer school, skills center, or alternative school staff. If the school with the immunization records closes during the summer, a copy of the CIS must be available at the summer school location.

Transfer Students

When a student transfers to another school district, the parent can take the original CIS or a copy of the CIS to the new school. If the school gives a copy to the parent, it can send the original with the student's other school records.

Note: A former school cannot withhold the student's CIS for any reason, including non-payment of fees. If the former school has no record, it's best to let the current school know because that will save time for everyone.

In-State Transfer Students
If a student transfers to a new school district within the state, he or she is considered 'new' and must have a completed and signed (CIS) on file at the new school. We recommend using a copy of the CIS from the former school.

Out-of-State Transfer Students
If a student transfers from another state, he or she must have a completed Washington State CIS on file at the new school. You cannot use forms from other states, even if the information complies with Washington State immunization law. We recommend parents or guardians use the immunization records from other states to complete the Washington State CIS.

Required Immunization Reporting

The reporting rule states that schools, preschools, and child cares must report the immunization status of their students/children.

Per **WAC 246-100-166,** the chief administrator of every school, preschool, and child care facility in Washington State must:

1. Submit an immunization status report to the Washington State Department of Health every year by November 1.
2. Submit the report either electronically or on a form provided by the department.

Schools, preschools, and child cares required to comply with immunization requirements and required to report:

	Comply with State Board of Health immunization requirements	**Required to report to DOH**
Public and private school	√	√
Licensed child care or preschool	√	√
Preschool located at a public or private school	√	√
Head Start, ECEAP*	√	√
Licensed child care for school age children	√	--
Licensed family home child care with 12 or fewer children	***Comply with DEL rules***	--
Coop preschool	--	--

*Contractors/grantees must ensure that all children are immunized or exempt according to Washington State law. Children may attend on a conditional basis when homeless or when following a schedule to complete immunizations (ECEAP performance standards). Washington State law (RCW 28A.210.110) requires all Head Start and ECEAP programs to complete and file an Immunization Status Report every year by November 1.

Online Reporting Information (look under reporting section)

www.doh.wa.gov/CommunityandEnvironment/Schools/Immunization.aspx

Required School Immunization Status Report Form

English only www.doh.wa.gov/Portals/1/Documents/Pubs/348-014a-RequiredSchoolImmunizationStatusReport.pdf

Required Preschool and Child Care Immunization Status Report Form

English only www.doh.wa.gov/Portals/1/Documents/Pubs/348-002-AnnualPreschoolChildCareImmunizationStatusReport.pdf

Each child's immunization status must be determined for the annual status report. Use the student's Certificate of Immunization Status (CIS) and/or Certificate of Exemption (COE). If the student is exempt, the COE must indicate which exemption the student has (medical, religious, religious membership, or philosophical). Find below descriptions of all four possible immunization statuses.

Status of Immunizations (WAC 246-105-020)

- **Complete**

  A child has an immunization status of "complete" if he or she is:
  - Fully immunized against each of the vaccine–preventable diseases listed in WAC 246-105-030 according to the national immunization guidelines described in WAC 246-105-040 OR
  - Provides proof of acquired immunity. For example, a child may have a lab test (titer) showing immunity to hepatitis B. If so, the healthcare provider can fill out the Documentation of Disease Immunity section on the CIS for hepatitis B, which then replaces the need for hepatitis B vaccine doses and dates to be filled out.

- **Conditional**

  A child has an immunization status of "conditional" if he or she:
  - Lacks immunization against one or more of the required vaccine-preventable diseases (WAC 246-105-040) AND
  - Attends school, preschool, or child care while working on getting the missing immunizations, and is making satisfactory progress toward full immunization. "Satisfactory progress" means the child must start, or continue, getting missed immunizations while following national immunization guidelines described in WAC 246-105-040 and within these timeframes:
    - Get any missing immunizations within 30 days after the first day of attendance or after a temporary medical exemption becomes invalid, unless getting the vaccine within such time creates an inconsistency with the guidelines.
    - Get missing immunization doses in a vaccine series at recommended intervals and no later than 30 days past the recommended date as established by the guidelines.
  - After child catches up on missing immunizations, "conditional" status changes to "complete."

- **Out of Compliance**

  A child has an immunization status of "out of compliance" if he or she is:
  - Has not gotten fully immunized,
  - Does not have a temporary conditional status, AND
  - Has no exemption(s) on file OR
  - Has no completed, signed, and dated CIS on file

  Any child with "out of compliance," status **must, by law,** be excluded from attending school, preschool, or child care until he or she meets the legal requirements of the law.

- **Exempt**

  A child has an immunization status of "exempt" if he or she is:
  - Exempt (excused) from immunization requirements for medical, personal/philosophical, or religious reasons AND
  - Has a COE on file signed and dated by the parent/guardian and licensed

healthcare provider

For the annual status report, each child can only have one status entered even though a child could be complete for some vaccines, conditional for others, and exempt for still others. Consider these examples:

- A child is **complete** if fully immunized at the appropriate ages and intervals.
- A child exempt for any dose or vaccine means the child's status is **exempt.**
- A child conditional for any vaccine or dose in a series and with no exemptions means the child's status is **conditional.**
- A child neither exempt nor conditional for any vaccine or dose in a series but out of compliance for a vaccine or dose in a series means the child's status is **out of compliance.**
- A child with no CIS means the child's status is **out of compliance.**

Required Notification Letters

The notification rules state that schools, preschools, and child cares must notify parents or guardians of certain immunization-related information.

Exclusion Notification (due to outbreak and student has an exemption)

Per **WAC 246-105-080,** parents/guardians must get notification that:

- Their child may need to stay home (get excluded) from school, preschool, or child care in the event of an outbreak of a vaccine-preventable disease for which their child has an exemption, for the duration of the outbreak.

Exclusion Notification (for failure to follow immunization requirements)

Parents/guardians must get written notification of their child's exclusion, prior to the child getting excluded, for failing to follow WAC immunization requirements, per:

- **392-380 WAC** for parents/guardians of children in public school
- **180-38 WAC** for parents/guardians of children in private school

Disease and Vaccine Information (parents must get by law)

Per **RCW 28A-210-080,** parents/guardians of all students from 6th through 12th grade must get a letter with information about meningococcal disease and vaccine.

Per **RCW 28A-210-080,** parents/guardians of students in:

- Public schools beginning with Grade 6 must get a letter about the Human Papillomavirus disease and vaccine.
- Private schools beginning with Grade 6 must get notification that they can access information about Human Papillomavirus prepared by the Department of Health.

Find School Sample letters here

www.doh.wa.gov/YouandYourFamily/Immunization/FormsandPublications/Forms.aspx, including:

- Notice of Child's Conditional Immunization Status (Public & Private Schools)
- Notice of Exclusion for Immunization Noncompliance (Public Schools)
- Notice of Exclusion for Immunization Noncompliance (Private Schools)
- Meningococcal Disease (Public & Private Schools)
- Human Papillomavirus (HPV) (Public Schools)
- Human Papillomavirus (HPV) (Private Schools)
- Meningococcal & HPV (combination)

Disease Prevention and Control

All schools, preschools, and child cares responsible for children must have clear policies and procedures to prevent and control the spread of communicable diseases in children, employees, and volunteer staff (Chapter 246-110 WAC). These policies must agree with current practices recommended by the Washington State Department of Health (www.doh.wa.gov/immunization/schoolandchildcare) or the local health jurisdiction (www.doh.wa.gov/AboutUs/PublicHealthSystem/LocalHealthJurisdictions).

> Per **Chapter 246-110 WAC—Contagious disease—school districts and day care centers,** all facilities responsible for children are required to establish policies and procedures for preventing and controlling the spread of communicable diseases in children, employees, and volunteer staff.

When children or students get sick, facilities must often take measures to prevent or control outbreaks in their care or school community. Facilities should promote healthy hygiene, such as "keep your child home if sick," cough into your sleeve, and wash your hands often with soap and warm water. Use other actions like:

- Review immunization records to protect peers or classmates who may not be immunized against a particular disease,
- Identify all students exposed to the disease and those susceptible, and
- Contact your local health jurisdiction to determine if susceptible students (those not vaccinated or not completely vaccinated) should be excluded until the danger of the outbreak passes.
- Review the Infectious Disease Control Guide for information about specific diseases: www.k12.wa.us/HealthServices/pubdocs/InfectiousDiseaseControlGuide.pdf

If you suspect a communicable disease in a child or staff member, call your local health jurisdiction right away. Find contacts here:
www.doh.wa.gov/AboutUs/PublicHealthSystem/LocalHealthJurisdictions

Washington State Immunization Information System

What is the Washington State Immunization Information System (www.waiis.wa.gov)?

The Washington State Immunization Information System is a tool for a child's healthcare provider to access patient immunization information in a shared, secure database. To help providers manage their immunization services, the system includes:

- Immunization histories.
- Recommendations and forecasts of immunizations needed.
- Recall/reminder lists, mailing labels, or postcards for patients who are due or who have missed immunizations.
- Vaccine usage reports.
- Data for practice-specific immunization assessment reports.

If a child changes healthcare providers, the new provider can access the system to review the child's record. This ensures that the child's health information gets continually updated in one central location. Healthcare providers who complete an Information Sharing Agreement with the Department of Health can always access the Immunization Information System. The agreement assures system confidentiality, privacy, and security.

Historically, only healthcare providers could access the Immunization Information System. In 2004, significant interest in to broaden access to the system prompted review by the state Attorney General's (AG) Office. The AG decided that school nurses, Head Start/ECEAP nurse consultants, and staff assigned by the nurse can use the system under the Washington State Health Care Information Act (RCW 70.02).

Patient Privacy and the Immunization Information System

The Immunization Information System must follow the Washington State Health Care Information Act (RCW 70.02) as well as other state and federal laws that govern the use and sharing of health information. RCW 70.02 allows licensed healthcare professionals to exchange patient-specific healthcare information without patient or parental consent for these reasons:

- providing, coordinating, or facilitating healthcare, and
- preventing and controlling disease.

HIPAA

The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule recognizes the legitimate need for public health authorities and others responsible for ensuring public health and safety to have access to protected health information to carry out their public health mission. The Privacy Rule permits a covered entity (such as a healthcare provider) to disclose protected health information for public health activities and purposes without individual authorization (Section 164.512(b)(1)(i)). These activities include: "…for the purpose of preventing or controlling disease, injury, or disability, including, but not limited to, the reporting of disease, injury, vital events such as birth or death, and the conduct of public health surveillance, public health investigations, and public health interventions; or…" The U.S. Department of Health and Human Services' Office for Civil Rights guidance issued on December 4, 2002 further clarifies that the public health purpose does not need to be mandated by law (pp. 4–5).

FERPA

The Family Educational Rights and Privacy Act (FERPA) law protects the privacy of student education records, including immunization records. This law applies to any educational agencies or institutions that get funding from the United States Department of Education. HIPAA rules do not apply to education records. Most private schools do not receive funding from this source and therefore do not need to follow FERPA rules.

Once a CIS is provided to the school, preschool, or child care, it becomes a part of the student education record and is covered under FERPA laws.

If the CIS is missing immunizations and staff finds immunizations in the IIS, staff can add the additional immunizations on the CIS without obtaining parent/guardian consent. Even though the CIS is a student record, school and child care staff are maintaining a record on behalf of the parent, so no permission is needed before the CIS is updated.

School Access

Do schools have access to the Immunization Information System?
Yes! Since September 2006, access is available to all school districts throughout the state for schools to view immunization records. Access was created after a 2004–2005 pilot program that the department conducted with school districts. Results of the pilot showed that school access to the system saves resources, time, and energy for staff and school nurses.

Private schools may also access the system as long as they have a licensed healthcare professional on staff or under contract whose job responsibilities include student immunization tracking and reporting.

How do schools get access to the system?
A "Step-by-Step Guide" outlines the five steps needed to complete the process for access for school districts: www.doh.wa.gov/PublicHealthandHealthcareProviders/HealthcareProfessionsandFacilities/DataReportingandRetrieval/ImmunizationInformationSystem/ForSchools.aspx. The guide shows a simple process that you can complete independently.

First, check with your school district superintendent's office to learn if an Information Sharing Agreement has already been signed and sent in.

- If yes, follow the instructions outlined in the "Step-By-Step Guide." If there is more than one school nurse in the district, meet with other school district nurses to develop a coordinated approach to implementation of view access.
- If no, begin with submitting a signed Information Sharing Agreement to the Department of Health. If there is more than one school nurse in the district, meet with other school district nurses to develop a coordinated approach to view access.
- **NOTE:** The school district superintendent or designee must sign the Information Sharing Agreement. See instructions outlined in Step Two of the Guide.

If you still have technical questions after reading the five-step instructions, call the Help Desk at 1-800-325-5599 or 206-205-4141.

Head Start/ECEAP Access

Do Head Start/ECEAP programs have access to the System?
Yes, as long as they have a licensed healthcare provider on staff or under contract who is responsible for healthcare coordination or overseeing of immunization records. All federal, tribal,

and migrant Head Start and Washington State ECEAP programs that meet this criterion may have access to the Immunization Information System to view individual immunization records.

How do Head Start/ECEAP programs get access to the System?
A "Step-by-Step Guide" outlines the five steps needed to complete the process for the Immunization Information System access for Head Start/ECEAP programs: www.doh.wa.gov/PublicHealthandHealthcareProviders/HealthcareProfessionsandFacilities/DataReportingandRetrieval/ImmunizationInformationSystem/ForHeadStartECEAP.aspx

The process for access begins by following the instructions outlined in the "Step-By-Step Guide" and the submission of a signed Information Sharing Agreement to the Immunization Information System. Instructions for the agreement are outlined in Step Two of the Guide. (Please note: The program director or designee must sign the Information Sharing Agreement.)

If you still have technical questions after reading the five-step instructions, call the Help Desk at 1-800-325-5599 or 206-205-4141.

Child Care Access

Do child care programs have access to the System?
The Immunization Information System cannot provide direct access to child cares, even if they have a nurse on staff, under contract, or as a volunteer. HOWEVER, a nurse consultant who supports a child care program in meeting immunization and other health requirements may sign an information sharing agreement with the system. The agreement is between the nurse consultant, who is a licensed health care professional, and the Immunization Information System. It is not between the child care agency and the Immunization Information System.

Key Points about Access

1. School nurses and Head Start/ECEAP nurse consultants can access the Washington State Immunization Information System because they:
   - Are licensed healthcare providers per RCW 70.02, and
   - Have a bona fide need to know the immunization status of students for the purpose of preventing or controlling disease.
2. The school district or Head Start/ECEAP program must first sign an Information Sharing Agreement and file it with the Washington State Department of Health.
3. Nurses can assign a non-licensed staff to use the Immunization Information System to view immunization information. These staff members must have signed a Confidentiality Agreement. Nurses have also elected to sign the agreement. The signed Confidentiality Agreement should be held by the nurse at the school office; it does not need to be sent to the Immunization Information System staff.
   - Download the Confidentiality Agreement for schools at www.doh.wa.gov/portals/1/Documents/Pubs/348-364-IISConfAgreeSchools.pdf
   - Download the Confidentiality Agreement for Head Start/ECEAP staff at www.doh.wa.gov/portals/1/Documents/Pubs/348-363-IISConfAgreeHeadStart.pdf
4. RCW 28A.210.100 and 28A.210.110 state that the parent must submit immunization information to the school or child care. School nurses, Head Start or ECEAP nurse consultants, or assigned staff members can print a CIS from the Immunization Information System. Then, they can tell the parents to review, change if needed, sign, and submit the CIS to the school.

School-Based Clinics

School-based clinics may need to follow HIPAA or FERPA rules. School-based clinics not receiving funding from the United States Department of Education must follow HIPAA rules. School-based

clinics that do receive funding from the United States Department of Education are covered under FERPA.

For example, in the event a public health clinic provides an on-site school clinic, the records belong to the public health clinic and must follow HIPAA rules. On the other hand, if a school contracts privately with an agency or individual healthcare provider to provide a school-based clinic, the records from that clinic belong to the school education record and must follow FERPA rules.

Exceptions to following these rules may occur. We encourage you to seek legal counsel about such conditions regarding HIPAA, FERPA, and other Washington State laws since we do not intend to give legal advice here. Exceptions to sharing immunization information without a proper release may include:

- Compliance with a lawfully issued subpoena.
- A significant health or safety emergency if necessary to protect the health or safety of students or other individuals. The exception in this case would be:
    - Limited to the period of the emergency
    - A specific release - not a blanket release
    - Only for "need to know" and "appropriate parties"
- A designated emergency by a public health authority. Note that:
    - An emergency can exist with or without a public health authority designation, and
    - A federal designation of an emergency means a current outbreak or safety issue in the school or school district.

If immunization records get shared because of an exception, school nurses must write this in the student's education record. They must write this within a reasonable period of time and include a description of why the exception happened. Schools must retain the record of each request for access to the educational record AND each disclosure made from the record.

References

- U.S. Department of Health and Human Services www.hhs.gov/ocr/privacy/
- U.S. Department of Education www.ed.gov/policy/gen/guid/fpco/ferpa/index.html
- WA OSPI FERPA Resources www.k12.wa.us/HealthServices/pubdocs/ferpa-hipaa-guidance.pdf

Vaccine Recommendations for Staff

While immunizations are not required for school staff, knowing staff's immunization status can prepare schools in advance of a disease outbreak. Suspected or confirmed cases or outbreaks of diseases associated with the school must be reported to the local health department (RCW 28A.210.010 and WAC 246-101-420). All susceptible staff not completely immunized or immune may be excluded from school.

Schools, preschools, and child cares must try to prevent the spread of disease. They must also protect the health of staff members. To do this, they should:

- Keep track of staff vaccinations. This will tell you which have no or limited protection to certain vaccine-preventable diseases. We call these staff members "susceptible."
- Promote vaccination for staff members in an effort to safeguard the school, preschool, and child care community.
- Exclude susceptible staff members during an outbreak (refer to your school or agency policies about whether staff can take sick leave when excluded).

The following immunizations are recommended for school staff: measles, mumps, and rubella (MMR); varicella (chickenpox); hepatitis B; diphtheria, tetanus, and pertussis (Tdap and Td); and influenza (flu).

<table>
<tr><th colspan="3">Recommended Immunizations for Teachers and School Staff</th></tr>
<tr><td>Vaccine</td><td colspan="2"></td></tr>
<tr><td rowspan="2">MMR (Measles, Mumps, Rubella)</td><td>Persons Born Before 1957</td><td>Persons Born in or After 1957</td></tr>
<tr><td>• 2 doses of vaccine recommended for healthcare personnel (including school nurses)
• Not at high risk: generally considered immune (US or foreign born). Vaccine not routinely recommended, but 1 dose may be given
• Testing is NOT necessary. However, if testing occurred and result is negative, 1 or 2 doses of MMR vaccine is recommended, depending on risk level</td><td>• 1 dose of vaccine if not at high risk
• 2 doses of vaccine if high risk (healthcare personnel, including school nurses, international travelers, and students attending college)
• Vaccine needed even with history of prior disease diagnosed by a provider
• No vaccine needed if documentation of blood test shows positive immunity
• No vaccination or testing needed if documentation of 1-2 doses of MMR vaccine (number of doses depends on risk level)</td></tr>
<tr><td>Varicella (chickenpox)</td><td colspan="2">• 2 doses of vaccine
• Other evidence of immunity: no vaccine needed
○ Healthcare provider verification of chickenpox disease or herpes zoster (shingles)
○ Persons born before 1980 (does NOT apply to healthcare personnel, pregnant women, and immunosuppressed persons)
○ Blood test showing positive immunity</td></tr>
<tr><td>Hepatitis B</td><td colspan="2">3 doses</td></tr>
<tr><td>Tdap/Td</td><td colspan="2">1 dose of Tdap, then Td booster every 10 years
Pregnant women should get Tdap during EACH pregnancy, regardless when the last dose was received</td></tr>
</table>

Recommended Immunizations for Teachers and School Staff	
Influenza (Flu)	Annual influenza vaccine is recommended for everyone 6 months of age and older

The national Recommended Adult Immunization Schedule includes additional vaccines. For more information, recommendations, and correct immunization schedules, visit the Department of Health at www.doh.wa.gov/YouandYourFamily/Immunization/Adult.aspx

Resources

- **Recommended Adult Immunization Schedule**
  English only www.cdc.gov/vaccines/schedules/index.html

- **Sample Staff Immunization History Form**
  English only www.doh.wa.gov/Portals/1/Documents/Pubs/348-496-StaffImmunizationHistoryForm.doc

- **Washington State School Directors' Association (WSSDA) Infection Control Policy and Procedure:** www.wssda.org/Services/PolicyandLegal/FeaturedPolicies.aspx

Additional Resources

Child Care

- **Child Care Susceptible List (Exempt Children)**
  English only www.doh.wa.gov/Portals/1/Documents/Pubs/348-280-ChildCareSusceptibleListExempt.pdf

- **Child Care Susceptible List (Need Follow-Up)**
  English only www.doh.wa.gov/Portals/1/Documents/Pubs/348-281-ChildCareSusceptibleListFollow-Up.pdf

Laws and Regulations

- **Revised Code of Washington**
  www.doh.wa.gov/CommunityandEnvironment/Schools/Immunization/Regulations.aspx

- **Washington Administrative Code**
  www.doh.wa.gov/CommunityandEnvironment/Schools/Immunization/Regulations.aspx

  WACs for child care and preschool only (Department of Early Learning)
  1. 170-151—School-age child care center minimum licensing requirements.
  2. 170-295—Minimum licensing requirements for child care centers.
  3. 170-296—Child care business regulations for family home child care.

  WACs for K–12 school only (Board of Education)
  1. 180-38—Private school pupil immunization requirement.

  WACs for child care, preschool, and K–12 school (State Board of Health)
  1. 246-101—Notifiable conditions.
  2. 246-105—Immunization of child care and school children against certain vaccine-preventable diseases.
  3. 246-110—Contagious disease—school districts and day care centers.

  WACs for K–12 school only (Office of the Superintendent of Public Instruction)
  1. 392-182—Student—health records.
  2. 392-380—Public school pupils – immunization requirement and life-threatening health condition.

  WACs for child care and preschool only
  1. 170-151 WAC; School-age child care center minimum licensing requirements.
  2. 170-295 WAC; Minimum licensing requirements for child care centers.
  3. 170-296 WAC; Child care business regulations for family home child care.

School Resources

- **School Susceptible List (Exempt Children)**
  English only www.doh.wa.gov/Portals/1/Documents/Pubs/348-282SchoolSusceptibleListExemptChildren.pdf

- **School Susceptible List (Need Follow-Up)**
  English only www.doh.wa.gov/Portals/1/Documents/Pubs/348-283-SchoolSusceptibleListNeed_Follow-Up.pdf

- **Sample Graduating Senior**
  English only www.doh.wa.gov/Portals/1/Documents/Pubs/348-270_GraduatingSeniorSampleLetter.doc

- **Sample Tdap Letter**
  English only www.doh.wa.gov/Portals/1/Documents/Pubs/348-289_TdapVaccination6thGradersSampleLetter.doc

  Sample Tdap/Varicella Letter
  English only
  www.doh.wa.gov/Portals/1/Documents/Pubs/348-329-TdapVaricellaComboSampleLetter.doc

Vaccine Resources

- **CDC: Vaccines for Specific Groups** (adoptions, specific medical conditions):
  www.cdc.gov/vaccines/spec-grps/default.htm

- **Foreign Language Terms: Aids to translating foreign immunization records**
  www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/foreign-products-tables.pdf

- **New Mexico Translation of Foreign Vaccines**
  www.nmschoolhealthmanual.org/forms/sectionIX/09_Foreign_Vaccine.pdf

- **Recommended Immunization Schedules**

  Adult: www.cdc.gov/vaccines/schedules/downloads/adult/adult-schedule.pdf
  Childhood: www.cdc.gov/vaccines/schedules/index.html

- **Vaccine Abbreviations and Trade Names**
  www.cdc.gov/vaccines/about/terms/USVaccines.html

- **Vaccine Acronyms and Abbreviations**
  www.cdc.gov/vaccines/about/terms/vacc-abbrev.htm

- **Vaccine-Preventable Diseases**
  www.doh.wa.gov/YouandYourFamily/Immunization/Diseases.aspx

- **Vaccine Terms in Multiple Languages**
  www.immunize.org/catg.d/p5122.pdf

References

- **Glossary of Immunization and Public Health Terms**
  English only www.doh.wa.gov/Portals/1/Documents/Pubs/348-269-GlossaryImmunizationPublicHealthTerms.pdf

- **Pink Book: Epidemiology and Prevention of Vaccine-Preventable Diseases**
  www.cdc.gov/vaccines/pubs/pinkbook/index.html

Office of Immunization and Child Profile School and Child Care Resources

- **Free Educational Materials**
  www.doh.wa.gov/YouandYourFamily/Immunization/FormsandPublications.aspx

- **Local Health Jurisdiction Contact List**
  www.doh.wa.gov/AboutUs/PublicHealthSystem/LocalHealthJurisdictions

Appendix A: Frequently Asked Questions about Conditional Status

Definitions

1. **Q: What does conditional status mean?**
   A: When a child is missing one or more immunizations required for school or child care entry, their immunization status is conditional. Children in conditional status are allowed to attend school or child care on the "condition" they make satisfactory progress to getting completely immunized.

2. **Q: What does satisfactory progress mean?**
   A: Satisfactory progress means starting or continuing to get all required immunizations based on national immunization guidelines and within certain time frames:
   (a) A student must get any missing immunizations within thirty days after the first day of attendance or after a temporary medical exemption expires.
   (b) When the immunizations are part of a series with recommended intervals between doses, the student must get the missing immunization no later than thirty days past the recommended date of the next dose.

3. **Q: When does a child enter conditional status and for how long?**
   A: The most common scenario occurs when a child arrives on their first day of school missing a required immunization(s). The child then has 30 days from their first day of attendance to get immunized or to get an exemption. A child also enters conditional status whenever a temporary medical exemption expires. In these rarer cases, the child has 30 days from the date the medical exemption expired to get the missing immunization(s).

4. **Q: Can students start conditional status after they enroll in school?**
   A: The WAC refers to the first day of attendance, not enrollment.

5. **Q: Does conditional status only apply to students attending a new school or district?**
   A: No, conditional status applies to any student missing immunizations and fails to make satisfactory progress toward full immunization, and does not have an exemption on file. The first day of attendance starts when a student enters a new school.

6. **Q: Does conditional status apply to children in child care?**
   A: Yes, Department of Early Learning's (DEL) rule, WAC 170-296A-3275, discusses conditional status for children in licensed child care. The rule is slightly different and requires immunizations to be initiated before or on enrollment. If you have questions about children in child care, please talk with the DEL licensor.

Questions related to the WAC

1. **Q: What is the WA Administrative Code (WAC) that talks about conditional status?**
   A: It is WAC 246-105-020.

2. **Q: When did this law take effect?**
   A: January 26, 2009.

3. **Q: Why did the WAC get updated in 2009?**
   A: The State Board of Health replaced WAC 246-100-166 with Chapter 246-105 Sections 010 to 090. In addition to reorganizing the WAC, the Department of Defense, Office of Superintendent of Public Instruction, State Board of Health, and Department of Health (DOH) met in 2008 to discuss the military compact. The military compact allows military students 30 days from the date of school enrollment to get required immunizations or to initiate the immunization series. A conflict existed between military students and non-military students not allowed to be in conditional status after the first day of attendance. These organizations made the decision to update WAC 246-105-020.

4. **Q: I'm familiar with the term conditional status because it has been around for a long time. What changed in 2009?**
   A: WAC 246-105-020 allows students with any missing immunizations to be in conditional status for thirty days AFTER the first day of attendance. Before 2009, the attendance of every student was conditioned upon the presentation of proof of full immunization before or on the first day of attendance.

5. **Q: Many school nurses are concerned about the changes in the WAC. Is there an opportunity for the State Board of Health to open this rule in the future?**
   A: The State Board of Health met with school nurses, including OSPI, School Nurse Corps Administrators, Department of Early Learning, Washington State School Directors' Association, principals, and DOH staff in 2012 to discuss conditional status and determine if the rule needed to be changed. A survey was sent out in 2012. Based on the discussion, the decision was made not to revise the WAC but to provide support to schools. The Board continues to welcome comments from school nurses.

6. **Q: Are schools required to implement the changes with conditional status if they haven't already?**
   A: The WAC was effective in 2009. Schools should follow their usual process to review school policies and discuss applicable state and federal regulations with their risk managers.

7. **Q: Is there a requirement to make more than one parent contact by letter or phone to let them know their child is in conditional status, or just the notice of exclusion noted in WAC 392-400-300?**
   A: No additional requirements exist beyond the WAC procedures for excluding students. Even thought not specified in WAC, it is best practice to send a written notice to parents about the student's conditional status.

Specific scenarios

1. **Q: What if the child needs more than one dose to complete a vaccination series?**
   A: The child has 30 days from their first day of attendance to get the first needed dose. The child stays in school under conditional status for up to 30 days after the next dose is due. The child remains under conditional status for the entire time they are in the process of completing the series.

   EXAMPLE: A Kindergartener on their first day of school has never been vaccinated against varicella. According to state requirements, the child needs two doses separated by the recommended minimum interval of three months. If the child got the first dose on October 1st they cannot get a second dose until January 1st (three-month minimum interval). The child would then have 30 days after January 1st to get the second dose.

2. **Q: A 4th grade student who transferred from another state needs hepatitis B vaccine dose #3. When is this student out of compliance with the school requirements?**
   A: Students in the process of getting vaccinated stay in conditional status after the first day of attendance for up to 30 days after the next dose is due, based on the recommended interval. Students who can't show satisfactory progress 30 days past the usual **recommended** interval for a dose are out of compliance.

3. **Q: If I notified the parents of a 2nd grader multiple times during the school year and the student does not show satisfactory progress toward full immunization status, can I exclude the student?**
   A: If you are in a situation where you need to send a conditional letter during the school year rather than on the first day of attendance, the student is in conditional status beginning on the day you send the letter. If the student fails to make satisfactory progress to get fully immunized or get an exemption during the following 30 day period, follow your policy and procedures to determine if a student should be excluded. If a student has received a conditional letter in one school year and has not met the requirements to come into compliance by the beginning of the next school year, he or she can be excluded at any time.

4. **Q: I notified parents of 5th graders that the students need a Tdap by 6th grade. I notified parents in the spring before the students started 6th grade. Is the student out of compliance on the first day of attendance if they show up without a Tdap?**
   A: Since Tdap is not required until 6th grade, students can attend school in conditional status for 30 days as long as they make satisfactory progress to get their required Tdap or they get an exemption.

5. **Q: How about a student entering kindergarten? If I notified parents about the kindergarten requirements the previous year and worked with parents to get their child in compliance in the spring, is the student out of compliance on the first day of school?**
   A: No, the requirement doesn't apply until kindergarten. A kindergartener gets 30 days after the first day of attendance to be in compliance, or they can get an exemption.

6. **Q: Can homeless students under the McKinney Vento Act be considered in conditional status? How long can we consider these students in conditional status**?
   A: Homeless students who lack immunizations or immunization records should be placed in conditional status until they get immunizations or until their immunization records have been received at the enrolling school. If, after 30 days, the students are not showing satisfactory progress toward getting immunized, or the school has not made progress in getting immunization records, then the student will be marked out of compliance. Homeless students cannot be excluded from school while they are marked out of compliance and the homeless liaison should continue to help homeless students get immunizations, their immunization records, or an exemption.

7. **Q: Can students trying to get an exemption be placed in conditional status until they get their Certificate of Exemption signed by a healthcare provider?**
   A: Students are in conditional status if they do not get one or more required vaccines on their first day of attendance or, in some cases, after they began school or child care. From the time they get notified that their child is in conditional status, parents or guardians have 30 days to get the child vaccinated, show a record of past vaccination, or exempt their child for the missing vaccine

8. **Q: Can students who have a signed CIS but didn't list any immunizations be placed in conditional status?**
   A: Yes. WAC 246-105-050 requires a signed CIS with vaccines that the student received as a condition of attendance in school or child care. Conditional status allows a student to have time to get fully immunized, finish their paperwork, or get an exemption.

9. **Does DOH have sample letters for students in conditional status or need to be excluded?**
   A: Yes, DOH developed sample letters. You can access them here:
   Conditional status letter:
   www.doh.wa.gov/Portals/1/Documents/Pubs/348-277-ConditionImmunStatus.doc
   Exclusion letter for Public Schools:
   www.doh.wa.gov/Portals/1/Documents/Pubs/348-279-ExclusionLetterPublic.doc
   Exclusion letter for Private Schools:
   www.doh.wa.gov/Portals/1/Documents/Pubs/348-278-ExclusionLetterPrivate.doc

List of Changes to this Manual

Date	Page(s)	Content
6/13/13	33	Inserted this table showing changes to the manual.
6/13/13	17-18	Clarification of homeless student information and categorization of immunization status.
6/13/13	20-21	Updated table showing schools, preschools, and child cares required to comply with immunization requirements and required to report.
10/8/13	5	Clarified that military physicians, naturopaths, or advanced registered nurses can sign the exemption form or write a letter, if this is within the scope of their official duties.
4/15/14	4	Added Appendix A: Frequently Asked Questions about Conditional Status
5/29/14	24	Revised 3rd bullet. Added wording about contacting the local health jurisdiction: • Contact your local health jurisdiction to determine if susceptible students (those not vaccinated or not completely vaccinated) should be excluded until the danger of the outbreak passes.
8/12/14	10 and 12	• Updated link to Individual Vaccine Requirements Summary • Changed reference to 2012 immunization schedule to 2013 immunization schedule • Added the following text: State law does NOT require the CIS to be resubmitted nor reviewed annually or at any other interval.
10/20/14	20	Updated table to include reporting requirement for licensed family home child cares.
3/15/15	2, 10, 12-13, 14, 15, 29-30	• Updated staff information due to staff changes • Updated link to Individual Vaccine Requirements Summary • Removed references to requiring parent consent when school or child care staff updates the CIS • Updated medical exemption information based on the new Certificate of Exemption • Added CIS overlays for middle and high school students • Added recommended vaccines for school staff and link to sample Staff Immunization History Form
4/27/15	29-30	Updated MMR, varicella, and Tdap vaccine recommendations for school staff
5/12/15	26	Updated FERPA section and clarified that parent consent is not required to update the CIS.
6/1/15	24, 30	• Inserted link to Infectious Disease Control Guide • Added link to WSSDA Infection Control Policy and Procedure
8/13/15	20	Clarified reporting requirements for licensed family home child cares and coop preschools
1/14/16	5	Clarified that parent consent may be required before health care providers can release immunization records to a school nurse.
1/21/16	26	• Updated links to Confidentiality Agreement for schools and

		Head Start/ECEAP staff • Removed number 6 in the Key Points about Access: "Unlawful: School nurses or assigned staff cannot submit information from the Immunization Information System directly to the school." The department received guidance from our Assistant Attorney General that parent consent is NOT required for staff to get immunizations from the IIS and add these immunizations to the CIS.

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Infectious Disease Control Guide for School Staff

2014

Student Support

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Acronyms

CDC	Centers for Disease Control and Prevention
CDI	Clostridium Difficile Infections
CMV	Cytomegalovirus Infection
DOH	Washington State Department of Health
DOSH	Division of Occupational Safety and Health
DT	Diphtheria/Tetanus
DTaP	Diphtheria/Tetanus/Acellular Pertussis vaccine
DTP	Diphtheria/Tetanus/Pertussis vaccine
ESD	Educational Service District
HAV	Hepatitis A Virus
HBIG	Hepatitis B Immune Globulin
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HFMD	Hand, Foot and Mouth Disease
HIV	Human Immunodeficiency Virus
HSV	Herpes Simplex Virus
HPV	Human Papilloma Virus
ICP	Infection Control Program
IDRH	Infectious Disease and Reproductive Health
LHJ	Local Health Jurisdiction
MMR	Measles, Mumps, and Rubella Vaccine
MRSA	Methicillin Resistant Staphylococcus Aureous
NGU	Non-Gonococcal Urethritis
OSPI	Office of Superintendent of Public Instruction

PPE	Personal Protective Equipment
RCW	Revised Code of Washington
STI	Sexually Transmitted Infection
TB	Tuberculosis
Td	Tetanus/Diphtheria
Tdap	Tetanus/ Diphtheria/Acellular Pertussis vaccine
VZIG	Varicella-Zoster Immune Globulin
WAC	Washington Administrative Code

Introduction

This material is provided to schools in the state of Washington to assist district staff members in their efforts to preserve and protect the health of both students and employees. Infectious diseases are very common in the school-age child. Because several of the diseases addressed in this manual are vaccine-preventable, it is expected that their incidence in the state will be reduced with the continued implementation of the Washington State immunization law (RCW 28A.210.060-170, see Appendix I) http://apps.leg.wa.gov/rcw/default.aspx?cite=28A.210.060. School districts should always refer to the most updated version of the specific law or regulation on the Department of Health (DOH) Web site.

The following pages contain guidelines for the control and reporting of diseases in the school-age population and among staff members of schools in the state of Washington. Because the authority for control of diseases of public health significance lies with local health jurisdictions, schools should consult with their local health jurisdiction for guidance regarding specific measures to be used in handling individual cases or outbreaks of disease. A number of diseases, although contagious, are not covered in this guide because they are not often seen in school or in people of school age. For some conditions, **we have included information on the effects that childhood diseases could have on adults when those effects are unusual or particularly serious in adults. Examples include chickenpox, cytomegalovirus, Fifth disease, measles, mumps, and rubella. Otherwise, this guide is not intended to be inclusive of adult/employee illness or disease.**

RCW 28A.210.010 Contagious Diseases, Limiting Contact—Rules and Regulations (http://apps.leg.wa.gov/rcw/default.aspx?cite=28A.210.010) requires the State Board of Health, in consultation with the Superintendent of Public Instruction (OSPI), to "adopt rules and regulations regarding the presence of persons on or about any school premises who have, or who have been exposed to, contagious diseases deemed by the State Board of Health as dangerous to the public health" (see Appendix II).

Chapter 246-110 WAC Contagious Disease—School District and Day Care Centers (http://apps.leg.wa.gov/wac/default.aspx?cite=246-110-001) was adopted for the purpose of governing the presence on or about any school or child care center premises of susceptible persons who have, or have been exposed to, an infectious disease. The law intends also that appropriate recommendation be made to the parent when medical treatment is necessary, and that parents be guided to an appropriate source of community sponsored medical care and/or their primary licensed health care provider. Additionally, WAC 246-110-010 (http://apps.leg.wa.gov/wac/default.aspx?cite=246-110-010) defines school as "each building, facility, and location at or within which any or all portions of a preschool, kindergarten, and grades one through twelve program of education and related activities are conducted for two or more children by or in behalf of any public school district and by or in behalf of any private school or private institution subject to approval by the state board of education" (see Appendix III).

Another WAC, 246-101-420 Responsibilities of Schools (http://apps.leg.wa.gov/wac/default.aspx?cite=246-101-420) establishes some steps required of local school districts (see Appendix III). The following are the requirements listed in this WAC:

1. Notify your local health jurisdiction of suspected or confirmed disease cases or outbreaks that may be associated with the school. Note that schools are not responsible for notifiable conditions reporting if a health care provider or laboratory makes the initial diagnosis of the case. A school should report an outbreak that is associated with the school whether or not it involves a notifiable condition and should report any suspected cases of notifiable conditions that are not yet diagnosed.

2. Cooperate with the local health jurisdiction in monitoring influenza.

3. Consult with a licensed health care provider or your local health jurisdiction for information regarding infectious diseases, when necessary.

4. Cooperate as requested by the local health jurisdiction in investigations of diseases of public health significance.

Confidentiality of medical information is also addressed in WAC 246-101-420 (http://apps.leg.wa.gov/wac/default.aspx?cite=246-101-420). School staff with knowledge of a person diagnosed with a notifiable condition may release that information only to others who are responsible for protecting the health of the public through control of disease. Additionally, schools are required to implement policies and procedures to maintain confidentiality of medical information possessed by the school. Child care programs may refer to WAC 246-101-415 Responsibilities of Child Day Care Facilities (http://apps.leg.wa.gov/wac/default.aspx?cite=246-101-415) for similar requirements (see Appendix III).

It is clear that some diseases are “nuisance” diseases that, while not considered particularly dangerous to the community’s health, do cause considerable anguish and disruption to schools. Some examples of include ringworm and infestation with lice or scabies. Because they are not a significant threat to health, these conditions may not be “high priority” for a local health jurisdiction; nevertheless, consultation between school district administrators and local health jurisdictions is important for effective control of “nuisance” diseases in schools.

Disease Reporting, Control, and Exclusion

The local health officer is the primary resource in the identification and control of infectious disease in the community, including child care centers and schools. School staff knowing of a case or suspected case of a notifiable disease such as contained in Chapter 246-110 WAC (see Appendix III), shall report the name and other identifying information to the principal or school nurse. School staff should also report suspected or confirmed outbreaks associated with the school. The school is required in WAC 246-101-420 (see Appendix III) to notify their local health jurisdiction of outbreaks associated with a school as well as suspected cases of notifiable conditions (e.g., suspected pertussis). Additionally, both Chapter 246-100 WAC Communicable and certain other diseases and Chapter 246-101 WAC Notifiable conditions (see Appendices IV and V), define "health care provider" as "any person having direct or supervisory responsibility for the delivery of care who is: (a) Licensed or certified in this state under Title 18 RCW." As health care providers licensed under Title 18 RCW, school nurses (registered nurses) shall follow the requirements of the following WACs (see Appendix V):

- WAC 246-101-101 Notifiable conditions and the health care provider (http://apps.leg.wa.gov/wac/default.aspx?cite=246-101-101).
- WAC 246-101-105 Duties of the health care provider (http://apps.leg.wa.gov/wac/default.aspx?cite=246-101-105).
- WAC 246-101-110 Means of notification (http://apps.leg.wa.gov/wac/default.aspx?cite=246-101-110).
- WAC 246-101-115 Content of notification (http://apps.leg.wa.gov/wac/default.aspx?cite=246-101-115).
- WAC 246-101-120 Handling of case reports and medical information (http://apps.leg.wa.gov/wac/default.aspx?cite=246-101-120).

Local health officers may require reporting of additional diseases and conditions within their respective jurisdictions.

The local health officer shall take whatever action he/she deems necessary to control or eliminate the spread of the disease. There are several options available to the local health officer:

1. Close the affected school(s).
2. Close other schools in the local health officer's jurisdiction.
3. Cause the cessation of selected school activities or functions.
4. Exclude any students, staff, and volunteers who are infected with or deemed susceptible to the disease (WAC 246-110-020 (http://apps.leg.wa.gov/wac/default.aspx?cite=246-110-020) , see Appendix III).

The local health officer is also required to discuss the ramifications of his/her actions with the superintendent of the school district prior to taking action and provide the board of directors and superintendent with a written order directing them to take action. See WAC 246-110-020, Appendix III, for additional requirements.

It is recommended that each school district prepare and adopt, in advance, a policy addressing infectious diseases in students so that, when necessary, appropriate action is taken and the parent/guardian is notified without delay. The Washington State School Directors' Association (WSSDA) offers model policies and procedures for local school districts. Appendix VI is WSSDA's model district policy, Policy No. 3414—Infectious Diseases. Contact WSSDA regarding other health related sample policies. See Appendix XIII, for contact information.

For temporary exclusion of inadequately immunized (susceptible) students and staff during a disease outbreak, refer to the Washington State Department of Health (DOH) *Immunization Manual for Schools, Preschools and Child Care Facilities.* See resources, Appendix XIII, for source. Also consult with the local health jurisdiction.

For information and recommendations on implementation of the Washington Industrial Safety and Health Act, Chapter Chapter 296-823, Bloodborne Pathogens, consult the Office of Superintendent of Public Instruction publication *Guidelines for Implementation of School Employee Training on HIV/AIDS and Other Bloodborne Pathogens (April 2011).* See Resources, Appendix XIII, for source, or your local office of the Department of Health and Safety www.lni.wa.gov.

General Considerations

Exposures to a variety of infectious diseases in a school population are not unexpected and may even be inevitable. This guide provides information to school personnel regarding appropriate actions that can be taken to identify infectious diseases, to assure appropriate health care for students and staff, and to control the spread of disease.

At-Risk Populations

In any school population, there are certain individuals who may have a higher risk of complications if exposed to specific diseases. Students and staff with anemia or immunodeficiencies, and those who are pregnant are all considered "high risk." In addition, those who have chronic disease, nutritional deficiencies, or debilitating illness should also be informed of the possible risks of acquiring an infection. The responsibility of the school is not to determine the extent of that risk, but to inform these individuals whenever there is increased risk of exposure to an infectious disease and to encourage them to consult with their licensed health care provider. The licensed health care provider will assess the risk and make appropriate recommendations for treatment of his/her patient.

Hand Washing and Hand Sanitizers

Frequent hand washing is the most important technique for preventing the transmission of disease. Proper hand washing requires the use of soap and water and vigorous washing under a stream of temperate (warm), running water. Dry with single use disposable towels.

Hand sanitizers are not as effective as washing with soap and water and should not be used as a replacement for standard hand washing with soap and water. When hand washing facilities are not available, an ethanol alcohol-based (minimum 62 percent) hand sanitizer can be used, preferably in fragrance-free gel or foaming form. Hands must be washed with soap and running water as soon as feasible. Hand sanitizers are never appropriate when there is significant contamination such as occurs during a visit to a petting zoo or farm, after handling an animal, after changing a diaper, after playing outside, before preparing food or eating, after touching an infected wound, or after using the bathroom. Hand sanitizers have not been shown to be effective against norovirus or *Clostridium difficile* spores or for soiled hands. Caution is recommended to avoid accidental ingestion or abuse of hand sanitizers by students.

Home/Hospital

Home/hospital instruction is provided to students who are temporarily unable to attend school for an estimated period of 4 weeks or more because of physical disability or illness. Tutoring is provided to **students who are ill or disabled**, requiring instruction at home or in a hospital. The program does not provide tutoring to students caring for an infant or a relative who is ill. Detailed information may be found at the OSPI Health Services Web site at http://www.k12.wa.us/healthservices or by contacting the OSPI Health Services office at 360-725-6040.

Common Indicators of Infectious Diseases in Children

Introduction

Since classroom teachers spend several continuous hours a day with their students, they are often in an excellent position to detect early physical and behavioral changes in students who are ill at school. Teachers may observe differences in the usual pattern for a particular student.

The physical and behavioral “indicators” listed below are nonspecific and do not in themselves suggest the presence of an infection.

Appetite

Often, a student who is ill or becoming ill with an infection will exhibit changes in eating habits. He/she may “pick at” solid foods, eat lightly, want only certain foods, and/or prefer liquids.

Behavior

Irritability may be associated with illnesses, often because of the accompanying fatigue, fever, and discomfort. Play activities may diminish and the student may become lethargic (drowsy or indifferent).

Fever

Parent/guardian and school staff may experience concern about fever, and yet fever does not automatically require intervention. Several scientific studies have shown that fever rarely causes harmful effects in itself. Recurrent low-grade fever may occur as the result of physiological changes in the body and may not cause any discomfort to the student.

Fever is a concern when it suggests the presence of an infectious disease. Students with fever over 100.4°F (38°C) may need to be sent home from school, especially if other symptoms are apparent. The student’s parent/guardian should be notified.

Symptomatic treatment of any illness in the school setting should be undertaken only if the parent/guardian has complied with school policy on the administration of oral medications for symptomatic treatment of illness or injury. Aspirin should not be administered for viral illnesses because of the possible association with Reye syndrome.

Skin Color

A pasty, pale appearance may signal an illness, especially if it is a change from a student’s normal skin color. The development of any of the following may also indicate an illness:

- a yellow tinge to the eyes or skin.
- a flushed appearance with rosy cheeks and glassy or red eyes.

Rash

The differential diagnosis of rash illnesses can be very difficult and even a licensed health care provider (HCP) will often require lab tests to confirm whether a certain disease is present. If measles or rubella is suspected, the school must notify the local health jurisdiction immediately. If a referral to a HCP is made, advise the student's parent/guardian to inform their HCP 's office staff of the presence of a rash illness so that appropriate medical isolation can be arranged prior to the visit.

Itchiness of the rash is not a signal of infectiousness or non-infectiousness, however, itching should also be evaluated. A rash can be a symptom of a serious or non-serious condition. Rashes can have an infectious or a non-infectious cause.

Change in Bowel Habit

Diarrhea may accompany a number of infectious diseases. Conversely, an intestinal infection can also cause sluggishness of the bowels and constipation, sometimes with abdominal cramps. Cramps can be due to inactivity, a change in the ill student's level of activity, or to dehydration that often occurs during infections. Cramping accompanied by fever and bloody diarrhea are always serious medical concerns and should be immediately referred to a health care provider for evaluation.

Diarrhea or even apparently normal feces following the resolution of diarrhea may carry an infectious organism that can transmit to others in a school setting. The local health jurisdiction may require that children or employees with certain infections not return to school until testing negative for the infection.

If a student vomits or has diarrhea at school, contact the school nurse for guidance. If the school nurse is not available contact the parent and have the child go home for further observation.

Nasal Discharge and Obstruction

Clear nasal discharge may signal an infection such as a cold or it may indicate an allergic reaction, especially if accompanied by watery eyes. Yellow or green discharge may indicate an infection or obstruction by a foreign body. Breathing may be noisy if the nasal passages are obstructed. If breathing is labored, immediate medical referral is indicated.

Sore Throat

A sore throat can be a minor problem, but it can also indicate more significant infections such as streptococcal pharyngitis, infectious mononucleosis, or other serious generalized illnesses. If the sore throat is accompanied by fever, difficulty swallowing,

and/or swollen lymph nodes (glands), notify the parent/guardian and recommend medical evaluation.

Cough

Some chronic conditions or allergic conditions are accompanied by a cough. However, a cough may also indicate an infectious disease. Persistent coughs, especially with other symptoms such as episodes of coughing followed by gagging, or a whooping sound, vomiting, fever, loss of appetite, or weight loss, need medical evaluation.

Earache and Discharge from Ear

A student may complain, pull at the ear, or put a hand to the ear if there is discomfort. When there is an earache, particularly when blood or pus is seen running from the ear, the student needs to be referred for medical care.

Pain (Back, Limbs, Neck, Stomach)

Pain in the body and limbs may be a normal part of the growth process, especially in adolescents. However, leg and back pains can also be seen during the course of infectious diseases. Stomach pains or cramps may not signal serious disease in children, although appendicitis must be considered when abdominal pain is severe or persistent. Gastrointestinal disturbances such as vomiting, diarrhea, and constipation may be accompanied by abdominal pain (see section on Change in Bowel Habits above). The student who is absent frequently for abdominal pain should receive medical evaluation.

Note

Prompt identification is important to the control of infectious diseases. Therefore, throughout this guide, distinguishing characteristics of various infectious diseases are given, along with the school's responsibility for intervention. Since this material has been developed for the purpose of assisting school nurses, principals, secretaries, and teachers in making decisions about the public health implications of certain disease situations, a statement here about the exclusion of an affected student from school or from certain school activities is necessary.

When a notifiable condition is suspected, the local health jurisdiction should be contacted. In addition to assisting the administrator or his/her designee in deciding whether a student should attend school, the local health jurisdiction can also assist in evaluating whether the disease has implications for the student's participation in such activities as physical education, athletics, field trips, and lunchroom work. For example, a student who may possibly infect others with a disease that can be spread via droplets, fecal-oral contamination, or sores on the skin cannot work in food services until approved to do so by the school nurse, licensed health care provider, or public health official.

Athlete's Foot (Tinea Pedis)

Description

Athlete's foot is a skin infection caused by a fungus in which there is scaling, cracking, and peeling between the toes and on the feet. There may be blisters with thin, watery fluid. Athlete's foot usually causes itching, stinging, and burning. Foul odor may occur. Athlete's foot is a common infection in adolescents and adults, but relatively uncommon in children. Similar fungal infections occurring on the body or head are called ringworm (see Ringworm).

Mode of Transmission

Athlete's foot is spread through contact with skin scales containing fungi, or with fungi in damp areas, such as swimming pools, locker rooms, and showers. It can also be spread through family household members.

Incubation Period

Unknown.

Infectious Period

Athlete's foot is infectious as long as the fungus is present on the skin and on contaminated surfaces.

School Staff/Nurse Responsibility

1. Over-the-counter topical medications are usually sufficient to treat athlete's foot. In persistent, severe cases, or when a secondary infection is suspected, referral to licensed health care provider may be necessary.

2. Maintain and support confidentiality for the student.

Control of Spread

1. Utilize standard precautions (see Appendix VIII, *Guidelines for Handling Body Fluids in Schools).*

2. Refer to district infection control program protocols and policy for infectious diseases.

3. The fungus that causes athlete's foot thrives in damp, moist environments. Therefore, thorough, frequent cleansing and **drying** of gymnasium, shower, and pool area floors are essential.

4. Students with an active infection should not use wet or damp areas withere the infection can be transmitted.

Athlete's Foot (Tinea Pedis) (cont.)

5. Instruct individuals with athlete's foot to:

    - **Keep feet dry**, especially between the toes. Thoroughly dry feet and toes when wet from water or sweat.
    - Remove shoes and socks to expose feet to the air whenever possible.
    - Wear clean, dry socks or stockings made of natural material, such as cotton, or a synthetic fabric designed to draw moisture away from the feet.
    - Change socks or stockings more than once a day, as necessary.

Future Prevention and Education

Physical and health education teachers can be helpful in preventing the spread of athlete's foot by ensuring the proper cleansing and drying of locker rooms, showers, and pool areas, particularly floors.

Instruct students about the causes, means of transmission, and prevention of this condition.

Bed Bugs

Description

Bed bugs are oval, rust colored, wingless insects up to a quarter inch long. They bite but are not known to spread any human diseases. The insects hide between mattresses or in crevices during the day and feed on human blood at night. The bites are small raised red bumps, often in a line, that may be itchy or painful. Bed bugs occur primarily in buildings with shared housing, such as hotels, motels, and apartment buildings.

It is rare for a school to have bed bug infestations because bed bugs feed at night. Bed bugs could be brought in on student, staff clothing, or belongings.

Mode of Transmission

Transmission occurs through contact with personal articles such as bedding or clothing that are infested. Animals do not transmit bed bugs.

Incubation Period

Bed bugs can survive months between blood meals.

Infectious Period

Bed bugs do not spread diseases between people.

School Staff/Nurse Responsibility

1. If a bed bug is found on a student, their clothing, or belongings, it is NOT necessary to send the student home; however, the parent or guardian should be notified.

2. Make referral to licensed health care provider as needed for diagnosis if bed bugs are observed or suspected.

3. If bed bugs are detected, collect a sample for identification by a professional. Bed bugs can closely resemble other insects, so accurate identification is essential.

4. Instruct the family to wash school clothing and other personal items taken to school, such as backpacks, in 130^{o} F water. Machine-dry using the hottest setting for at least 20 minutes.

5. Assess family situation and if necessary assist the family with community resources.

6. Maintain and support confidentiality for the student.

Control of Spread

1. Utilize standard precautions (see Appendix VIII, *Guidelines for Handling Body Fluids in Schools)*.

Bed Bugs (cont.)

2. Refer to district infection control program protocols and policy for infectious diseases.

3. If a bed bug is tentatively identified, a person experienced with bed bug identification should thoroughly inspect the area.

4. Thoroughly clean the building location where the bed bug was found. Professional advice may be needed. Vacuum carpeting and crevices. Wash fabric items and dry in a hot dryer. Personal items such as coats and backpacks should be stored in plastic containers or bags (both at home and at school) while the problem is being resolved.

5. Monitor and re-inspect the classroom and personal belongings/storage areas.

Future Prevention and Education

General cleanliness measures will protect against bed bugs in schools:

1. Eliminate clutter that can shelter pests, such as cardboard boxes.

2. Seal cracks and crevices in walls.

3. Minimize upholstered furniture in the classroom. Launder floor pillows, mats, and other shared fabric items regularly and dry in a hot dryer.

4. Vacuum carpeted areas regularly.

5. Backpacks and coats can spread pests such as bed bugs. Use separate lidded plastic containers or bags for these items and for lost and found collections.

Resources

Bed Bugs: What Schools Should Know (May 2010)
Michigan Bed Bug Working Group
http://www.michigan.gov/documents/emergingdiseases/Bed_bugs_schools_293498_7.pdf

Washington State University School Integrated Pest Management. Pest Press - Bed Bugs (2011)
http://schoolipm.wsu.edu/bedbugs.html

Washington State Department of Health. Bed Bugs
http://www.doh.wa.gov/CommunityandEnvironment/Pests/BedBugs.aspx

Bites

Animal Bites

Description

Bites from animals carry several different risks:

1. Trauma and damage to tissue.
2. Infection by organisms from the animal including the possibility of rabies.
3. Infection by human skin organisms and environmental organisms introduced into the wound.
4. Toxic exposures (e.g., certain snakes or spiders, which are not appropriate for school settings).

Most schoolroom bites are from laboratory or small pet animals such as white mice, gerbils, guinea pigs, and hamsters. Bites from these animals are generally minor injuries and since the animals are not wild, there is very little risk of rabies. Although tetanus may be the first infection that comes to mind in connection with a bite, other infections, severe bruising, or skin cuts may occur. These injuries require first aid and referral for medical care. Rare infections, such as lymphocytic choriomeningitis virus have been spread from mice or hamsters. Animal feces, which can contaminate the entire animal, can transmit infections such as salmonellosis and hand washing with soap and water is important after handling animals.

Bites from certain wild or ill mammals carry a risk of transmitting rabies. The risk of rabies exposure varies by region. In Washington State, bats and, very rarely, dogs or cats have been rabid. Elsewhere in the United States, rabies has been associated with bats, raccoons, foxes, skunks, coyotes, and occasionally other animals bitten by a rabid animal. Rabbits, rodents, squirrels, and any animals raised indoors and kept inside in cages have minimal risk of carrying rabies.

Rabies is almost always a fatal disease once the person develops symptoms. Prompt medical treatment following an animal bite can reliably prevent rabies from developing. Any suspected human exposure to rabies from an animal should be evaluated by your local health jurisdiction or a designated authority.

Mode of Transmission

Bacteria in an animal's mouth may cause an infection. A bite may also become infected with skin organisms. Certain animal bites can transmit infectious conditions such as rabies. Imported animals, including dogs, may be rabid. Exotic animals (not from North America) may carry other serious infections.

Bites (cont.)

Incubation Period

Skin infections typically occur within a few days of the initial trauma. The incubation period for rabies is typically 3–8 weeks, but ranges from 9 days to 7 years.

Infectious Period

Animals with rabies may be infectious for various periods of time. Rabid animals may not show classic symptoms of rabies such as foaming at the mouth or aggression.

School Staff/Nurse Responsibility

1. Provide basic first aid immediately, washing the wound thoroughly with soap and water.

2. Utilize standard precautions (see Appendix VIII, *Guidelines for Handling Body Fluids in Schools).*

3. Refer to district infection control program protocols and policy for infectious diseases.

4. Notify parent/guardian.

5. Immediately report to your local health jurisdiction suspected rabies exposure or known toxic snake or spider bites. Evaluation of the animal may be necessary. Washington Department of Health also recommends you report finding dead or ill bats to your local health jurisdiction.

6. Make referral to licensed health care provider for evaluation of the bite and for additional medical care if needed for bruising, skin damage, or other injury.

7. Make referral to licensed health care provider for tetanus booster, if needed.

8. If a bat or wild animal is the biting animal, do not touch or move the animal. Contain the animal only if it is safe to do so. For example, put a bucket over a bat on the ground.

9. If a student receives an animal bite, report the incident to your local animal control agency.

10. Maintain and support confidentiality for the student.

11. Refer to district policy and procedure related to animals in the classroom. If the District does not have a policy and procedure, consider adopting them. Guidance is available from the DOH School Environmental Health and Safety Program.

Bites (cont.)

12. If the bite occurred on school grounds, during school hours, or while in the care of school staff, report to building administrator and document incident per district policy and procedure.

13. Retain thorough documentation and evidence.

Future Prevention and Education

1. Teach students not to touch wild or unfamiliar animals, particularly bats or any animals that are acting sick.

2. Do not allow students or teachers to bring wild animals onto school property.

3. Discourage students from bringing exotic animals onto school property.

4. Advise students to wash their hands properly with soap and vigorous washing under a stream of temperate (warm) running water. Hand sanitizers are never appropriate when there is significant contamination such as would occur when touching an animal.

5. Refer to the *Health and Safety Guide Section for K–12 Schools in Washington,* Section O: Animals in Schools and Appendix F: Animals in the Classroom at http://www.k12.wa.us/SchFacilities/Publications/pubdocs/CompleteSafety&HealthManual2002-2003.pdf.

6. Under the 2011 notifiable conditions rule revisions, the WAC was modified to no longer require reporting of all animal bites. Only those situations in which human exposure to rabies is suspected are reportable to the local health jurisdiction. For the purposes of reporting, "Suspected Rabies Exposure" includes two conditions listed in the 2011 rule revisions:

    - Rabies, suspected human exposure (due to a bite from or other exposure to an animal that is suspected of being infected with rabies); and
    - Animal bites (when human exposure to rabies is suspected).

7. The Washington State Department of Health School Environmental Health and Safety Program recommends that districts have animal polices and procedures that at a minimum:

    a. Allow in school facilities only those animals, other than service animals, approved under written policies or procedures.

    b. Address for any animals allowed in school facilities measures to prevent:

        i. Injuries caused by wild, dangerous, or aggressive animals;

Bites (cont.)

ii. Spread of diseases from animals known to commonly carry those diseases including, but not limited to, rabies, psittacosis, and salmonellosis;

iii. Allergic reactions;

iv. Exposure to animal wastes; and

v. Handling animals or their bedding without proper handwashing afterward.

c. Address service animals in the school facility that are not well behaved or present a risk to health and safety.

Resources

- WAC 246-100-191 Animals — general measures to prevent human disease http://apps.leg.wa.gov/wac/default.aspx?cite=246-100-191
- WAC 246-100-192 Animals in public settings — Measures to prevent human disease http://apps.leg.wa.gov/wac/default.aspx?cite=246-100-192
- WAC 246-100-197 Rabies — Measures to prevent human disease http://apps.leg.wa.gov/wac/default.aspx?cite=246-100-197
- National Association of State Public Health Veterinarians Animals in Public Settings Compendium

Bites (cont.)

Human Bites

Description

Human bites have a higher complication and infection rate than animal bites. Wounds of the lips and the tissue surrounding the fingernails account for most self-inflicted bites that come to the attention of medical personnel. Occlusional bites (made by the upper and lower teeth closing) may affect any part of the body, but most often the ends of the index and long fingers. About 10–20 percent of human bites seen in emergency rooms are “love nips,” and these injuries may come to the attention of school nurses. Human bites to the hands are generally more serious and more frequently become infected. Human bites may also be caused by, or have reason to be investigated for, child abuse.

Remember that although tetanus may be the first infection that comes to mind in connection with a bite, other infections, severe bruising, or skin cuts may occur. These injuries may require first aid and possibly referral for medical care.

Incubation Period

Development of infection from a bite depends on the depth of the wound, the extent of tissue damage, and the type of infecting bacteria. Organisms may be antibiotic resistant. Common organisms are streptococci and *S. aureus.* Other organisms are *H. influenzae, Bacterioides* spp., *Peptostreptococcus* spp., and *Fusobacterium nucleatum*.

Infectious Period

Bacteria in the mouth or on the skin can cause serious infections. There has never been clearly documented rabies transmission between humans.

School Staff/Nurse Responsibility

1. Provide basic first aid immediately, washing the wound thoroughly with soap and water. Remember that bites to the hand have greater potential for infection.

2. Utilize standard precautions (see Appendix VIII, *Guidelines for Handling Body Fluids in Schools)*.

3. Refer to district infection control program protocols and policy for infectious diseases.

4. Notify parent/guardian of the bite.

5. Make referral to licensed health care provider for evaluation of the bite and for additional medical care, if needed, for bruising, skin damage, or other injury.

6. Make referral to licensed health care provider for tetanus booster, if needed.

Bites (cont.)

7. Investigate bites for child abuse, if necessary.
8. Report to building administrator and document incident per district policy and procedure.
9. Retain thorough documentation and evidence.
10. Maintain and support confidentiality for the student.

Chickenpox (Varicella)

Description

Chickenpox (varicella) is an acute viral illness characterized by a rapid onset of fever, fatigue, and a generalized eruption of the skin. Each lesion begins as a small dewdrop-like vesicle (blister) that scabs over in 3–4 days. These lesions tend to be more abundant on the trunk than on the arms and legs. Lesions in the eyes and mouth may also occur.

A vaccine is available to prevent the disease. However, sometimes people who have had the vaccine will still get chickenpox (called 'breakthrough disease'). If vaccinated people do get chickenpox, it is usually very mild. They will have fewer spots which may not appear typical and may not have vesicles (blisters), and they are less likely to have a fever, and usually recover faster.

Although the total number of varicella cases is declining, a shift of the remaining varicella disease burden to middle school years is being observed. In 1995, the median age of varicella infection ranged from 3–5 years in vaccinated persons and from 5–6 years in unvaccinated persons. By 2005, the median age increased to 6–8 years in vaccinated persons and 13–19 years in unvaccinated persons.

This illness is often more severe in teens and adults than in younger children. Use of antiviral medication such as acyclovir, may decrease the number of lesions and duration of outbreak of lesions but is most beneficial if started within 24 hours of rash development.

If a pregnant woman gets **varicella** during the first 20 weeks of pregnancy, her baby has a 1 in a 100 risk of having serious birth defects**.** Pregnant women who have been exposed to somebody with chickenpox should contact their doctor immediately**.** Those who are not sure if they had chickenpox can have a blood test to see if they are protected against the virus.

Mode of Transmission

Transmission of this highly contagious disease is person-to-person by direct contact, through droplets or airborne spread of secretions of the respiratory tract, or indirectly through articles freshly soiled by discharges from vesicles (blisters) and mucous membranes of infected persons. Chickenpox is not transmitted to or from animals.

Incubation Period

10–21 days, usually 14–16 days.

Infectious Period

Persons with varicella are considered infectious from 1–2 days before the rash appears and until all lesions are crusted over (average range, 4–7 days after rash onset).

Chickenpox (Varicella) (cont.)

School Staff/Nurse Responsibility

The identification of a single case of varicella should trigger intervention measures because this case could lead to an outbreak. Varicella outbreaks have been documented in highly vaccinated populations and vaccinated persons acted as the index cases in several outbreaks. Because one case of chickenpox in a school represents the potential for an outbreak, the local health jurisdiction should be notified whenever chickenpox occurs in a school environment.

1. Referral to a licensed health care provider is recommended. During an outbreak, laboratory confirmation of varicella is recommended for one or more cases (regardless of the patients' vaccination status), especially at the beginning of the outbreak. Advise parent/guardian to inform their licensed health care provider's office staff of the presence of a rash illness so that appropriate medical isolation during the visit can be arranged.

2. Notify classmates' parent/guardian of the presence of chickenpox in the class (or at the school) as appropriate.

3. Any time a case of chickenpox occurs in a school, inform students and staff with certain high-risk conditions (anemia, immunodeficiencies, and pregnancy) of the increased risks of acquiring the infection. Refer them to their licensed health care provider for guidance. Individual student health plans for high-risk students should include planning for exclusion, in consultation with the student's licensed health care provider, as a way to avoid contact with specific infections.

4. Inform the parents/guardians that children with chickenpox should not receive aspirin because of its possible association with Reye Syndrome.

5. Maintain and support confidentiality for the student.

Control of Spread

1. Screen for school vaccine entry requirement.

2. Utilize standard precautions (see Appendix VIII, *Guidelines for Handling Body Fluids in Schools).*

3. Refer to district infection control program protocols and policy for infectious diseases.

4. Exclude students with chickenpox from school until all lesions have crusted.

5. Parents of children without evidence of varicella immunity should be advised to have their child vaccinated with the appropriate dose or, if vaccination is contraindicated or refused, exclude the child from school up to 21 days after the last case is identified.

Chickenpox (Varicella) (cont.)

6. If a student develops a rash following varicella vaccination, refer to primary care provider for decision regarding communicability and safe return to school.

7. Clean or dispose of any articles soiled with nose and throat discharges.

8. Instruct students never to share items that may be contaminated with saliva such as beverage containers.

9. Cover mouth with tissue when coughing or sneezing. If no tissue is available, encourage students to “catch your cold in your elbow” by covering their mouth and nose with the crook of their arm and coughing or sneezing into their shirt or coat sleeve.

10. Encourage proper hand techniques.

11. Dispose of bandages that have been in contact with the vesicles (blisters) in appropriate bagged receptacle.

12. Disinfect surfaces that have been in direct contact with fluid from the vesicles (blisters) (see Appendix VIII, *Guidelines for Handling Body Fluids in Schools).*

Clostridium difficile (*C. difficile*)

Description

Clostridium difficile is a toxin-producing, spore-forming bacterium that can cause infectious diarrhea. *C. difficile* infections (CDI) are most commonly found in older adults who are in hospitals or long-term care facilities; they often occur after antibiotic therapy for another infection. Healthy people usually don't become ill even if the bacteria are in their intestines. However, in recent years, some *hospitalized individuals and* otherwise healthy people who are not taking antibiotics or hospitalized have become ill with CDI.

Watery diarrhea (three or more times a day for two or more days) and fever are the most common symptoms of CDI. Loss of appetite, nausea, and abdominal pain can also occur. Some people recover without treatment when they stop taking the antibiotic that precipitated the CDI. With more serious infections treatment with a specific antibiotic that targets the C. *difficile* bacterium may be necessary. Because Washington State does not conduct surveillance for *CDI*, the number of CDIs occurring in school-aged children is unknown, but likely remains rare.

Mode of Transmission

C. difficile is spread through the feces, most commonly by touching contaminated items or surfaces. Health care providers who do not wash their hands between patients can transfer the infection from one patient to another.

Incubation Period

Variable, since *C. difficile* can be in the intestine without causing an infection until antibiotics are taken.

Infectious Period

People can have *C. difficile* in their intestines without having an infection, and could spread the bacteria to others through their feces.

School Staff/Nurse Responsibility

1. Refer suspected cases to licensed health care provider.

2. Report groups or clusters to the local health jurisdiction immediately.

3. Refer food handlers with diarrhea to a licensed health care provider or their local health jurisdiction so they can be cleared before returning to work. The school's responsibility for all students, staff, and parents/guardians who prepare food or handle shared food cannot be overemphasized. The importance of proper handwashing techniques must be stressed to employees, volunteers, and students.

Clostridium difficile (*C. difficile) (c*ont.)

4. Assure that diaper changing areas or other surface/items contaminated with *diarrheal stool* are cleaned and disinfected with EPA-registered detergents/disinfectants that kill *C. difficile* spores or a 1:10 bleach solution (see Appendix VIII, *Guidelines for Handling Body Fluids in Schools)*.

5. Instruct students and staff regarding proper hand washing techniques.

6. Maintain and support confidentiality for the student.

Control of Spread

1. Utilize standard precautions (see Appendix VIII, *Guidelines for Handling Body Fluids in Schools).*

2. Refer to district infection control program protocols and policy for infectious diseases.

3. Encourage good personal hygiene and proper hand washing techniques after going to the bathroom, before and after preparing food, before and after eating, after sneezing, coughing, or using tissue, before feeding a baby, before and after changing diapers, after touching dirty laundry, after touching garbage or trash, after taking off disposable gloves, and after touching animals or animal waste. This is the most important means of preventing the spread of intestinal diseases. Soap and water is the best choice for hand hygiene when someone is infected with *C. difficile* because alcohol-based hand sanitizers will not destroy *C. difficile* spores.

4. Ensure adequate handwashing facilities for all students and staff handling food (warm water, soap, and paper towels). This is required under Chapter 246-366 WAC (see Appendix VII).

5. Do not allow a child or staff person who was infected with *C. difficile* to return to school until the person has been diarrhea-free for at least 48 hours.

6. Carry out proper handwashing techniques, dispose of feces-contaminated materials properly, and clean and disinfect areas contaminated by feces appropriately because an infected individual may show no symptoms.

7. *Always* use gloves when changing diapers. Remove and dispose of gloves properly following diaper change and wash hands with soap and water immediately. Surfaces where diapers are changed must be cleaned and disinfected after each use. If a surface is visibly dirty, a cleaner or detergent must be used first, then the surface should be rinsed, *then* disinfected. A 1:10 solution of chlorine bleach is needed to kill *C. difficile* spores with a minimum wet contact time of 5 minutes, or an EP-registered detergent/disinfectant for killing *C.*

Clostridium difficile (*C. difficile) (c*ont.)

difficile spores (see Appendix VIII, *Guidelines for Handling Body Fluids in Schools).*

Future Prevention and Education

To prevent the spread of infections from the intestine, including *C. difficile*, wash hands frequently with soap and water. Alcohol-based hand gels do not kill *C. difficile* spores.

Clean surfaces that have been contaminated with feces in the bathroom or diaper changing area or other areas. First use a cleaner or detergent and friction to remove fecal material, rinse with water, then disinfect using a product that contains a 1:10 solution of chlorine bleach or an EPA-registered detergent/disinfectant for killing *C. difficile* spores. Follow the product label for contact time (see Appendix VIII, *Guidelines for Handling Body Fluids in Schools).*

Common Cold

Description

The common cold is a viral upper-respiratory infection that inflames the lining of the nose and throat. Symptoms include runny or stuffy nose, watery eyes, sneezing, coughing, congestion, mild aches, pains, and occasionally fever. Nasal discharge is usually watery and clear at the onset but may become thick and discolored within a few days. Colds are caused by viruses, not by drafts or failure to dress warmly.

Mode of Transmission

The common cold is transmitted by direct contact, by respiratory droplets from sneezing or coughing, or by sharing items contaminated with saliva or droplets.

Incubation Period

Usually 2 to 3 days, but occasionally up to 7 days.

Infectious Period

The common cold is infectious a few days before the onset of symptoms and while clear, running secretions are present.

School Staff/Nurse Responsibility

1. Reporting to your local health jurisdiction is not necessary.
2. Make referral to licensed health care provider if symptoms of significance persist beyond 14 days, or if secondary complications develop.
3. Maintain and support confidentiality for the student.

Control of Spread

1. Utilize standard precautions (see Appendix VIII, *Guidelines for Handling Body Fluids in Schools)*.
2. Refer to district infection control program protocols and policy for infectious diseases.
3. Clean or dispose of articles soiled with nose and throat discharges.
4. Instruct students not to share items that may be contaminated with saliva, such as beverage containers
5. Cover mouth with tissue when coughing or sneezing. If no tissue is available, encourage students to “catch your cold in your elbow” by covering their mouth and nose with the crook of their arm and coughing or sneezing into their shirt or coat sleeve.

Common Cold (cont.)

6. Encourage proper handwashing techniques.

7. Exclusion from school is not necessary, regardless of the color or consistency of nasal discharge, unless the student is feeling ill or has a temperature higher than 100.4 degrees Fahrenheit (F) or (38 C).

Future Prevention and Education

1. Colds generally disappear on their own within 14 days. If the student develops ear pain, severe sore throat, difficulty breathing, or exhibits symptoms beyond 10 days, advise the parent/guardian to call their licensed health care provider.

2. Colds are a viral infection and do not respond to antibiotics.

3. Infants, children, and teenagers should not use aspirin unless prescribed by a health care provider because of its association with Reye Syndrome.

Conjunctivitis (Pink Eye)

Description

Conjunctivitis is a common infection affecting one or both eyes that causes the white of the eye to appear pink or red. Vision is usually normal; however, the eye may water profusely and feel irritated. Eyelids may be swollen. A discharge of liquid or mucus from the infected eye may occur. Eyelids and lashes may become crusted and stick together as the mucus hardens, particularly while sleeping. The student may complain of itching, pain, or sensitivity to light.

Conjunctivitis is commonly caused by viruses or bacteria that may first manifest in one eye and then spread to the other eye within days. Viral conjunctivitis usually produces a clear, watery discharge. Bacterial conjunctivitis usually produces a thicker, yellow-green discharge. Eyelids stuck together after sleeping are most common with bacterial conjunctivitis. Rare severe causes of conjunctivitis are herpes and gonococcui, which need treatment.

Conjunctivitis may also be caused from allergens, such as cosmetics or pollen; reaction to air pollutants, such as dust or smoke; and foreign bodies in the eye, such as contact lenses. Certain chronic illnesses may also cause conjunctivitis.

Mode of Transmission

Bacterial and viral conjunctivitis are easily spread through contact with discharge from the eye or respiratory passages, or from touching or sharing contaminated items of the infected person, such as eye cosmetics, contact lenses, pillows, towels, and microscope eyepieces.

Incubation Period

The incubation period varies depending on the type of conjunctivitis but is usually a few days.

Infectious Period

Bacterial conjunctivitis generally lasts fewer than 5 days, but may persist up to 2–3 weeks. It is contagious while symptoms are present, or until a course of treatment (such as an antibiotic) is started.

The symptoms of viral conjunctivitis are usually worse on days 3–5 of infection, and will usually clear up on their own within 7–14 days. Viral conjunctivitis may be contagious up to 14 days after the appearance of signs and symptoms.

School Staff/Nurse Responsibility

1. Notify the student’s parent or guardian. The family may seek further consultation from a licensed health care provider. The role of antibiotics in treatment of most

Conjunctivitis (Pink Eye) (cont.)

bacterial conjunctivitis and in prevention of spread is unclear. Health care professionals may vary in how they choose to treat this condition.

2. Refer to a licensed health care provider promptly if the conjunctivitis is accompanied by moderate to severe pain in the eye, swelling of the skin around the eye, or vision problems that are not resolved from wiping discharge from the eye.

3. If the student wears contact lenses, refer to a licensed eye care provider to determine if the conjunctivitis may be caused from contact lenses or solution. (Contact lenses can be a source of both bacterial and irritant-caused conjunctivitis).

4. Maintain and support confidentiality for the student.

Control of Spread

1. Utilize standard precautions (see Appendix VIII, Guidelines for Handling Body Fluids in Schools.

2. Refer to district infection control program protocols and policy for infectious diseases.

3. Exclude student from school and refer to licensed health care provider if there is white or yellow drainage from the eye, altered vision, and/or redness of the eyelid or skip surrounding the eye. Minimal redness to the white of the eye with no other symptoms is not grounds for exclusion.

4. Readmit to school upon licensed health care provider approval (with or without treatment).

5. Frequent handwashing is the best method to control and prevent the spread of conjunctivitis.

6. Wipe eyes as necessary to keep free of discharge. Discard soiled tissue or cotton balls. Use a clean tissue, cotton ball, wash cloth, or towel each time.

7. Wash hands after touching infected eyes and items like eyedrop dispenser and eyeglasses.

8. Educate students not to share personal items that touch the eyes, such as towels and cosmetics.

9. Advise students to throw away and replace cosmetics that were used during the infection.

Conjunctivitis (Pink Eye) (cont.)

10. If the student wears contact lenses, advise the student and parents to consult with a licensed eye care professional. The eye care provider may advise the student to replace the lenses, solution, and case that were used during the infection, or to discontinue use of a particular brand of contact lenses or brand of solution. The eye care professional may also recommend that the lenses be removed and glasses worn until the infection is over.

11. Students with conjunctivitis should not use swimming pools.

12. Students with conjunctivitis should not share school or classroom equipment that touches the eyes, such as microscopes.

13. Report to your local health jurisdiction clusters of cases, regardless of the suspected cause of conjunctivitis.

Future Prevention and Education

Reinforce the practice of frequent handwashing.

Educate students not to share personal items that touch the eyes, such as towels and cosmetics.

Educate students with conjunctivitis not to share school equipment that touches the eyes, such as microscopes.

Remember that a source of recurrent eye infections may be contact lenses, solution, or cosmetics.

Remind students to wear, handle, store, and clean their contact lenses as instructed by their licensed eye care provider.

Remind students that eye cosmetics and applicators used during the infection should be discarded.

Seek to identify and remove the source of possible eye allergens and irritants.

Cytomegalovirus Infection (CMV)

Description

Cytomegalovirus infection (CMV) is a member of the herpes virus group. CMV is a common childhood infection (between 50–85 percent of the United States population tests positive by the age of 40 years) and is usually asymptomatic in healthy children. If symptoms do occur they may mimic those of infectious mononucleosis (sore throat, fever, fatigue, and swollen glands). The infection can be severe in immunocompromised persons and newborn infants, and birth defects can occur if a pregnant woman becomes infected.

CMV is spread by contact with secretions or excretions of a previously infected person. In adults, CMV is probably sexually transmitted. Because CMV infection is so common and signs of disease rarely occur in healthy adults and school-age children, testing students for CMV is not recommended. During outbreaks in schools, students and staff with certain high-risk conditions (anemia, immunodeficiencies, and pregnancy) should be informed of the possible risks of acquiring the infection. Pregnant women or those of childbearing age, should always follow proper hand washing techniques, especially if working in a child care setting.

Incubation Period

3–12 weeks.

Infectious Period

CMV is infectious months to episodically for years.

CMV is commonly present in the general population; infected neonates (infants less than the age of 4–6 weeks) may excrete the virus for 5–6 years. Anywhere from 8–60 percent of infants begin shedding the virus during the first year of life.

School Staff/Nurse Responsibility

1. Instruct staff who care for infants in proper methods of diaper changing and disposal of soiled materials.

    There appears to be little risk of CMV-related complications in infants born to mothers who were infected 6 months or more before conception. This group makes up the majority (50 percent–80 percent) of women of child-bearing age in the United States. Among women who were infected with CMV 6 months or more before becoming pregnant, the rate of congenital CMV infection in their infants is approximately 1 percent, and significant illness or abnormalities among these infants appears to be less common than in infants with congenital CMV infection born to women who had a primary CMV infection during pregnancy.

Cytomegalovirus Infection (CMV) (cont.)

> Since CMV is transmitted through contact with infected body fluids, including urine and saliva, contact with young children who are shedding CMV may be a source of exposure to the virus. Pregnant women who have close contact with young children, such as childcare providers and family members, appear to be at a greater risk of CMV infection than persons who do not have ongoing contact with children.
>
> (http://www.cdc.gov/cmv/clinical/at-risk.html)

A woman's susceptibility to the disease can be determined by means of a blood titer (test). On the basis of the test and in consultation with her licensed health care provider, a decision can be made on acceptable risk in unusual school settings involving frequent, sustained contact with secretions or urine. Pregnant women should follow precautions below under Control of Spread.

2. Wash hands after contact with respiratory secretions, urine, or feces, and properly discard any material contaminated with secretions or excretions, such as tissues or diapers.

3. Maintain and support confidentiality for the student.

Control of Spread

1. Utilize standard precautions. (See *Guidelines for Handling Body Fluids in Schools*, Appendix VII).

2. Refer to district infection control program protocols and policy for infectious diseases.

3. Wash hands after diaper changes and after contact with body secretions, especially urine and saliva.

4. Handle diapers carefully, and properly dispose of articles soiled with body fluids.

5. Avoid sharing beverage containers and eating utensils.

Diarrhea

Description

Infectious diarrhea, sometimes with abdominal pain, nausea, vomiting, or fever, has many causes. Most cases are due to viruses, but other causes include bacteria and parasites like *Giardia*. Type and severity of symptoms vary by the causative organism and the resistance of the person infected. Fecal-oral transmission (carrying an infection from human feces to the mouth) is a common means of infection. Transmission can also be through contaminated food, water, or swimming water. *Salmonella*, *E. coli*, *Cryptosporidium*, and *Giardia* are carried by animals and can be transmitted if animal waste is carried to a person's mouth. Determining the specific cause of infectious diarrhea is difficult in a school setting. A student with severe or persistent diarrhea, especially if accompanied by fever and cramps, should be referred for medical care. A common source of infection could cause multiple cases in a given group (e.g., classroom, school, outdoor education program) within a short period of time.

Agent	Description	Incubation	Infectious Period	Duration
Clostridium Difficile	Watery, diarrhea, fever, sometimes nausea and abdominal pain.	Unknown	During illness, up to 48 hours after diarrhea clears. (may be carrier)	Variable
E. coli O157:H7 and related shiga toxin-producing *E. coli*‡	Diarrhea, cramps, may have blood in stool or severe complications	1–9 days (usually 3–4)	During illness and as long as organism is in stool (usually 1–4 weeks)	Variable (days to weeks)
Giardia and Cryptosporidium+	Diarrhea (pale, greasy with Giardia); cramps; fatigue; weight loss; may be asymptomatic	5–25 days or longer; median 7–10 days	During entire infection, which may be asymptomatic	Variable (weeks to months)
Hepatitis A*	Diarrhea, jaundice; may be asymptomatic	5–50 days (usually 28–30 days)	Before and during symptoms	Variable (usually weeks)
*Salmonella**	Cramps, diarrhea, nausea, vomiting, may have blood or pus in stool, may have fever	6–72 hours (usually 12–36)	During illness and as long as organism is in stool (usually 1–4 weeks)	Variable (days to weeks)
*Shigella**	Diarrhea, fever, vomiting, cramps, may have blood or pus in stool	1–7 days (usually 2–4)	During illness and as long as organism is in stool (usually 1–4 weeks)	Variable (days to weeks)
Viral gastroenteritis (also called stomach flu)	Low fever, vomiting, cramps, diarrhea, body aches, headache	Usually 24–72 hours	During illness and shortly thereafter	1–2 days

* Requires a case report to the local health jurisdiction within 1 day of diagnosis or if suspected.
‡ Requires a case report to the local health jurisdiction within immediately on diagnosis or if suspected.
\+ Requires a case report to the local health jurisdiction within 3 business days of diagnosis or if suspected.

Diarrhea (cont.)

School Staff/Nurse Responsibility

1. Immediately report to your local health jurisdiction groups or clusters of suspected foodborne or waterborne illness associated with the school.

2. Report to your local health jurisdiction parental reports of children infected with notifiable conditions such as *Salmonella, Shigella*, Shiga toxin-producing *E. coli*, hepatitis A virus, *Cryptosporidium,* or *Giardia*.

3. Food handlers with diarrhea should be cleared by a licensed health care provider or their local health jurisdiction before returning to work. The school's responsibility for all students, staff, and parents/guardians who prepare food or handle shared food cannot be overemphasized. The importance of proper handwashing techniques, refrigeration, cooking, and serving of food must be stressed to employees. Raw milk and raw eggs may not be served. Food must be protected against contamination.

4. Animals including mammals, birds, reptiles, and amphibians can carry *Salmonella*, *E. coli*, *Giardia,Cryptosporidium*, and other causes of diarrhea. Baby chicks or ducks, wild animals, small "silver dollar" turtles, and animals with diarrhea are not appropriate for classrooms. Children should practice careful handwashing after touching or handling other animals either in school or during field trips. Hand sanitizers are not appropriate for such situations. Handwashing is always recommended before eating. For more information about prevention of human disease from animals, turtles, or birds see:

    - WAC 246-100-191 Animals—general measures to prevent human disease http://apps.leg.wa.gov/wac/default.aspx?cite=246-100-191

    - WAC 246-100-192 Animals in public settings—Measures to prevent human disease http://apps.leg.wa.gov/wac/default.aspx?cite=246-100-192

    - WAC 246-100-201 Psittacosis—Measures to prevent human disease. http://apps.leg.wa.gov/wac/default.aspx?cite=246-100-201

5. Instruct students and staff regarding proper handwashing techniques after using the bathroom, before eating, and after changing diapers.

6. Refer to district policy on animals in the classroom.

7. Maintain and support confidentiality for the student.

Control of Spread

1. Utilize standard precautions (see *Guidelines for Handling Body Fluids in Schools*, Appendix VII).

Diarrhea (cont.)

2. Refer to district infection control program protocols and policy for infectious diseases.

3. A child with diarrhea may transmit the infection to other children in a school setting. The local health jurisdiction may require that children or employees with certain infections not return to school until they test negative for the infection or symptoms resolve.

4. An infected individual may show no symptoms. Therefore, proper hand washing techniques and appropriate disposal of feces and materials contaminated with fecal material must be completed.

5. Surfaces where diapers are changed must be cleaned, rinsed, and disinfected after each use.

6. A child with diarrhea may be infected with *C. difficile*, *Cryptosporidiu*m, or norovirus, which are resistant to many cleansers. A 1:10 bleach solution or wipe, or an EPA-registered detergent/disinfectant for *C. difficile* or noroviruses will be needed to disinfect surfaces or items that may have been in contact with any diarrheal stool (see *Guidelines for Handling Body Fluids in Schools,* Appendix VIII).

Future Prevention and Education

The main methods of prevention are reinforcement of principles of personal hygiene such as proper hand washing techniques after using the bathroom or touching animals.

Food handlers with diarrhea or open skin sores must be excluded from work. Surveillance for further cases may also be appropriate. Students will be kept at home during the times that symptoms make them uncomfortable or when their health care provider or local health jurisdiction so advises. Students may be excluded for certain transmissible infections until testing negative. Persons ill with diarrhea should not swim in pools or lakes and should not handle food to be eaten by others until symptoms are gone.

School pets and animals encountered on field trips can carry *Salmonella, Giardia*, *E. coli*, or other organisms. DOH recommends that animals be visitors for educational purposes, not residents, in schools. Hand washing is essential after touching animals and before eating. For more information about animals in school, refer to the Health and Safety Guide listed below.

Resources

- The *Health and Safety Guide Section for K–12 Schools in Washington,* Section O: Animals in Schools and Appendix F: Animals in the Classroom at http://www.k12.wa.us/SchFacilities/Publications/pubdocs/CompleteSafety&HealthManual2002-2003.pdf.

Diarrhea (cont.)

- The National Association of State Public Health Veterinarians Animals in Public Settings Compendium: http://www.nasphv.org/documentsCompendiumAnimals.html

- Washington State Department of Health *Salmonella* from Chicks and Ducklings: http://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/AnimalTransmittedDiseases/SalmonellafromChicksandDucklings.aspx

- Washington State Department of Health Salmonella from Reptiles and Amphibians: http://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/AnimalTransmittedDiseases/SalmonellafromReptilesandAmphibians.aspx

- Washington State Department of Health Foodborne Illness: http://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/FoodborneIllnesses.aspx

Diphtheria

Description

Diphtheria is an acute infection of the mouth, pharynx, nose, or skin characterized by an inflamed throat sometimes accompanied by the appearance of a grayish membrane. The lymph nodes of the neck tend to be enlarged and there may be marked swelling of the neck. Diphtheria is usually transmitted from person-to-person by airborne droplets from an infected person or carrier. It may be a very serious disease with frequent complications, including heart muscle involvement and respiratory obstruction. Death occurs in 5–10 percent of confirmed cases. However, childhood vaccination has almost eliminated diphtheria in this country. There has not been a case of diphtheria in Washington State for over 30 years.

Incubation Period

Usually 2–5 days.

Infectious Period

Diphtheria is usually infectious for 14 days or less but may be longer. People who have been treated with antibiotics are generally infectious for only 1–2 days after treatment is started. Carriers (persons who are infected but not ill) may shed the organism for an extended period and can spread the disease.

School Staff/Nurse Responsibility

1. Report to your local health jurisdiction of suspected diphtheria cases is mandatory. Follow your local health jurisdiction's recommendation regarding exposed, susceptible persons.

2. Make referral to licensed health care provider of suspicious cases immediately.

3. Maintain and support confidentiality for the student.

Control of Spread

1. Screen for school vaccine entry requirement.

2. Utilize standard precautions (see *Guidelines for Handling Body Fluids in Schools*, Appendix VII).

3. Refer to district infection control program protocols and policy for infectious diseases.

4. Your local health officer will advise the school about control measures. Generally, exclusion from school is mandatory until there are two negative cultures more than 24 hours apart, collected more than 24 hours after the cessation of antibiotic treatment.

Diphtheria (cont.)

5. Unimmunized or inadequately immunized school contacts are at risk of infection. Additional doses of a diphtheria-containing vaccine and prophylactic antibiotics may be recommended for close contacts of a case.

6. Close contacts of a person with diphtheria will be excluded until their cultures are negative and your local health jurisdiction clears them to return.

Future Prevention and Education

1. Properly clean or dispose of articles soiled with nose and throat discharges.

2. Instruct students never to share items that may be contaminated with saliva such as beverage containers.

3. Cover mouth with tissue when coughing or sneezing. If no tissue is available, encourage students to “catch your cold in your elbow” by covering their mouth and nose with the crook of their arm and coughing or sneezing into their shirt or coat sleeve.

4. Encourage proper hand washing techniques.

Fifth Disease (Erythema Infectiosum)

Description

Fifth disease, also known as erythema infectiosum, is a common mild rash illness caused by human parvovirus B19. It usually occurs in students in late winter and early spring, often as clusters or outbreaks. The illness is characterized first by headache, body ache, no or low-grade fever, and chills. These symptoms are usually mild and resolve after a few days. Then, following a week of no symptoms, a bright red rash appears on the cheeks giving a “slapped face” appearance, sometimes with a “lacy” rash on the chest, arms, and legs. The rash is benign but can fade and recur for a few days or a few weeks, especially in response to changes in environmental temperature (e.g., hot bath, exposure to sunlight). Adults may not develop the rash but sometimes experience pains in the joints, especially the hands and feet. Approximately 25 percent of adults who contract the infection have no symptoms.

Although the symptoms are usually mild and in many cases goes unnoticed, the virus has been associated with miscarriages and stillbirths for infections acquired by a woman during pregnancy. The risk of fetal death is less than 10 percent after proven maternal infection in the first half of pregnancy. Infection has also been associated with transient aplastic crisis in some individuals with chronic blood disorders such as sickle cell anemia. Immunosuppressed people may develop severe, chronic anemia if infected with Fifth disease. Exposed persons at risk for severe disease should be referred to their health care provider.

Mode of Transmission

Fifth disease is spread by contact with respiratory secretions. It can also be spread from a pregnant woman to the fetus and through blood transfusion.

Incubation Period

Estimated to be 4–20 days from exposure to development of rash.

Infectious Period

Individuals with mild Fifth disease are probably contagious from respiratory secretions only early in the illness. Thus, by the time the rash appears, the individual is no longer contagious. People with aplastic crisis are infectious up to one week after onset of symptoms. Immunosuppressed people with chronic infection may be infectious for months to years.

School Staff/Nurse Responsibility

1. Students with a rash illness, especially if fever and/or other symptoms are present, should be referred to a health care provider for diagnosis. Students should not return to school until after the fever is gone (normally for 24 hours) and the child feels well enough to participate in normal activities. No treatment is

Fifth Disease (Erythema Infectiosum) (cont.)

indicated for this illness and once diagnosed, it is not necessary to exclude the ill student from school unless a fever is present or there is discomfort from symptoms.

2. Inform known pregnant women of potential exposure and make referral to licensed health care provider.

3. During outbreaks in schools, inform students and staff with certain high-risk conditions (anemia, immunodeficiencies, and pregnancy) of the possible risks of acquiring the infection. High-risk students should have individual health plans that include exclusion, in consultation with the student's licensed health care provider, to avoid contact with specific infections.

4. Maintain and support confidentiality for the student.

Control of Spread

1. Utilize standard precautions (see *Guidelines for Handling Body Fluids in Schools*, Appendix VII).

4. Refer to district infection control program protocols and policy for infectious diseases.

5. Wash hands after contact with respiratory secretions and dispose of facial tissues containing respiratory secretions.

6. Pregnant women with sick children at home are advised to wash hands frequently and to avoid sharing eating utensils.

7. Clean or dispose of articles soiled with nose and throat discharges.

8. Instruct students not to share items that may be contaminated with saliva such as beverage containers.

9. Cover mouth with tissue when coughing or sneezing. If no tissue is available, encourage students to "catch your cold in your elbow" by covering their mouth and nose with the crook of their arm and coughing or sneezing into their shirt or coat sleeve.

10. Encourage proper hand washing techniques.

Future Prevention and Education

The virus causing Fifth disease is quite prevalent in the general community. Approximately 50 percent of young adults demonstrate immunity to Fifth disease resulting from infection in childhood. A serologic test is available and can be used to determine if a pregnant woman is immune, susceptible, or recently infected with

Fifth Disease (Erythema Infectiosum) (cont.)

parvovirus. However, much needs to be learned about the potential risks to pregnant women.

Students and staff with certain high-risk conditions (anemia, immunodeficiencies, and pregnancy) who may be exposed to Fifth disease should be advised that there might be some risk. Their licensed health care providers and local health jurisdictions are responsible for determining risk and recommending any intervention.

Foodborne Disease

Description

Foodborne disease is a broad term referring to many different kinds of infections and poisonings that are spread by food. Foodborne disease can be caused by bacteria, viruses, parasites, chemicals, naturally occurring poisonous plants, and other agents. Depending on the agent and the patient, foodborne disease often manifests with any combination of the following: diarrhea (with or without blood), vomiting, nausea, abdominal cramps, fever, decreased energy, headache, loss of appetite, sore throats, and allergic reactions. In rare cases, kidney failure, blood clotting disorders, neurological symptoms, blood stream infections, and death can result.

Mishandled or contaminated food is a leading cause of diarrheal illness in the United States. Norovirus or other viral agents are probably the most common cause of gastroenteritis (often called “stomach flu”) and can be spread by contaminated food, contaminated water, or person to person including contaminated surfaces such as doorknobs and railings. The extent to which viral gastroenteritis contributes to school absenteeism appears significant, but remains undocumented because testing is rarely done. *Campylobacter jejuni* gastroenteritis is the most commonly diagnosed and reported cause of foodborne illness in Washington State. Other causes of foodborne illnesses reported in Washington include norovirus, *Clostridium perfringens*, *Salmonella*, *E. coli* O157:H7 and related shiga toxin-producing *E. coli*, *Bacillus cereus,* and viral hepatitis A.

Foodborne disease is usually self limiting. Treatment is generally supportive and focused on fluid replacement and, in some cases, fever control. More aggressive treatment may be indicated in severe cases as determined by the licensed health care provider.

Mode of Transmission

The transmission of foodborne illness requires one or more of the following conditions: inherently contaminated produce, raw or inadequately cooked contaminated foods (meat, milk, eggs), bacterial multiplication in food held at room temperature instead of being chilled or kept hot, cross-contamination of food with raw meat or raw poultry, or contamination of food by an infected food handler.

Different agents of foodborne illness have different characteristics. The incubation period and symptoms can suggest the agent. (See the section on Diarrhea for more information about agents.)

Foodborne Disease (cont.)

Agent	Examples	Usual Incubation Periods
Bacteria	Campylobacter Salmonella *E. coli* O157:H7 Shigella	2–5 days 12–72 hours 1–10 days 2–7 days
Bacterial Enterotoxins	*Staphylococcus aureus* *Clostridium perfringens* *Bacillus cereus*	30 minutes to 5 hours 8–22 hours 30 minutes to 5 hours (vomiting) 8–16 hours (diarrhea)
Chemical poisonings	Copper Pesticides Mushrooms	15 minutes to 2 hours (sometimes up to 4 hours)
Viruses	Norovirus Hepatitis A	12–48 hours 15–50 day (average 30 days)

Infectious Period

Infected individuals may be infectious before, during, and after symptoms, depending on the agent, the patient, and treatment received. For example, a case of salmonellosis treated with antibiotics may remain infectious for several weeks after symptoms have ceased. This is important when evaluating infected food handlers for return to work.

School Staff/Nurse Responsibility

1. Immediately report to your local health jurisdiction suspected or confirmed foodborne outbreaks associated with a school (see Appendix V and the above chart).

2. Exclude food handlers with gastrointestinal upsets (diarrhea and/or vomiting), enteric disease, and respiratory infections from working with food or food contact surfaces for at least 24 hours after the symptoms have ceased. If a food handler is diagnosed with a disease transmissible through food, the school must get approval from the local health jurisdiction before the food handler can work with food or food contact surfaces.

3. Assist local and state public health investigators as appropriate.

4. Maintain and support confidentially for the student.

Foodborne Disease (cont.)

Control of Spread

1. Utilize standard precautions (see *Guidelines for Handling Body Fluids in Schools*, Appendix VII).

2. Refer to district infection control program protocols and policy for infectious diseases.

3. A child with diarrhea or vomiting may transmit the infection to other children in a school setting. Your local health jurisdiction may require that children or employees with certain infections not return to school until they test negative for the infection or symptoms resolve.

4. An infected individual may show no symptoms. Therefore, proper hand washing techniques and appropriate disposal of feces and materials contaminated with fecal material is always necessary.

5. Ensure safe food handling practices for students and staff in the school environment, especially hand washing, use of gloves or utensils when preparing uncooked items, control of food holding temperatures, rapid cooling, adequate cooking and reheating, protecting food from contamination by raw meats, poultry or eggs, and preparing food only when feeling well. It is important to note that, with few exceptions, foods of animal origin (meat, dairy, eggs) or containing animal products, and cooked rice or beans must be refrigerated (less than 40°F) or held hot (greater than 140°F).

6. Prior to preparing or serving food in a classroom, teachers and students should be made aware of safe food handling practices and sanitize surfaces where food is prepared or served, including student desks.

7. Ensure adequate hand washing facilities for all students and staff handling food (warm water, soap, and paper towels). This is required under Chapter 246-366 WAC (see Appendix VII).

8. Educate students of all ages in proper hand washing techniques before eating, after using the bathroom, and after touching or handling animals.

9. Provide education on the basic principles of food safety to students as appropriate, based on student's ability to understand and utilize concepts. Emphasis should be placed on hand washing, proper cooking, cooling, temperature control, and preventing contamination.

10. Do not allow raw milk or inadequately cooked meat or eggs to be served to students, including during field trips. Also have students wash hands after being in an environment with animals, particularly during field trips.

Foodborne Disease (cont.)

11. Surfaces where diapers are changed must be cleaned, rinsed, and disinfected after each use (see Appendix VIII, *Guidelines for Handling Body Fluids in Schools*). Whenever possible, different staff should change diapers and prepare food for students.

Resources

- Washington State Department of Health Foodborne Illness: http://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/FoodborneIllnesses.aspx

Hand, Foot, and Mouth Disease (HFMD)

Description

Hand, foot, and mouth disease (HFMD) is a common viral illness of infants and children. It is characterized by fever, sores in the mouth, and a rash with vesicles (blisters). HFMD begins with a mild fever, poor appetite, fatigue, and, frequently, a sore throat. One or two days after the fever begins, sores develop in the mouth. They begin as small red spots that blister and then often become ulcers. The sores are usually located on the tongue, gums, and inside of the cheeks. The skin rash develops over 1–2 days with flat or raised red spots, some forming fluid-filled vesicles (blisters). The rash does not itch and is usually located on the palms of the hands and the soles of the feet. It may also appear on the buttocks. A person with HFMD may have only the rash or the mouth ulcers.

Outbreaks of HFMD occur from time to time. Beginning in 2008, large outbreaks of HFMD were reported from Asia (China, Singapore, Vietnam, Mongolia, and Indonesia) due a specific virus (HEV 71). Neurological complications and deaths have been reported from these outbreaks.

Mode of Transmission

Several related viruses cause HMFD. They are spread from person to person by direct contact with nose and throat discharges or the stool of infected persons. A person is most contagious during the first week of the illness but may shed the virus after symptoms are gone. HFMD is not transmitted to or from pets or other animals.

Incubation Period

Usually 3–6 days. Fever is often the first symptom.

Infectious Period

HFMD is infectious 2 days before the rash appears and during the acute stage of illness, perhaps longer. Virus may be found in respiratory secretions for several days and in stool for several weeks.

School Staff/Nurse Responsibility

1. Students with a rash illness, especially if fever and/or other symptoms are present, should be referred to a health care provider for diagnosis. Students should not return to school until after the fever is gone (normally for 24 hours) and the child feels well enough to participate in normal activities.

2. Immediately report to your local health jurisdiction suspected HFMD outbreaks associated with a school.

3. Maintain and support confidentiality for the student.

Hand, Foot, and Mouth Disease (HFMD) (cont.)

4. Exclude students only if they are too ill to participate in school activities. Isolation is not necessary.

Control of Spread

1. Utilize standard precautions (see Appendix VIII, *Guidelines for Handling Body Fluids in Schools).*

2. Refer to district infection control program protocols and policy for infectious diseases.

3. Clean or dispose of articles soiled with nose and throat discharges and wash hands after handling such articles.

4. Instruct students not to share items that may be contaminated with saliva such as beverage containers.

5. Cover mouth with tissue when coughing or sneezing. If no tissue is available, encourage students to “catch your cold in your elbow” by covering their mouth and nose with the crook of their arm and coughing or sneezing into their shirt or coat sleeve.

6. Encourage proper hand washing techniques.

Hepatitis

The word hepatitis is a general term meaning “inflammation of the liver.” Symptoms may include fatigue, loss of appetite, low-grade fever, nausea, abdominal pain, gastrointestinal upset, diarrhea, and, in some cases, jaundice (new yellow color of the skin or eyes, with dark urine).

Hepatitis can be caused by many things including drugs, toxins, and viruses. There are several types of infections classified as viral hepatitis, each caused by a different virus. The types of viral hepatitis differ in modes of transmission and clinical course. The signs and symptoms of these infections are indistinguishable so laboratory testing is necessary to distinguish between them. The major types are hepatitis A, hepatitis B, and hepatitis C. These viruses affect only humans.

Hepatitis A Virus (HAV) Infection

Description

The onset of hepatitis A virus (HAV) infection is usually abrupt with symptoms as described above. HAV infection varies from a disease that causes no symptoms to a mild illness lasting 1–2 weeks or, rarely, to a severely disabling disease lasting several months. Many cases are mild and without symptoms, especially in children, and are only recognized by positive laboratory tests of serum for antibodies to HAV along with abnormalities in liver function tests. There is no chronic infection with HAV.

Mode of Transmission

Transmission of HAV is usually by the fecal-oral route (human waste carried to the mouth) and most often directly from person-to-person from inadequately cleaned hands. It may also be spread by contaminated water or food such as contaminated shellfish. Most cases in Washington result from travel outside the country.

Previous infection or vaccine protects against HAV infection. If given within 2 weeks of exposure, vaccine or immune globulin may prevent infection with HAV in somebody exposed.

Incubation Period

15–50 days, average 28–30 days.

Infectious Period

A person with HAV infection is most likely to spread it during the 2 weeks before onset of jaundice and probably for 1 week after. Infectiousness falls off dramatically at this point. In cases without jaundice, the peak of infectiousness occurs during the latter half of the incubation period or when liver function abnormalities are most evident in blood tests. The virus can spread through fecal-oral transmission even if there is no diarrhea.

Hepatitis (cont.)

School Staff/Nurse Responsibility

1. Immediately report to your local health jurisdiction suspected or confirmed HAV outbreaks associated with a school and any suspected case.

2. Refer students or staff with jaundice or acute symptoms to a licensed health care provider immediately.

3. Consult with your local health jurisdiction to determine if anyone exposed to a case should receive HAV vaccine or immune globulin. Under normal circumstances, casual contacts at school (teachers, classmates, etc.) are not at significant risk for contracting the disease. Friends sharing food with an infected student may be considered exposed. In the unusual circumstance of a school-centered epidemic, vaccine or immune globulin is recommended for prevention (prophylaxis) of infection in close contacts.

4. Enforce strict confidentiality of health care information for known or suspected acute infections.

5. Enforce a ban on food handling by infected staff or students until cleared by your local health jurisdiction.

6. Transmission at child care centers and among preschool groups is more common than in schools. Child care centers should stress measures to eliminate the danger of fecal-oral transmission by enforcing proper handwashing techniques after every diaper change and before eating. Immune globulin or vaccine may be necessary for staff, attendees, and family members when there is a child care outbreak.

Control of Spread

1. Utilize standard precautions (see Appendix VIII, *Guidelines for Handling Body Fluids in Schools).*

2. Refer to district infection control program protocols and policy for infectious diseases.

3. Exclude cases from school until cleared by a licensed health care provider to return.

4. Illness among a student's family members may be the tip-off of possible HAV transmission in a classroom, particularly among younger children. Students may be infectious and spread the disease even though they do not themselves show signs of illness.

Hepatitis (cont.)

5. HAV vaccine or immune globulin should be administered to family or other close contacts of cases as soon as possible. Prevention is effective only when given within two weeks of exposure. Your local health jurisdiction will advise schools as to the appropriate course of action.

6. Using gloves during diaper changing and paying strict attention to hand washing are required in child care settings.

7. Discourage sharing of beverage containers and food among students.

Future Prevention and Education

A safe and effective Hepatitis A vaccine is available and routinely recommended for children beginning at 12 months of age. It is given in two doses, the second dose 6 months after the first. Hepatitis A vaccine is not required for school entry.

HAV is generally spread by fecal-oral transmission. Students should be instructed in proper hand washing techniques before eating and after using the bathroom. Personal hygiene, especially careful hand washing after every diaper change and before eating, is important.

Because HAV is transmitted through food and water as well as person-to-person, no student or adult with suspected HAV, or in a family with HAV cases, should be allowed to work as a food handler.

Hepatitis B Virus (HBV) Infection

Description

The onset of hepatitis B virus (HBV) infection is generally more gradual and subtle than viral HAV but with the same symptoms: anorexia, nausea, vomiting, abdominal discomfort, and sometimes jaundice (new yellow color of the skin or eyes, with dark urine). Severity of the disease can vary from unapparent cases recognized by blood tests, to a rapidly worsening or fatal illness. Most people recover from the infection, though up to 5 percent of adults born in the United States become chronically infected. The overall rate of chronic infection for people from other parts of the world is 1–20 percent. Chronic infection may result in liver damage and liver cancer. Since about 50 percent of infections are without symptoms, persons with acute or chronic HBV infection may not know they have HBV but still may be able to infect others.

Mode of Transmission

HBV is transmitted by exposure to body fluids including infected blood or blood products, vaginal fluids, semen, and possibly saliva. Transmission from body fluids occurs through mucous membranes or non-intact skin. HBV is transmitted from person to person mainly by contaminated syringes, needles and other instruments (including ear piercing instruments), intravenous drug use, sexual contact, or from an infected mother to her infant. Close contact with an infected person can also result in transmission, particularly in residential facilities. High rates of infection have been found among users of illegal intravenous drugs, men who have sex with men, patients on hemodialysis, residents of long-term care institutions, and those requiring frequent transfusions. If given within 2 weeks of exposure, hepatitis B immune globulin (HBIG) may prevent infection.

Incubation Period

45–160 days, average 120 days.

Infectious Period

During the acute infection, blood and body fluids are most contagious prior to and for weeks after jaundice develops. Blood from experimentally infected volunteers has been shown to be infectious many weeks before the onset of any symptoms, throughout the clinical course of the illness, and, in some cases, for the rest of the person's life if the illness develops into a chronic infection.

School Staff/Nurse Responsibility

1. Screen for school vaccine requirement.

2. Immediately report to your local health jurisdiction any suspected or confirmed HBV cases. Reporting is mandatory.

Hepatitis (cont.)

3. Refer students or staff with jaundice or acute symptoms to a licensed health care provider immediately.

4. Consult with your local health jurisdiction to determine if anyone should receive HBIG. Under normal circumstances, casual contacts at school (teachers, classmates, etc.) are not at significant risk for contracting the disease. In the unusual circumstance of a facility outbreak, HBIG is recommended for prevention (prophylaxis) for close contacts who may have been exposed.

5. Enforce strict confidentiality of health care information for known or suspected acute or chronic infections.

6. Use cleaning precautions with all body fluids as outlined in *Guidelines for Handling Body Fluids in Schools,* Appendix VIII.

Control of Spread

1. Utilize standard precautions (see Appendix VIII, *Guidelines for Handling Body Fluids in Schools).*

2. Refer to district infection control program protocols and policy for infectious diseases.

3. Consult with your local health jurisdiction if there are any questions about a person with acute or chronic HBV infection attending or working in a school.

4. HBIG is not indicated for casual school contacts, although HBIG and HBV vaccine may be administered to certain contacts if blood transmission occurs.

5. Use cleaning precautions with all body fluids as outlined in *Guidelines for Handling Body Fluids in Schools,* Appendix VIII.

6. Using gloves during first aid care of students or when handling bloody items and paying strict attention to hand washing are required in child care settings

7. Employers are required to provide evaluation for employees exposed to blood or other potentially infectious material under the Washington Industrial Safety and Health Act (WISHA) bloodborne pathogens rule (WAC 296-823). (See http://www.lni.wa.gov/WISHA/Rules/bbpathogens/default.htm.)

Future Prevention and Education

1. A safe and effective vaccine is available and recommended for all children from birth through the age of 18 years. It is a three-dose series with the second and third doses given 1–6 months after the first.

Hepatitis (cont.)

2. School staff with designated job duties that may involve exposure to blood must be offered HBV vaccine. Staff having frequent or routine contact with blood, skin lesions, saliva, or infected secretions (such as occurs in doing first aid, health or nursing procedures) of potentially HBV-infected individuals or high-risk groups (de-institutionalized mentally disabled persons, individuals from certain areas of Asia and Africa) should receive HBV vaccine. Contact your local health jurisdiction and/or Washington State Department of Labor and Industries industrial hygiene consultant to evaluate the need to immunize individual school staff. The employer is responsible for complying with all provisions of the WISHA bloodborne pathogens rule WAC 296-823 . For additional information, see *Guidelines for Implementation of School Employee Training on HIV/AIDS and Other Bloodborne Pathogens* (available from OSPI Health Services at 360-725-6040 or http://www.k12.wa.us/healthservices/pubdocs/GuidelinesHIVBloodborne.pdf).

3. In institutions for the developmentally disabled, vaccination of classroom contact is strongly encouraged if a classmate who is a HBV carrier behaves aggressively or has special medical problems that increase the risk of exposure to his/her blood or serous secretions.

   -*Mortality and Morbidity Weekly Report*, February 9, 1990, see page 15.

4. Persons in casual contact with carriers in settings such as schools and offices are at minimal risk of HBV infection and vaccine is not routinely recommended for them.

   -*Mortality and Morbidity Weekly Report,* February 9, 1990, see page 16.

5. If exposure to likely infectious blood or serous secretions occurs through a needlestick, a cut or wound, or through the eyes or mucous membranes, treatment with HBIG and/or HBV vac*cine may be indicated. Immediate referral of employees after an exposure incident for evaluation and* treatment by a licensed health care provider is required by the WISHA bloodborne pathogens standard.

6. Instruct all staff in standard precautions and reinforce training each school year.

Hepatitis C Virus (HCV) Infection

Description

The onset of hepatitis C virus (HCV) infection is generally more gradual and subtle than viral HAV with the following symptoms: anorexia, nausea, vomiting, abdominal symptoms, and sometimes jaundice (new yellow color of the skin or eyes, with dark urine). The vast majority of people with acute HCV infection (up to 90 percent) have no symptoms so infection is frequently unrecognized. Up to 80 percent of infections become chronic and up to 20 percent of those cases develop cirrhosis after many years. Chronic infection may also result in liver cancer. About 2 percent of the population in the United States is chronically infected and HCV is currently the most common reason for a liver transplant. Worldwide, the overall rate of chronic infection is 3 percent but reaches 10 percent in some countries. Similar to viral HBV, acutely and chronically infected persons may lack symptoms but can still infect others.

Mode of Transmission

HCV is transmitted primarily by exposure to infected blood and other body fluids and, prior to the routine HCV screening of blood products, was transmitted by blood products. Currently, most HCV infections are acquired through sharing of contaminated injection equipment. HCV can also be transmitted through sex or from mother to infant during childbirth; however, this is much less common than with HBV. Unfortunately, there is no effective method of post exposure prevention (prophylaxis) for HCV.

Incubation Period

2 weeks to 6 months, average 6–9 weeks.

Infectious Period

Blood and other potentially infectious materials are contagious days to weeks before the onset of symptoms. Those with a chronic infection are infectious indefinitely. HCV is not as easily transmitted as HBV.

School Staff/Nurse Responsibility

1. Immediately report to your local health jurisdiction suspected or confirmed HCV cases.

2. Refer students or staff with jaundice or acute symptoms to a licensed health care provider immediately.

3. Enforce strict confidentiality of health care information for known or suspected acute infections.

Hepatitis (cont.)

Control of Spread

1. Utilize standard precautions (see Appendix VIII, *Guidelines for Handling Body Fluids in Schools).*

2. Refer to district infection control program protocols and policy for infectious diseases.

3. Consult with your local health jurisdiction if there are any questions about a person with acute or chronic HCV infection attending or working in a school.

4. Using gloves during first aid care of students or when handling bloody items and paying strict attention to hand washing are required in child care settings.

5. Unlike HAV and HBV, there is no effective treatment to prevent infection after exposure. Employers are required to provide evaluation for employees exposed to blood or other potentially infectious materials under the WISHA bloodborne pathogens rule (WAC 296-823). (See http://www.lni.wa.gov/WISHA/Rules/bbpathogens/default.htm.)

6. Use cleaning precautions with all body fluids as outlined in *Guidelines for Handling Body Fluids in Schools,* Appendix VIII.

Future Prevention and Education

1. There is currently no effective vaccine to prevent HCV. The primary means of transmission to school staff would probably occur through contamination of cuts or wounds, or by exposure of mucous membranes to blood or other potentially infectious material. Employers of staff whose designated job duties may expose them to blood or other potentially infectious material must comply with provisions under the WISHA bloodborne pathogens rule (WAC 296-823). See *Guidelines for the Implementation of School EmployeeTraining on HIV/AIDS and Other Bloodborne Pathogens* (available from OSPI Health Services at 360-725-6040 or http://www.k12.wa.us/healthservices/pubdocs/GuidelinesHIVBloodborne.pdf or the WISHA Web site at http://www.lni.wa.gov/wisha/ for additional information.

2. If exposure to blood or other potentially infectious material from a person with HCV occurs through a needlestick, a cut or wound, through the eyes, or mucous membranes, exposed employees must be referred immediately for evaluation as required by the WISHA bloodborne pathogens rule.

3. The Advisory Committee on Immunization Practice recommends that persons with HCV be immunized with HAV and HBV vaccines.

4. Instruct all staff in standard precautions and reinforce the training each school year.

Hepatitis (cont.)

Resources

- The CDC Web site on hepatitis provides updated material on viral hepatitis at http://www.cdc.gov/hepatitis. Clinicians seeking more information or question and answer sheets on hepatitis topics can also find material at this site.

- The Washington State Department of Health Hepatitis Information: http://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/Hepatitis.aspx

- Clinicians can call San Francisco General's 24-hour bloodborne pathogen hotline (National Clinician's Prophylaxis Hotline) at 1-888-448-4911 for the latest post exposure treatment information or visit their Web site at. http://www.nccc.ucsf.edu/about_nccc/pepline/

- For Washington State Department of Labor and Industries information on bloodborne pathogens and training see http://www.lni.wa.gov/safety/topics/atoz/topic.asp?KWID=39.

Herpes Simplex Virus, Oral Area (Cold Sores)

Description

Herpes simplex virus (HSV) causes a recurrent, life-long viral infection. Of those infected, 70 percent have no symptoms. Symptoms occur as single or grouped vesicles (blister) usually located around mucous membranes, the lips (cold sores), throat, inside the mouth or on the skin (e.g., herpetic whitlow consisting of one or more vesicular lesions on the fingertips). Fever can occur along with the vesicles.

There are two types of HSV. Type 1 HSV (orales) has primarily been associated with infections of the oral area but can cause genital disease. Oral infections are extremely common in children, and by adulthood 80 percent of Americans have antibodies to Type 1 HSV. Type 2 HSV (labalis) is most commonly associated with genital disease but can also cause oral disease. The two types have the same infectiousness or risk to others. Complications include conjunctivitis, keratitis (inflammation of the cornea), herpes infection of existing eczema or meningitis. Infection in the newborn can be severe.

Mode of Transmission

Types 1 and 2 HSV are both transmitted by direct contact with infected skin and secretions during periods viral shedding, regardless of symptoms. HSV lesions are most infectious while they are in the vesicular stage. The virus may be transmitted from the mouth or skin during contact sports such as wrestling, resulting in localized skin lesions (herpes gladiatorum, commonly called Wrestler's Herpes).

Incubation Period

2–20 days.

Infectious Period

Skin lesions are infectious until firmly crusted over and healed. The virus can be shed from the site of infection at any time. Sores need **not** be present to transmit herpes. The virus can be shed for at least 1 week during primary infections, less (perhaps 3–5 days) during recurrences.

Infectiousness is greatly reduced when lesions have crusted. Spread of HSV from oral lesions is difficult to prevent since these lesions are not easily covered with bandages. Only students with primary infection who do not have control of oral secretions should be excluded from school or child care. Students with uncovered lesions on exposed surfaces pose a small potential risk to contacts except during certain sports. Exclusion of students with recurrent infection of cold sores only is not indicated, but exclude from contact sports if there are skin lesions.

Herpes Simplex Virus, Oral Area (Cold Sores) (cont.)

School Staff/Nurse Responsibility

Cold Sores—Skin Lesions

1. Immediately report to your local health jurisdiction suspected or confirmed herpes outbreaks associated with a school (e.g., among a wrestling team).
2. Cover skin lesions with a bandage or clothing when possible.
3. Avoid direct contact with infected lesions if possible. Wear gloves if direct hand contact to lesions is necessary. Wash hands after gloves are removed.
4. Exclude students with skin lesions from contact sports such as wrestling.
5. Conduct routine cleaning of shared sports equipment such as wrestling mats.
6. Encourage keeping children less than the age of 3–4 years at home when cold sores are present, especially during the initial episode. It is difficult to prevent young children from spreading the virus by fingers and/or mouth contact.
7. Registered nurses may assess skin lesions to allow student to return to school-related activities.
8. Maintain and support confidentiality for the student.

Genital Herpes (see page 117 for more information).

1. Report suspected initial (primary) genital infection to your local health jurisdiction.
2. Report of suspected child abuse cases is mandatory.
3. Use gloves if having direct contact with infectious lesions such as diapering.

Control of Spread

1. Utilize standard precautions (see Appendix VIII, *Guidelines for Handling Body Fluids in Schools)*.
2. Refer to district infection control program protocols and policy on infectious diseases.
3. Advise student to avoid spread of HSV by fingers, shared items, or kissing. Reinforce proper hand washing techniques.
4. Educate student about good personal hygiene and avoiding oral-oral or genital-oral transmission.

Herpes Simplex Virus, Oral Area (Cold Sores) (cont.)

5. Instruct students not to share items that may be contaminated with saliva such as lipstick and beverage containers.

6. Dispose of bandages that have been in contact with the vesicles (blisters) in an appropriate bagged receptacle.

7. Disinfect surfaces that have been in direct contact with fluid from the vesicles (blisters).

Future Prevention and Education

Provide education and counseling regarding transmission of diseases, recurrence potential, available treatments, and recommended sexual practices to prevent spread (see Appendix VIII, *Guidelines for Handling Body Fluids in School).*

Herpes Zoster (Shingles)

Description

Herpes zoster, commonly known as shingles, is caused by the chickenpox (varicella) virus. Herpes zoster represents a recurrence of a previous chickenpox infection. When an individual has chickenpox, the virus infects the nerves and stays dormant. If immunity decreases the person develops shingles. Children who had chickenpox during the first year of life are more likely to develop herpes zoster in adolescence. Otherwise, herpes zoster usually occurs in elderly or immunocompromised individuals.

Herpes zoster causes pain (post-herpetic neuralgia) sometimes severe, over the pathways of the sensory nerves under one body area, followed by an outbreak of small vesicles (blisters) in the same area. It usually lasts 3–4 weeks. Individuals who are immunocompromised or are being treated for malignancies may develop severe disease with involvement of not only skin but also internal organs. These individuals should be seen by their licensed health care provider as soon as possible if herpes zoster develops. The virus, which is present in the vesicle (blister) fluid of a person who has herpes zoster, is contagious and can cause chickenpox in a non-immune individual.

Incubation Period

Uncertain, but may be years since the virus stays dormant after the chickenpox virus.

Infectious Period

Skin lesions are infectious in the water vesicle (blister) stage until crusted over. The virus can be shed from the site of infection at any time. Herpes zoster has a much lower rate of transmission than that of chickenpox. Virus from the vesicle fluid of a person with herpes zoster can rarely cause chickenpox in a non-immune individual.

School Staff/Nurse Responsibility

1. Report to your local health jurisdiction is not required.
2. Make referral to licensed health care provider if necessary.
3. Advise student not to touch or scratch lesions.
4. Educate student about good personal hygiene, especially proper hand washing techniques.
5. Avoid direct contact with infected lesions if possible. Wear gloves if direct hand contact to lesions is necessary. Wash hands after gloves are removed.
6. Ensure that lesions are covered with a bandage or clothing when possible. Students with herpes zoster are to be excluded from school if lesions are not or cannot be covered with a bandage or clothing.

Herpes Zoster (Shingles) (cont.)

7. Exclude students with skin lesions from contact sports such as wrestling.

8. Conduct routine cleaning of shared sports equipment such as wrestling mats.

9. Avoid direct contact with infected lesions when possible. Wear gloves if direct hand contact to lesions is necessary. Hands must be washed after gloves are removed.

10. Maintain and support confidentiality for the student.

Control of Spread

1. Utilize standard precautions (see Appendix VIII, *Guidelines for Handling Body Fluids in Schools*).

2. Refer to district infection control program protocols and policy for infectious diseases.

3. Dispose of bandages that have been in contact with the vesicles (blisters) in an appropriate bagged receptacle.

4. Disinfect surfaces that have been in direct contact with fluid from the vesicles (blisters).

Future Prevention and Education

Routine administration of varicella vaccine to prevent wild-virus chickenpox disease may reduce the incidence and severity of herpes zoster. Two doses of varicella vaccine are required for school entry. See implementation schedule at http://www.doh.wa.gov/Portals/1/Documents/Pubs/VaricellaImplementationPlan.pdf

Make sure all students are up to date on varicella vaccine. Notify parent or guardian of inadequately or unimmunized students in the effected classroom(s) that exposure to chickenpox could possibly have occurred.

A vaccine for shingles was licensed in the United States in 2006. Adults 60 years and older should receive a single dose.

Human Immunodeficiency Virus (HIV)

Description

Human Immunodeficiency Virus (HIV) is a virus that can cause Acquired Immunodeficiency Syndrome (AIDS). Special white blood cells that coordinate the body's fight against infection (CD4 lymphocytes) are killed by the virus as the HIV infection progresses, making the person vulnerable to other serious infections and cancers. These infections, which would not be a threat to people with normal immune systems, are called opportunistic infections. The virus also multiplies in the central nervous system, destroying brain cells, and may cause memory loss, personality changes, and dementia late in the course of the illness. Infection with HIV may have several results:

1. Most infected people remain without symptoms for many years after infection. These people develop antibodies to HIV but have no other signs of infection. Although they have no symptoms, these HIV-infected persons can still infect others through needle sharing and sexual intercourse. In rare occasions, HIV can also be transmitted through blood exposure to eyes, mucous membranes, or cuts or sores in the skin.

2. Some people with HIV infection develop opportunistic infections or have nonspecific symptoms such as lymphadenopathy (swollen glands), loss of appetite, chronic diarrhea, weight loss, fever, and fatigue. The signs and symptoms of HIV may be very mild or quite severe. For example, some children with HIV infection may have life-threatening diarrhea, while others feel well. The number of HIV-symptomatic people who go on to develop AIDS is the subject of many current studies.

3. Many people living with HIV disease take antiretroviral treatment (ARTs) to control their infection. As new medications are developed, ART continues to become more effective. As a result, HIV-infected persons who are fully adherent to their ART regimens can have undetectable HIV viral loads. Suppressed viral load reduces the health consequences associated with HIV infection and reduces the probability that an HIV-infected person will transmit the virus to an uninfected person. Early diagnosis is crucial in assisting HIV-infected people to obtain appropriate medical care and treatment.

4. Untreated, HIV often will lead to AIDS. AIDS is a life-threatening condition. Opportunistic infections may eventually overwhelm the immune system, resulting in death.

Mode of Transmission

HIV has not been shown to be transmitted through casual contact such as occurs in the normal school setting. HIV is transmitted through sexual intercourse, through sharing needles or syringes, and, in rare cases, through contact with blood or its components from infected individuals. When a student with HIV infection or AIDS is enrolled in public

Human Immunodeficiency Virus (HIV) (cont.)

school, no real risk is present to other students unless the student has severe behavioral problems that make blood-to-blood contact likely. The student, however, may be particularly susceptible to infectious diseases. Standard precautions will be effective in eliminating any threat of infection with HIV (see *Guidelines for Handling Body Fluids in Schools,* Appendix VIII).

Antibody Development and the Incubation Period

Antibodies to HIV usually appear in a person's blood from 3 weeks to 3 months after infection with the virus. In rare instances, it may take as long as 6 months for children or adults to develop antibodies. Infants born to infected mothers may have maternal antibodies that disappear between 12 and 18 months after birth. If the baby is infected, it will not produce its own antibodies until its immune system is developed, at about 18 months. There are tests available to diagnose HIV infection in infants. The incubation period for the symptoms of HIV infection (AIDS) may depend on many factors, including: (1) the immune status of the infected person, and (2) access to medical care or treatment facilities. Estimates of possible incubation periods for symptoms range from a few months to several years for children infected at birth to over 10 years in adults who were infected through sexual intercourse.

Infectious Period

People living with HIV disease (including AIDS) are infected with the virus for life. A majority of HIV-infected people will have positive virus cultures from blood and semen. Tears and saliva contain very few, if any, viral particles and are not considered significant vectors of transmission. Recent dental research has shown that saliva contains enzymes that inhibit HIV, including HIV in the blood cells of saliva. Saliva containing visible blood is considered potentially infectious under the WISHA bloodborne pathogens rule WAC 296-823.

Household contact is not considered a significant mode of transmission. Children acquire the infection from their infected mothers before birth or, in rare cases, during a blood transfusion or during breastfeeding. Washington State currently has few diagnosed pediatric AIDS cases.

School Staff/Nurse Responsibility

1. School nurse should function as:

    a. The liaison with the student's licensed health care provider.

    b. The HIV/AIDS-infected student's advocate in the school (assist in problem resolution, arrange for accommodations, answer questions, and educate staff).

Human Immunodeficiency Virus (HIV) (cont.)

c. A member of the local advisory panel (see *Guidelines for the Placement of Children and Adolescents Infected with the Human Immunodeficiency Virus [HIV],* Appendix IX*).*

d. A resource and educator provide in-service education for school staff, parent/guardian, and local school boards on infectious diseases as well as on *Guidelines for Handling Body Fluids in Schools* (see Appendix VIII).

2. Maintain and enforce confidentiality for the student. The consent to exchange information and medical records is governed by the Family Educational Rights and Privacy Act (FERPA), the Health Insurance Portability and Accountability Act (HIPAA), RCW 70.24.105, and Chapter 70.02 RCW.

3. Make referral to licensed health care provider promptly for acute symptoms.

4. Use cleaning precautions with all body fluids as outlined in *Guidelines for Handling Body Fluids in Schools,* Appendix VIII*.*

6. Utilize standard precautions (see Appendix VIII, *Guidelines for Handling Body Fluids in Schools).*

7. Refer to district infection control program protocol and policy for infectious diseases.

8. Inform parent/guardian to keep the immune-compromised student at home during outbreaks of diseases potentially serious for the student such as chickenpox, measles, and influenza. They should consult with their licensed health care provider and the licensed health care provider should determine whether the individual should stay home from school.

Resources

Access HIV treatment information at: AIDS Info at National Institutes of Health (NIH): http://www.aidsinfo.nih.gov/guidelines/http://www.aidsinfo.nih.gov/guidelines/

HIV Care—Washington State Department of Health (DOH): http://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/HIVAIDS/HIVCareClientServices.aspx

Impetigo

Description

Impetigo is a common skin infection caused by Streptococcal or Staphylococcal bacteria. Fluid-filled blisters with “honey-colored” scabs often form. Some skin lesions also may appear as red-colored pimples. Lesions may be found on the face, especially around the mouth and nose, but may be found on other areas of the body. Other streptococcal infections include sore throat, scarlet fever, and necrotizing fasciitis (flesh-eating bacteria). See Streptococcal section.

Mode of Transmission

The bacteria which cause Impetigo are found normally on the skin. Any injury or break in the skin can permit the bacteria to invade the skin and cause infection.

Impetigo may be acquired most commonly from contact with a person with Impetigo lesions, or less likely from contact with objects or surfaces containing the bacteria. An infected person with sores on one pare of the body can also spread sores to a different location on the body.

Incubation Period

Sores develop 7 to 10 days after bacteria enter the skin.

Infectious Period

Lesions are considered infectious until treatment has been administered for 24 hours. Lesions are less likely to be infectious once the scabbing lesions have healed.

School Staff/Nurse Responsibility

1. Notify parent or guardian and make make referral to licensed health care provider if lesions are identified. The student does not need to be sent home prior to the end of the day if the lesions can be covered and kept dry. The disease responds very quickly to systemic antibiotic treatment and/or prescription topical antibiotic ointments.

2. Exclusion from school should be reserved for those with extensive draining lesions and is generally not essential unless the licensed health care provider suggests it.

3. Notify your local health jurisdiction if several children develop Impetigo.

4. Maintain and support confidentiality for the student.

Impetigo (cont.)

Control of Spread

1. Utilize standard precautions (see Appendix VIII, *Guidelines for Handling Body Fluids in Schools).*

2. Refer to district infection control program protocols and policy for infectious diseases.

3. Wash hands frequently to prevent spread, especially after coughing or sneezing.

4. Students should not participate in swimming, body contact sports, or food preparation activities until all lesions are healed.

5. Antibiotics will decrease the spread of the disease and decrease the incidence of complications from the bacterial infection.

6. Good personal hygiene and soap and water cleansing of minor skin breaks will help to prevent spread.

7. Students should be discouraged from sharing towels, clothing, and other personal items.

Future Prevention and Education

No vaccine is available.

Skin wounds should be kept clean and observed for possible signs of infection.

Infectious Mononucleosis (Mono)

Description

Infectious mononucleosis (Mono), also known as the “kissing disease,” is an acute illness caused by the Epstein-Barr virus (herpes family) and is characterized by fever, sore throat that may resemble strep throat, fatigue, headache, and swollen glands (especially of the neck). There may be a rash, more often in patients who have been treated with amoxicillin/ampicillin. Mono may be very mild or severe. It is recognized more often in adolescents and young adults than in small children. In the adolescent in particular, there can be swelling and tenderness of the spleen. Mono is a disease that may be difficult to identify and is usually diagnosed through laboratory procedures. It may be important to distinguish mono from other conditions such as Strep throat. Mono is not highly contagious and there is no specific treatment.

Mode of Transmission

Mono is transmitted through close person-to-person contact (including sharing of water bottles).

Incubation Period

10–50 days.

Infectious Period

Uncertain, but may be long (several months).

School Staff/Nurse Responsibility

1. Students with a rash illness, especially if fever and/or other symptoms are present, should be referred to a health care provider for diagnosis. Students should not return to school until after the fever is gone (normally for 24 hours) and the child feels well enough to participate in normal activities.

2. Report to your local health jurisdiction is not required.

3. Make referral to a licensed health care provider if mono is suspected. Follow medical recommendations for confirmed cases.

4. Modify the student’s schedule if necessary. If periods of fatigue persist, student should be allowed to rest.

5. Request physical activity clearance from licensed health care provider before student returns to school-related physical activities.

6. If acute abdominal pain occurs in first 6 weeks of illness after participation in a contact sport, monitor vital signs and arrange immediate evaluation by health care provider.

Infectious Mononucleosis (Mono) (cont.)

7. Maintain and support confidentiality for the student.

Control of Spread

1. Utilize standard precautions (see Appendix VIII, *Guidelines for Handling Body Fluids in Schools).*

2. Refer to district infection control program protocols and policy for infectious diseases.

3. Instruct students not to share items that may be contaminated with saliva such as lipstick and beverage containers.

4. Clean or dispose of articles soiled with nose and throat discharges.

5. Cover mouth with tissue when coughing or sneezing. If no tissue is available, encourage students to “catch your cold in your elbow” by covering their mouth and nose with the crook of their arm and coughing or sneezing into their shirt or coat sleeve.

6. Encourage proper hand washing techniques.

Future Prevention and Education

Provide health education for students and their parent/guardian as to the usual mode of transmission and reinforce that Mono is not highly contagious.

Influenza (Flu)

Description

Influenza (flu) is an acute viral infection characterized by abrupt onset of fever, headache, fatigue, chills, cough, sore throat, and/or aching muscles. Vomiting and diarrhea may occur but are not common. Infections can be mild to severe with symptoms lasting from a few days to several weeks. Annual activity most commonly occurs between December and April. Complications are more severe for the very young, the very old, and pregnant women.

Note

Influenza is a disease of the respiratory tract. Gastrointestinal symptoms alone, often reported as “flu” or “stomach flu,” do not constitute influenza. Diagnosis can be confirmed by laboratory tests on respiratory secretions.

Mode of Transmission

Influenza is spread from person-to-person by respiratory droplets produced when a person coughs, sneezes, or talks.

Incubation Period

1–4 days.

Infectious Period

People are generally infectious to others beginning 1 day before symptoms start until up to 7 days after becoming sick. Some children can be infectious longer than 7 days.

School Staff/Nurse Responsibility

1. Report to your local health jurisdiction significant increases in school absenteeism resulting from influenza-like illness or clusters of particularly severe infections. (WAC 246-101-525).

2. Some local health jurisdictions may request notification of student absenteeism greater than 10 percent during flu season.

3. Make referral to licensed health care provider for exceptionally severe cases.

4. Maintain and support confidentiality for the student.

Note

Children with symptoms of influenza should not receive aspirin because of its possible association with Reye syndrome.

Influenza (Flu) (cont.)

Control of Spread

1. Utilize standard precautions (see Appendix VIII, *Guidelines for Handling Body Fluids in Schools).*

2. Refer to district infection control program protocols and policy for infectious diseases

3. Annual Influenza vaccination is the most effective way to control the spread of influenza in schools.

4. Respiratory and hand hygiene should be encouraged to help reduce the spread of influenza in the classroom setting.

5. Students with flu-like illness should be excluded from school until after the fever is gone (normally for 24 hours) and the child feels well enough to participate in normal activities.

Future Prevention and Education

Annual seasonal influenza shots are recommended for all persons beginning at 6 months of age. Some children 6 months through 8 years require 2 doses one month apart. Persons 9 years and older only need 1 dose of seasonal influenza vaccine annually.

Influenza season in the United States generally occurs sometime between December and April. Two types of vaccine are available in the United States for children—trivalent inactivated influenza vaccine (TIV) and live attenuated influenza vaccine (LAIV). Both types of vaccine are effective in the control of influenza. The vaccine is made each year with the strains of influenza virus expected to cause the most infection. Annual vaccinations should begin with the availability of the seasonal vaccine and continue until flu activity subsides. Influenza has a substantial impact among school-aged children and their contacts. These impacts include school absenteeism, medical care visits, and parental work loss. Outbreaks of influenza can cause large increases in absenteeism rather suddenly. Consult your local health jurisdiction to determine the recommendations you should make to students, parents/guardians, and school staff. Often, school cases will signal the onset of an epidemic in the community. School closure is not generally recommended during an outbreak unless inadequate number of staff is available to carry on a program.

1. In order to limit transmission of influenza in a school, students should be instructed to:

   - Avoid sharing items that may be contaminated with saliva such as beverage containers.

   - Clean or dispose of articles soiled with nose and throat discharges.

Influenza (Flu) (cont.)

- Cover their mouths with tissue when coughing or sneezing. If no tissue is available, encourage students to “catch your cold in your elbow” by covering their mouth and nose with the crook of their arm and coughing or sneezing into their shirt or coat sleeve.

- Use proper hand washing techniques.

Lice (Pediculosis)

Body Lice (Pediculosis humanus corporis)

Description

Different kinds of lice affect the head, body, and pubic areas.

Body lice are tiny parasitic insects, about the size of a sesame seed. Body lice are most commonly found in crowded and unhygienic conditions, among populations that have experienced disasters and/or difficult life circumstances, with no access to bathing facilities or the ability to change or launder clothing.

Body lice can be found in bedding and clothing, particularly in the inner seams of clothing. Body lice travel to the skin of a human host to feed on blood. The most common sites for lice bites are around the waist, groin and armpits—places where clothing seams are most likely to touch the skin.

Body lice are rare among children in the United States. The main signs of body lice infestation are intense itching, scratch marks, and the detection of lice eggs or moving lice. However, body lice are rarely seen on the body because they are usually sequestered in clothing.

Body lice have been associated with outbreaks of typhus, trench fever, and other epidemic conditions in the past among soldiers and refugees. Secondary bacterial infections may develop due to skin damage from scratching.

Mode of Transmission

Transmission occurs through contact with a person who has body lice or with personal articles such as clothing or bedding that are infested. Dogs, cats, and other animals do not transmit lice.

Incubation Period

Body lice eggs (nits) normally hatch in 1 to 2 weeks, depending on the temperature. Mature body lice are capable of laying eggs 9 to 19 days after hatching. The adult life span is about 1 month with access to blood.

Infectious Period

Body lice can be spread as long as lice remain alive on the host or in clothing. Body lice are capable of moving to other human hosts and infesting the new host. Body lice cannot live away from a human host for more than 5 to 7 days at room temperature. Nits may survive for a month.

Lice (Pediculosis) (cont.)

School Staff/Nurse Responsibility

1. Make referral to licensed health care provider for diagnosis if body lice are observed or suspected.

2. All family members should be examined and treated simultaneously to avoid re-infestation.

3. Instruct the family to wash clothing and other personal items, such as bedding and towels, in 130°F water. Machine-dry using the hottest setting for at least 20 minutes. Temperatures of at least 130°F will kill the lice and eggs.

4. Home hot water heater temperatures can be raised to 130°F for washing clothing and bedding, and then returned to lower temperatures for showering and bathing. If water temperatures cannot be adjusted to 130°F, such as with public washing machines located in homeless shelters and laundromats, then infested items should be sealed in a plastic bag for 2 weeks to kill the lice and eggs, and then laundered afterwards to remove the dead lice and eggs.

5. Items that cannot be washed or dried in at least 130°F temperatures, or sealed in a plastic bag, may need to be discarded.

6. Assess family situation and if necessary assist the family with community resources. Support the family in accessing showering or bathing facilities and regular changes of clean clothing and bedding.

7. Maintain and support confidentiality for the student.

Control of Spread

1. Utilize standard precautions (see Appendix VIII, *Guidelines for Handling Body Fluids in Schools).*

2. Refer to district infection control program protocols and policy on infectious diseases.

3. Instruct family members to avoid having close physical contact with a person who is infested, and to avoid sharing bedding or clothing with that person.

4. All family members should be examined and treated simultaneously to avoid re-infestation.

Future Prevention and Education

Improved access to bathing and laundering facilities, and access to regular changes of clean clothing, will decrease the likelihood of body lice outbreaks.

Lice (Pediculosis) (cont.)

Crab Lice (Pediculosis humanus pubis)

Description

Different kinds of lice affect the head, body, and pubic areas.

Crab lice are parasitic insects measuring less than 1/8 of an inch that feed on human blood. Because their bodies and claws resemble sea crabs, they are nicknamed “crab lice” or “crabs.” The primary symptom of crab lice is itching in the genital area. Nits (lice eggs) attached to the pubic hair shaft, or crawling lice may be seen. An infestation of crab lice is usually detected in the pubic hair but may also be found less commonly in other places where there is coarse body hair, such as armpits, legs, mustaches, beards, eyebrows, or eyelashes. Crab lice are not likely to be on the scalp or in head hair.

Crab lice do not carry infections. Secondary bacterial infections may develop due to skin damage from scratching. A person with crab lice may also have other sexually-transmitted infections or diseases.

Mode of Transmission

Crab lice are most frequently transmitted by sexual contact. Crab lice found on children may be a sign of sexual abuse or sexual exposure. However, a child may also become infested with crab lice if he or she shares a communal bed with adults who are infested. Occasionally, crab lice may be transmitted by contact with clothing or bedding of a person infested with lice.

A common misbelief is that crab lice can be spread by sitting on a toilet seat. This is extremely unlikely because lice do not have feet designed to hold on to smooth surfaces such as toilet seats, and lice need a human blood source to survive.

Incubation Period

Pubic lice eggs (nits) normally hatch in 6–10 day, depending on the temperature. Mature pubic lice are capable of laying eggs 2–3 weeks after hatching. The adult life span is about 1 month with access to blood.

Infectious Period

Body lice can be spread as long as lice remain alive on the host or in clothing. Body lice are capable of moving to other hosts and infesting the new host. Crab lice cannot live away from a human host; most die within 2 days.

School Staff/Nurse Responsibility

1. Make referral to licensed health care provider for diagnosis and treatment if crab lice are observed or suspected.

Lice (Pediculosis) (cont.)

2. Consider child sexual abuse when crab lice are present in a student who is not sexually active. Reporting of suspected child abuse cases is mandatory.

3. Individuals with crab lice should be examined by a licensed health care professional for other sexually transmitted infections or diseases.

4. All potentially-affected persons (such as sexual partners or those sharing a bed) should be examined and treated simultaneously to avoid re-infestation.

5. Maintain and support confidentiality for the student.

Control of Spread

1. Utilize standard precautions (see Appendix VIII, *Guidelines for Handling Body Fluids in Schools).*

2. Refer to district infection control program protocols and policy on infectious diseases.

3. Instruct family members to avoid having close physical contact with a person who is infested, and to avoid sharing bedding or clothing with that person.

Lice (Pediculosis) (cont.)

Head Lice (Pediculosis humanus capitis)

Description

Different kinds of lice affect the head, body, and pubic areas.

Head lice are parasitic insects less than 1/8 of an inch in length that feed on blood from the scalp. Lice eggs, called “nits”, attach to a hair shaft until they hatch into live lice.

Lice and nits can be found on the head, eyebrows, or eyelashes, but are usually found on the scalp, particularly around and behind the ears and near the neckline at the back of the head. Head lice outbreaks are common in the United States among children between the ages of 3–12 years. Head lice are not a sign of poor hygiene or unclean homes or schools. Students of all socio-economic groups can be affected.

Signs and symptoms of head lice infestation include:

1. Itching on the head and scalp.
2. A tickling feeling of something moving on the head or in the hair.
3. The detection of live lice.
4. Nits (lice eggs) or empty cases from hatched lice attached to hairs.
5. Sores or scratch marks on the head caused by scratching.
6. Irritability and trouble sleeping. (Head lice are most active in the dark.)

Unlike body lice, head lice are not a health hazard and are not responsible for the spread of any disease. Thus, infestation is principally a nuisance rather than a major threat to the student’s well-being.

Approaches to treating and controlling the spread of head lice have evolved over the years and continue to evolve. Some chemical agents used in the past to eradicate head lice have proven to be dangerous and toxic to children. In some instances, head lice have become resistant to certain treatment methods. The information in this section reflects the current thinking of professional groups regarding head lice in schools.

The American Academy of Pediatrics provides current clinical reports that clarify and update the protocols for diagnosis and treatment of head lice, and provide guidance for the management of infested children in the school setting.

Mode of Transmission

Transmission of head lice occurs most commonly by direct contact with a live louse through head-to-head contact. Transmission may be through play and interaction at school and at home, such as slumber parties, sports activities, at camp and on a

Lice (Pediculosis) (cont.)

playground. It is uncommon for lice to be spread from inanimate objects such as hats, combs, brushes, pillows, helmets, headphones, or movie theatre seats. This is because head lice are not able to hold onto these materials or survive without the warmth and blood source of a human scalp. Head lice cannot survive away from the scalp for more than 2 days at room temperature. Nits are not easily transmitted because they are glued to the hair shaft.

Incubation Period

Head lice eggs (nits) normally hatch in 7–12 days. Mature head lice are capable of laying eggs 9–12 days after hatching. The adult life span is about 1 month.

Infectious Period

Head lice can be transmitted as long as the lice remain alive. Only live, hatched lice—not nits—spread the infestation. By removing the nits, the possibility of hatching new lice is minimized. Nits found more than a quarter of an inch away from the scalp have already hatched or will never hatch. Nits need warmth from the scalp to remain viable.

School Staff/Nurse Responsibility

1. Reporting to your local health jurisdiction is not required.

2. **Immediate or long-term exclusion is no longer recommended.** Students with live head lice can remain in class and go home at the end of the school day, be treated, and return to school after the appropriate treatment has begun. Students can return to school with nits following treatment. Nits may persist after initial treatment, therefore, students with nits should be allowed back in school the next day. Successful treatment should kill crawling lice.

3. Notify parent/guardian of the suspected case. Suggest resources for parents on how to treat head lice, such as those available through the Washington State Department of Health Lice Web page: http://www.doh.wa.gov/CommunityandEnvironment/Pests/Lice.aspx.

   Other local health departments not listed on this site may also have materials available to share with families and staff (see Appendix XII for a listing of Washington State health jurisdictions).

4. Refer to a licensed health care provider for evaluation of secondary infection (such as skin infections from scratching), if suspected.

5. Maintain and support confidentiality for the student.

6. Utilize standard precautions (see Appendix VIII, *Guidelines for Handling Body Fluids in Schools)*.

Lice (Pediculosis) (cont.)

7. Refer to district infection control program protocol and policy for infectious diseases.

8. All family members should be examined and treated simultaneously to avoid re-infestation.

9. Discreetly manage lice infestations so that the student is not ostracized, isolated, humiliated, or psychologically traumatized.

10. Dispel head lice myths.

11. Routine or periodic classroom and schoolwide screenings are no longer recommended.

12. Students should be discouraged from close head-to-head contact with others.

13. Follow-up with the student and family to ensure that the infestation is being addressed appropriately until the infestation has ended.

14. Have pro-active policies and procedures in place for dealing with head lice in schools. Communicate the policy to parents and staff.

15. Advocate for discontinuation of “No Nit policies.” Inform school administrators of current scientific research, evidenced based practice, recommendations from experts, and for reasons stated below.

NOTE

Both the American Academy of Pediatrics (AAP) and the National Association of School Nurses (NASN) advocate discontinuing “No Nit” policies (which require students to be free of lice and nits before returning to school). Such policies are not effective in controlling head lice outbreaks for the following reasons:

- Many nits are more than 1/4 inch from the scalp, which means they have already hatched and have left an empty casing, or will not hatch because they are too far away from the warm scalp to survive the nit stage.

- Nits are naturally attached or “glued” to hair shafts and are unlikely to transfer to other students.

- Unnecessary absenteeism negatively affects students, families, and schools.

- Misdiagnosis of nits is common during nit checks conducted by non-medical personnel.

Lice (Pediculosis) (cont.)

Future Prevention and Education

1. Educate school personnel and the parent/guardian in recognizing and managing a head lice infestation. This could include periodically providing information to families of all students on the diagnosis, treatment, and prevention of head lice.

2. Assure students, parents/guardians, and staff that anyone can get head lice, and it is not an indication of lack of cleanliness. The parent/guardian should be encouraged to check their student's head for lice if the student is symptomatic.

3. Educate school personnel and parents about the revised guidelines regarding "No Nit" school policies.

4. The use of chemical sprays or "bug bombs" to treat the environment within the school setting is not recommended due to potential toxicity, harm to humans, and their lack of efficacy.

5. Minimize upholstered furniture in classrooms. Launder floor pillows, mats, and other shared fabric items regularly and dry in a hot dryer.

Resources

American Academy of Pediatrics: Head Lice Policy (2002)
Statement of reaffirmation (2009)
Policy revision (2010)
http://aappolicy.aappublications.org/cgi/content/full/pediatrics;110/3/638

American School Health Association (2005). School Policies in the Management of Pediculosis. http://www.ashaweb.org/files/public/Resolutions/Pediculosis.pdf.

Centers for Disease Control and Prevention, Head Lice Information for Schools, http://www.cdc.gov/parasites/lice/head/schools.html.

National Association of School Nurses, Position statement: Pediculosis Management in the School Setting. (2011)

National Association of School Nurses, S.C.R.A.T.C.H: Head Lice Community Education Program
http://www.nasn.org/ToolsResources/SCRATCHHeadLiceResources.

Washington State Department of Health, Head Lice
http://www.doh.wa.gov/CommunityandEnvironment/Pests/Lice.aspx.

Measles

Description

Measles is a highly infectious viral disease that can lead to serious complications. These complications include ear infections, diarrhea, pneumonia, encephalitis, and even death. Before the introduction of a measles vaccine in 1963, there were more than 500,000 measles cases a year and 500 deaths a year in the United States. Measles is now mainly related to international travel by persons who are not fully protected by vaccination with the measles, mumps, rubella (MMR) vaccine. A single case of measles is considered a public health emergency.

Measles begins with cold-like symptoms. The symptoms include a cough; runny nose; red, itchy, watery eyes; and a high fever (as high as 103–105°F). Two to four days after the symptoms begin; a raised, red rash will appear on the head and spread downward to become a full-body rash, usually lasting 5–6 days. People with measles appear quite ill.

Mode of Transmission

Measles is spread from person-to-person by airborne droplets or by the nasal and throat secretions of an infected person.

Incubation Period

About 10 days (range 7–18 days) from exposure to upper-respiratory symptoms. The average time from exposure to beginning of rash is 14 days.

Infectious Period

Measles is infectious from one day before the beginning of the respiratory symptoms (usually about 4 days before the rash onset) to 4 days after the appearance of the rash.

School Staff/Nurse Responsibility

1. Screen for school vaccine entry requirement.

2. Any student with a rash illness, especially if fever and/or other symptoms are present, should be referred to a health care provider for diagnosis.

3. Report to your local health jurisdiction of suspected cases by telephone is mandatory and must be immediate.

4. Refer to a licensed health care provider for assessment. Assure that the provider's office staff is informed about possible measles before patient arrival in order to prevent transmission in the office waiting room.

Measles (cont.)

5. Be alert to any student with a high fever; cough; runny nose; red, itchy, watery eyes; and a rash. Be especially alert to symptoms in students at about two weeks after international travel or travel to an area with known measles cases or after contact with someone with recent international travel or travel to an area with measles that has had a rash illness in the past 2–3 weeks.

6. Ensure students comply with Washington State immunization requirements (two documented doses of MMR vaccine). If a case is suspected, prepare a list of students and staff who may be susceptible—those who are unimmunized, or those who have no documentation of having had the disease or having been immunized with two doses of MMR.

7. Support school administrator in exclusion of susceptible students and staff as advised by your local health officer.

8. Measles vaccine is recommended for all adults born since 1957. Most adults born before 1957 are immune because they had measles infection. However, there are still some adults born prior to 1957 that have had neither the vaccine nor the disease and thus remain susceptible. State law does not require documentation of staff immunization. However, in the event of a single case of measles in a school, staff will have to produce proof of immunity or vaccination, and your local health officer will exclude susceptible staff.

9. Maintain and support confidentiality for the student.

Control of Spread

1. Utilize standard precautions. Measles is highly contagious through respiratory aerosols. (see Appendix VIII, *Guidelines for Handling Body Fluids in Schools).*

2. Refer to district infection control program protocols and policy for infectious diseases.

3. If a student in your school develops confirmed measles, your local health officer may require implementation of the following control measures:

    a. Exclude confirmed case from school until four full days have passed since the appearance of rash.

    b. Exclude students exempted from measles immunization or students without documentation of measles immunization for 21 days after last exposure, regardless of vaccine doses or immunoglobulin received after exposure.

    c. Outbreak control measures listed above also apply to all staff at the affected school.

Measles (cont.)

4. Provide a second dose of measles vaccine to all students with a history of only one dose of measles vaccine. Students that do not receive a second dose of measles vaccine during an outbreak will be excluded from school.

5. Instruct students never to share items that may be contaminated with saliva such as beverage containers.

6. Clean or dispose of articles soiled with nose and throat discharges.

7. Cover mouth with tissue when coughing or sneezing. If no tissue is available, encourage students to “catch your cold in your elbow” by covering their mouth and nose with the crook of their arm and coughing or sneezing into their shirt or coat sleeve.

8. Encourage proper hand washing techniques.

Future Prevention and Education

Measles can be controlled and eventually eliminated if children are vaccinated fully and on time.

Meningitis

Description

Meningitis is an infection of the fluid of a person's spinal cord and the fluid that surrounds the brain. The infection can be caused by bacteria or viruses. Viral meningitis is generally less severe and resolves without treatment. Bacterial meningitis can be very severe and may result in brain damage, hearing loss, disability, and death. The two primary bacteria that cause meningitis are *Streptococcus pneumoniae* (Pneumococcal) or *Neisseria meningitides* (Meningococcal). *Haemophilus influenzae* (H. flu) meningitis, which occurs mainly in children under five years, has been greatly reduced since the 1990s when the *Haemophilus influenzae* type b (Hib) vaccine was introduced. There are also vaccines for Pneumococcal and Meningococcal disease, but neither is required for school entry. Symptoms of bacterial invasive disease can include bacteremia, meningitis, infected joints, or pneumonia and usually develop quickly (over several hours or up to 1–2 days) and include high fever and chills, stiff neck, headache, photophobia (light sensitivity), vomiting, and sometimes a rash, coma, and seizures. Diagnosis is made by a spinal tap and a blood or joint culture, depending on the symptoms. When treatment with antibiotics is started early, the likelihood of survival is increased.

Mode of Transmission

Meningococcal disease is transmitted person-to-person through direct contact with respiratory and throat secretions such as through kissing or coughing in close proximity. It may also be spread by sharing beverage containers, cigarettes, or other smoking-related paraphernalia. It is not transmitted through the air after an infected person has left the room. Meningococcal disease is less contagious than the common cold or influenza. Outbreaks in schools or communities are extremely rare in this country. Both meningococcal and pneumococcal organisms are often found in the upper respiratory tract of healthy persons.

Incubation Period

Variable depending on the agent, for meningococcal disease usually 2–10 days, for pneumococcal disease usually 1–4 days.

Infectious Period

Meningitis is infectious until the bacteria is no longer present in discharges from the nose and mouth; susceptible organisms will disappear from the nose and throat within 24 hours after appropriate treatment is started.

School Staff/Nurse Responsibility

1. Report to your local health jurisdiction immediately suspected or confirmed cases of meningitis or outbreaks associated with a school.

Meningitis (cont.)

2. Report to your local health jurisdiction of confirmed invasive meningococcal disease is immediate and mandatory.

3. Referral to licensed health care provider of suspected cases is immediate and mandatory for meningitis.

4. Obtain accurate facts from your local health jurisdiction so appropriate information can be shared with school staff and parent/guardian of exposed students.

5. Maintain and support confidentiality for the student.

Control of Spread—Bacterial Meningitis

1. Utilize standard precautions (see Appendix VIII, *Guidelines for Handling Body Fluids in Schools).*

2. Refer to district infection control program protocols and policy for infectious diseases.

3. Exclude from school until licensed health care provider releases student in consultation with your local health jurisdiction.

4. Household or other close contacts that may have been exposed to the respiratory secretions of a person with meningococcal disease should be referred to licensed health care provider for possible antibiotic prophylaxis.

5. Schoolroom classmates, teachers, or other school personnel usually do not require antibiotic prophylaxis unless they have had prolonged, close exposure, such as best friends sharing lunch. However, classroom contacts should be observed for signs of illness and be advised to seek medical care promptly if any suspicious symptoms occur. Teachers and the parent/guardian should contact their licensed health care provider or local health jurisdiction if they have further questions about preventive measures.

6. Risk of acquiring the disease in a normal classroom situation is typically low. Your local health jurisdiction will advise school staff when students and staff are at risk and what action should be taken.

7. In rare situations, certain types of meningococcal organisms cause clusters of cases, particularly in colleges. Special vaccination programs may be carried out in such circumstances. Your local health jurisdiction will provided specific guidance in these situations.

8. Instruct students not to share items that may be contaminated with saliva such as beverage containers.

Meningitis (cont.)

9. Clean or dispose of articles soiled with nose and throat discharges.

10. Cover mouth with tissue when coughing or sneezing. If no tissue is available, encourage students to “catch your cold in your elbow” by covering their mouth and nose with the crook of their arm and coughing or sneezing into their shirt or coat sleeve.

11. Encourage proper hand washing techniques.

Future Prevention and Education

1. Current available meningococcal vaccines are protective against only four strains of meningococcal bacteria (A, C, Y, W-135). There are two kinds of meningococcal vaccine in the United States. Meningococcal conjugate vaccine (MCV4) is the preferred vaccine for people 55 years of age and younger. Meningococcal polysaccharide vaccine (MPSV4) is the only meningococcal vaccine for people older than 55.

2. Vaccination with a MCV4 vaccine is recommended routinely starting at age 11 years with revaccination at age 16 years. The meningococcal conjugate vaccines can be used at ages as early as 9 months for certain high risk infants/toddlers.

3. Routine meningococcal vaccination is recommended for certain high-risk groups including college freshman (particularly those living in dormitories or residence halls), persons who have certain immunosuppression such as asplenia, laboratory personnel, and travelers to countries of endemic meningococcal disease.

4. Meningococcal vaccine is recommended for use in control of serogroup C meningococcal outbreaks.

5. Pneumococcal vaccine is available to prevent invasive disease due to *Streptococcus pneumoniae* in children.

6. Meningococcal vaccine is not required, but schools in Washington State are required to provide educational material about meningococcal disease to parents and guardians: http://apps.leg.wa.gov/RCW/default.aspx?cite=28A.210.080.

Resources

National Association of School Nurses (NASN) Voices of Meningitis Campaign
http://www.nasn.org/ToolsResources/Immunizations/VoicesofMeningitisChallenge

Methicillin Resistant *Staphylococcus Aureus* (MRSA)

Description

Staphylococcus aureus (*S. aureus*) is a bacterium that normally occurs on the skin. *S. aureus* can cause minor skin infections such as boils or impetigo. Rarely, *S. aureus* causes more serious infections of the bloodstream, urine, lungs, or other organs or tissues. An antibiotic resistant form, methicillin resistant *S. aureus* (MRSA), causes the same types of infections as antibiotic sensitive forms, but is harder to treat. Combined with influenza infection, MRSA pneumonia can be severe or fatal.

MRSA skin infections may be abscesses, impetigo, boils, or an infected open wound, causing fever, reddening, pain, warmth, swelling, and pus. The infection may be mistaken for a spider bite. Even without a culture for MRSA, any draining skin lesion should be considered infectious. There are no specific data for Washington about MRSA, but past studies suggest that the infection occurs at typical rates in the state.

Mode of Transmission

Skin bacteria such as *S. aureus* spread by direct person-to-person contact, by shared items, or through contaminated surfaces. Shared items at schools could include towels, soap, razors, sports equipment such as helmets, and clothing.

Incubation Period

Variable, since *S. aureus* can be on the skin or in the nares (nostrils) or an extended period before causing infection in a wound.

Infectious Period

People can have MRSA on the skin and not be infected, but spread the bacteria to others. Any boil, abscess, or open wound could have *S. aureus* or other bacterial infection.

School Staff/Nurse Responsibility

1. Refer suspected cases to a licensed health care provider. MRSA may be treated with local care only or antibiotics may be appropriate.

2. Report to your local health jurisdiction of individual cases is not required. If a cluster of three or more cases occurs in a single classroom or athletic team, notify your local health jurisdiction.

3. Follow standard precautions when doing wound care or touching a patient's mucous membranes. Wear gloves and wash hands immediately after removing the gloves.

4. Maintain and support confidentiality for the student.

Methicillin Resistant *Staphylococcus Aureus* (MRSA) (cont.)

Control of Spread

1. Utilize standard precautions (see Appendix VIII, *Guidelines for Handling Body Fluids in School).*

2. Refer to district infection control program protocols and policy for infectious diseases.

3. Cover any wound that is draining or has pus with a clean, dry bandage that is closed on all four sides.

4. If a draining wound cannot be safely covered, consult with health care provider to determine when it is safe for a student to return.

5. Consult with the health care provider to determine when it is appropriate for the student with skin lesions to return to a contact sport. Examine the wound to insure that it is not open and/or draining prior to their return.

6. Individuals with compromised immune systems may need to consult with their health care provider to determine if it is safe for them to be in a classroom with a student recovering from a MRSA infection.

Return to play

The determination to return to sports following referral for a skin infection or diagnosis of MRSA or other skin infection is made by the school nurse in collaboration with the student's physician and/or the local health jurisdiction. It is made on a case by case basis using health information and is not a set number of days.

CDC Guidance for Excluding Students with MRSA Infections from School

Unless directed by a physician, students with MRSA infections should not be excluded from attending school.

http://www.cdc.gov/mrsa/groups/advice-for-school-officials.html

All students should be instructed in the following, including students with possible or known MRSA infections:

1. Wash hands thoroughly with soap and water only, if soap and water **is not available**, use a generous amount of alcohol-based (62 percent plus) hand rub: before, or if not available, using an alcohol-based hand rub before eating, after bathroom use, and especially after changing bandages, touching nares (nostrils), mouth, eyes, wounds, drainage, other bodily fluids.

Methicillin Resistant *Staphylococcus Aureus* (MRSA) (cont.)

2. Do not share personal items such as towels or razors.

3. Keep cuts and scrapes clean and covered with a bandage until healed.

4. Avoid contact with other people's wounds or bandages.

Future Prevention and Education

The school should clean potentially contaminated surfaces with an EPA-registered disinfectant labeled effective against MRSA.

Clean health clinic surfaces frequently including cots and change or use disposable covers for pillows. Schools should establish cleaning procedures with EPA-registered disinfectants for frequently touched surfaces and surfaces that come into direct contact with the skin. There are special recommendations for sports settings:

1. Exclude athletes with active skin and soft tissue infections from participating in wrestling or other contact sports unless the wound can be properly covered.

2. Exclude athletes with active skin and soft tissue infections from use of common use water facilities such as pools, whirlpools, or therapy pools unless cleaned between users.

3. Encourage use of a barrier (towel or layer of clothing) between the skin and shared equipment as well as surfaces such as benches.

4. Establish routine disinfectant cleaning of shared surfaces such as benches in weight-room, shower, pool areas, and wrestling mats (see *Guidelines for Handling Body Fluids in Schools,* Appendix VIII, L. Athletics).

5. Strongly encourage showering with soap immediately after participating in sports involving close personal contact (e.g. wrestling and football).

6. Strongly encourage athletes to wash athletic clothing after each use.

7. Require athletes to report skin lesions to coaches and require coaches to assess athletes regularly for skin infections and report findings to the school nurse.

Resources

Centers for Disease Control (CDC):

- MRSA Infections
  http://www.cdc.gov/mrsa/prevent/schools.html

- Information and guidance for school officials
  http://www.cdc.gov/mrsa/groups/advice-for-school-officials.html

Methicillin Resistant *Staphylococcus Aureus* (MRSA) (cont.)

- Tacoma Pierce County Health Department (TPCHD)—MRSA: http://www.tpchd.org/health-wellness-1/mrsa-methicillin-resistant-staphylococcus-aureus/
- See the TPCHD Toolkits for Athletics, School Custodians, Elementary, Middle, and High Schools
- Washington State Department of Health—MRSA http://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/AntibioticResistance/MRSA.aspx

Molluscum Contagiosum

Description

Molluscum Contagiosum is a viral skin infection (pox family) that causes raised, pearl-like papules or nodules on the skin. It is a common infection in children often seen on the face, neck, armpit, arms, and hands.

Typically, the lesion of molluscum begins as a small, painless papule that may become raised up to a pearly, flesh-colored nodule. The papule often has a dimple in the center. The skin lesion commonly has a central core or plug of white, cheesy or waxy material.

The papules are about 2–5 millimeters wide. There is usually no inflammation and subsequently no redness unless there is trauma or a secondary infection. Scratching or other irritation may cause the virus to spread in a line or in groups, called crops. Typically there are a small number of lesions, usually between 2 and 20.

Mode of Transmission

Molluscum lesions are mildly contagious and most often spread to other areas of the infected child's body instead of spreading to other children.

The virus can spread to others through direct contact with a lesion and contaminated objects, such as towels, clothing, or toys. Outbreaks have occasionally been reported in child care centers. Wrestlers or gymnasts may get it through contact with infected mats. Transmission has been associated with swimming pools though epidemiologic studies have failed to demonstrate conclusively how, or under what circumstances, recreational swimming might facilitate Molluscum Contagiosum virus transmission. The virus also spreads by sexual contact. Early lesions on the genitalia may be mistaken for herpes or warts but, unlike herpes, these lesions are painless. Having atopic dermatitis, the most common type of eczema, also increases the risk of getting Molluscum Contagiosum.

Incubation Period

Little has been verified with regard to the incubation period; however, it is estimated to be between 2 weeks and 6 months.

Infectious Period

The period of communicability is unknown but once the lesions are gone, the individual is no longer contagious. Lesions may persist from a few months to a few years. In healthy individuals, these lesions ultimately disappear without scarring, unless there is excessive scratching, which may leave marks. Individual lesions usually disappear within about 2–3 months. Complete disappearance of all lesions generally occurs within about 6–18 months. The infection may persist and show rapid progression in immunosuppressed people.

Molluscum Contagiosum (cont.)

School Staff/Nurse Responsibility

1. Refer to licensed health care provider if there are symptoms suggestive of Molluscum Contagiosum. Because Molluscum Contagiosum is self-limited in healthy individuals, treatment may be unnecessary. Nonetheless, issues such as lesion visibility, underlying atopic disease, and the desire to prevent transmission may prompt therapy. There are a variety of treatment options currently available.

2. If possible, keep the area with growths clean and covered with clothing or a bandage to minimize risk of direct contact.

3. Participation in close-contact sports such as wrestling and basketball, or those that use shared equipment like gymnastics and baseball should be avoided unless all lesions can be covered by clothing or bandages. Seek guidance from the licensed health care provider to determine when the student can safely return to these activities.

4. Swimming should also be avoided unless all growths can be covered by watertight bandages. Personal items (such as towels, goggles, and swim suits) should not be shared. Other items and equipment (such as kick boards and water toys) should be used only when all bumps are covered by clothing or watertight bandages.

5. Follow cleaning guidance found in Appendix VIII to minimize the risk of spreading this and other viruses in schools and child care settings. Note that careful cleaning of shared toys or sporting equipment such as wrestling and gymnastic mats, is important.

6. Use precautionary measures to minimize the risk of spreading Molluscum Contagiosum in communal swimming pools. Routine disinfection of pools with chlorine, cleaning of pool toys, kickboards, and thorough washing of towels, can help prevent transmission.

7. Use standard precautions when there is any risk that you may come into contact with lesions (see Appendix VIII, *Guidelines for Handling Body Fluids in School*).

8. Refer to district infection control program protocols and policy for infectious diseases.

9. Maintain student confidentiality.

Future Prevention and Education

- Inform students that scratching or picking the lesions can spread it to other parts of the body. In some cases, covering the lesions with a bandage may help stop scratching and spread of the virus.

Molluscum Contagiosum (cont.)

- Avoid shaving any area with lesions.
- Teach students not to share towels, washcloths, clothing, and other personal items.
- Remind staff and students of the importance of frequent handwashing to reduce the spread of infections.

Mosquito-borne Illness

Description

Mosquitoes are a problem because besides an itchy bite they can spread rare but serious diseases in this country such as Western equine encephalitis, St. Louis encephalitis, and West Nile viral infection. In the United States, West Nile virus infection is the most common of these infections. In other countries, mosquitoes spread malaria and other diseases.

Symptoms of mosquito-borne infectious vary. Around 80 percent of people infected with West Nile virus will not show any symptoms. About 20 percent of people who become infected will display mild symptoms including fever, headache, body aches, nausea, vomiting, and sometimes swollen lymph glands or skin rash on the chest, stomach, and back. These symptoms typically last a few days. About 1 in 150 people infected with West Nile virus will develop severe illness such as encephalitis. Encephalitis is an inflammation of the brain with severe symptoms including high fever, headache, neck stiffness, disorientation, convulsions, muscle weakness, vision loss, numbness, paralysis, and coma. Severe symptoms may last several weeks. Some neurological effects are permanent. Severe illness is much more likely in those over age 50 years and is rare in children. Over 30,000 cases of West Nile virus infection have been reported in this country with 45 cases acquired in Washington State.

Mode of Transmission

Generally, West Nile encephalitis is spread by the bite of an infected mosquito. Mosquitoes become infected with the West Nile virus when they feed on infected birds, particularly crows and related birds. Infected mosquitoes can then spread West Nile encephalitis to humans and other animals when they bite. Rare person-to-person transmission occurs through blood transfusion or from woman to fetus. West Nile virus is not spread through contract or sharing items.

Incubation Period

3–14 days for West Nile encephalitis infection.

Infectious Period

Mosquito-borne illnesses are spread from infected people only rarely, such as through blood transfusion or during pregnancy.

School Staff/Nurse Responsibility

1. Make referral to licensed health care provider of suspected cases.
2. Maintain and support confidentiality for the student.

Mosquito-borne Illness (cont.)

Control of Spread

1. Utilize standard precautions (see Appendix VIII, *Guidelines for Handling Body Fluids in Schools).*

2. Refer to district infection control program protocols and policy for infectious diseases.

3. Do not touch a dead bird with bare hands. Contact your local health jurisdiction for instructions on reporting and disposing of the dead bird.

Prevent mosquito bites:

1. Make sure window and door screens are "bug tight." Repair or replace them if needed.

2. Stay indoors at dawn and dusk when mosquitoes are the most active.

3. Encourage field trip participants to wear a long sleeved shirt, long pants, and a hat when going into mosquito-infested areas such as wetlands or woods. Prepare students and staff for field trips to such areas.

Reduce mosquito habitat:

1. Empty anything outside that holds standing water such as old tires, buckets, plastic covers, and toys.

2. Change water in birdbaths, fountains, wading pools, and animal troughs weekly.

3. Recycle unused containers (bottles, cans, and buckets) that may collect water.

4. Make sure roof gutters drain properly and do not pool water.

5. Fix leaky outdoor faucets and sprinklers.

6. Drill drainage holes in tire swings so water drains out.

7. Keep children's wading pools empty and on their sides when they are not being used.

Future Prevention and Education

Washington State Department of Health Mosquitoes:
http://www.doh.wa.gov/CommunityandEnvironment/Pests/Mosquitoes.aspx

The CDC's West Nile encephalitis Web page:
http://www.cdc.gov/ncidod/dvbid/westnile/index.htm.

Mumps

Description

Mumps is a viral illness characterized by painful inflammation of the glands that lie just above the back angle of the jaw. Involvement can be one-sided or bilateral. Other glands, including those in the floor of the mouth beneath the tongue and below the jaw, may also be involved, although less commonly. Viruses other than mumps and some bacteria are also known to cause swelling of the parotid glands. Mumps patients may have fever, headache, and mild respiratory symptoms or may have no symptoms other than parotitis. In post pubertal individuals, the testes may become inflamed in males and the ovaries in females. Very rarely sterility can result. The central nervous system may become involved, usually manifested by increased irritability, stiff neck, headache, and even convulsions in some cases. Symptoms of mumps generally resolve after 7–10 days.

Mode of Transmission

Transmission is by direct contact with or droplet spread of the saliva of infected persons. It should be remembered that approximately one-third of all susceptible individuals exposed to mumps will not develop apparent disease but will still be infectious.

Incubation Period

16–18 days (range 12–25 days).

Infectious Period

Mumps virus has been found in the saliva from 7 days before to 9 days after the onset of parotitis (salivary gland infection). However, persons with mumps are most contagious from 2 days before the onset of illness to 4 days after swelling first appears.

School Staff/Nurse Responsibility

1. Report to your local health jurisdiction of mumps cases is mandatory.
2. Refer suspected mumps cases to a licensed health care provider.
3. Maintain and support confidentiality for the student.

Control of Spread

1. Screen for school vaccine entry requirement.
2. Utilize standard precautions (see Appendix VIII, *Guidelines for Handling Body Fluids in Schools).*

Mumps (cont.)

3. Refer to district infection control program protocols and policy for infectious diseases.

4. A confirmed case should be isolated until the swelling and other manifestations of the illness have subsided, or at least 4 days after the onset of swelling.

    a. Post exposure vaccination of individuals is not clearly protective against the disease and its complications. However, use of vaccine is recommended because it will protect against any subsequent exposure.

5. Instruct students never to share items that may be contaminated with saliva such as beverage containers.

6. Clean or dispose of articles soiled with nose and throat discharges.

7. Cover mouth with tissue when coughing or sneezing. If no tissue is available, encourage students to “catch your cold in your elbow” by covering their mouth and nose with the crook of their arm and coughing or sneezing into their shirt or coat sleeve.

8. Encourage proper hand washing techniques.

Future Prevention and Education

A live, attenuated virus vaccine is available in combination with the measles and rubella vaccine (MMR) at the age of 12 months. Vaccination is required for child care and school entry in Washington State. Parents/guardians should be encouraged to have their children vaccinated on time.

Norovirus (Norwalk-like Viruses)

Description

Norovirus is the term used for the group of viruses previously called Norwalk virus and related viruses causing similar symptoms. Illness is an acute viral infection of the gastrointestinal system characterized by nausea, vomiting, non-bloody diarrhea, and abdominal cramps and can include a low-grade fever, chills, headache, muscle aches, and lethargy. Some persons might experience only vomiting or diarrhea and up to 30 percent of infections are asymptomatic. Symptoms typically resolve without treatment after 1–3 days, but in young children the course could be 4–6 days.

The CDC estimates that 21 million cases of acute gastrointestinal infections are due to norovirus each year, and that at least 50 percent of all foodborne outbreaks of gastrointestinal infections can be attributed to noroviruses. There are many different strains of the viruses and no persisting immunity after infection, so people can and do develop repeated similar illnesses, particularly during childhood. Treatment consists of supportive care, primarily fluid and electrolyte replacement.

Mode of Transmission

Norovirus is primarily shed in stools and is easily spread person-to-person by hands, toys, bathroom surfaces, and contaminated food. It can also be transmitted by aerosolized vomitus to persons nearby. The viruses can persist on surfaces, so infection can occur several days after the initial contamination unless thorough cleaning is done.

Incubation Period

24–48 hours typically, but can occur within 12 hours of exposure.

Infectious Period

Peak viral shedding is 2–5 days after infection, and may continue for 2 weeks or more. Noroviruses are highly contagious and as few as 10 viral particles may be sufficient for infection.

School Staff/Nurse Responsibility

1. Immediately report to your local health jurisdiction suspected or confirmed foodborne outbreaks associated with a school.

2. Exclude food handlers with vomiting or diarrhea from work until cleared by a licensed health care provider or their local health jurisdiction.

3. Staff and students should remain home through their illness and for 24 hours after symptoms resolve. The local health jurisdiction may issue additional requirements for food handlers. In the event of a large school-wide occurrence of

Norovirus (Norwalk-like Viruses) (cont.)

gastrointestinal disease, consult with your local health jurisdiction regarding environmental cleaning and possible closure of food service or the school to stop the cycle of infection.

4. Remove any contaminated clothing or linens immediately. Clean thoroughly any contaminated surfaces with a detergent to remove organic material (such as feces). Rinse detergent off surface and then disinfect with an EPA-approved disinfectant for norovirus. Antibacterials such as triclosan and general use disinfectants such as quarternary ammonium compounds are not generally effective against norovirus and related viruses. Bleach solutions for disinfecting must be prepared fresh daily (see Appendix VIII Guidelines for *Handling Bodily Fluids*).

5. Maintain and support confidentiality for the student.

Control of Spread

1. Utilize standard precautions (see Appendix VIII, *Guidelines for Handling Body Fluids in Schools).*

2. Refer to district infection control program protocols and policy for infectious diseases.

3. Encourage good personal hygiene and proper hand washing techniques after going to the bathroom, before eating, and after changing diapers.

4. A child with diarrhea or vomiting may transmit the infection to other children in a school setting. Your local health jurisdiction may require that children or employees with certain infections not return to school until they test negative for the infection or symptoms resolve.

5. An infected individual may show no symptoms. Therefore, proper hand washing techniques and appropriate disposal of feces and materials contaminated with fecal material must be completed.

6. Surfaces where diapers are changed must be cleaned and disinfected after each use (see *Guidelines for Handling Body Fluids in Schools,* Appendix VIII).

Future Prevention and Education

1. It appears that immunity for noroviruses may be strain-specific and lasts only a few months. Therefore, due to the different types of noroviruses, individuals are likely to be repeatedly infected throughout their lifetimes. This may explain the high attack rates in all ages reported in outbreaks.

Norovirus (Norwalk-like Viruses) (cont.)

2. Most foodborne outbreaks of norovirus are likely to arise through direct contamination of food by a handler immediately before its consumption. Outbreaks have frequently been associated with cold foods, including salads, sandwiches, and bakery products. Liquid items, such as salad dressing or cake icing that allow the virus to mix evenly, are often implicated in outbreaks. Food can also be contaminated at its source. Oysters from contaminated waters have been associated with widespread outbreaks of gastroenteritis. Other foods, including raspberries and salads, have been contaminated before widespread distribution and subsequently caused extensive outbreaks.

3. Waterborne outbreaks of norovirus in community settings have often been caused by sewage contamination of wells and recreational water.

4. Noroviruses are relatively resistant to environmental challenge. They are able to survive freezing, temperatures as high as 60°C (140 degrees Fahrenheit), and have been associated with illness after being steamed in shellfish. Moreover, noroviruses can survive in up to 10 parts per million (ppm) chlorine, in excess of levels routinely present in public water systems. Despite these features, it is likely that relatively simple measures such as correct handling of cold foods, no bare-hand contact with ready-to-eat food by foodworkers, and frequent hand washing, may substantially reduce foodborne transmission of noroviruses.

Resources

CDC, MMWR, Updated Norovirus Outbreak Management and Disease Prevention Guidelines, March 4, 2011/60(RR03):1–15.
http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6003a1.htm?s_cid=rr6003a1_e

CDC, NCIRD, Norovirus: Technical Fact Sheet
http://www.cdc.gov/ncidod/dvrd/revb/gastro/norovirus-factsheet.htm

Pertussis (Whooping Cough)

Description

Pertussis is a highly contagious, bacterial infection of the nose and throat. Pertussis begins with an upper-respiratory "catarrhal" stage that is characterized by coughing, sneezing, runny nose, and occasional vomiting. This stage can lasts up to 2 weeks. The disease then enters its paroxysmal stage where the coughing is staccato and comes in multiple, exhausting bursts. A cough episode may be followed by a sudden characteristic "whooping" sound as the child breathes in and sometimes by vomiting at the end of the episode. Sweating, exhaustion, gagging, and excessive amounts of thick mucus secretions may accompany the cough. This stage lasts for 2–4 weeks followed by a recovery phase of gradually diminishing frequency of cough episodes over a period of 2–3 weeks. Children under the age of 1 year are much more liable to suffer serious consequences than older children. In young infants the disease can be fatal. In older children who were never immunized, incompletely immunized, or whose immunity has waned since the last vaccination, the disease can vary from quite mild to a prolonged (several month) bout of uncomfortable, exhausting coughing episodes. Infection among adults is common but is generally milder and is often mistaken for bronchitis.

Mode of Transmission

Transmission of pertussis is usually spread by droplets or direct contact with the respiratory secretions of an infected person.

Incubation Period

Average 9–10 days, (range 6–21 days).

Infectious Period

Pertussis is most infectious during the early catarrhal stage and at the beginning of the paroxysmal stage. Communicability gradually declines and is negligible by 3 weeks after the onset of paroxysms. Patients need to be isolated during the first 5 days of an appropriate antibiotic treatment, but may return when 5 days of antibiotic therapy has been completed, even though they may continue to cough for some time.

School Staff/Nurse Responsibility

1. Report to your local health jurisdiction of cases is mandatory and should be immediate.

2. Make referral to licensed health care provider of suspected case for diagnosis and treatment.

3. Maintain and support confidentiality for the student.

Pertussis (Whooping Cough) (cont.)

4. If pertussis has been confirmed and the student is not treated with antibiotics, he/she should be excluded from school until 4 weeks after the onset of the illness or until the cough has stopped. If treated, the student may return after 5 days of treatment have been completed.

Control of Spread

1. Screen for school vaccine entry requirement.

2. Utilize standard precautions (see Appendix VIII, *Guidelines for Handling Body Fluids in Schools).*

3. Refer to district infection control program protocols and policy for infectious diseases.

4. Exclude infected student per local health officer recommendation. (Generally until the fifth day of antibiotic therapy or, if not treated, until they are no longer coughing, or until 4 weeks after cough onset, whichever period is shorter.)

5. Recommend immunization of all unimmunized or incompletely immunized students less than the age of 7 years with a booster at age 11 years or older.

6. Your local health officer will make recommendations regarding treatment of school and household contacts.

7. All immunized close contacts may continue to attend school if started on prophylactic antibiotics. At the direction of your local health jurisdiction, unimmunized close contacts may be excluded from school until an incubation period has passed. In most instances, however all exposed close contacts—regardless of immunization status—are evaluated for symptoms and excluded if symptoms develop in the 21 days after exposure. Exposed close contacts who develop symptoms should be referred to a licensed health care provider for evaluation and treatment.

8. Instruct students never to share items that may be contaminated with saliva such as beverage containers.

9. Clean or dispose of articles soiled with nose and throat discharges.

10. Cover mouth with tissue when coughing or sneezing. If no tissue is available, encourage students to “catch your cold in your elbow” by covering their mouth and nose with the crook of their arm and coughing or sneezing into their shirt or coat sleeve.

Pertussis (Whooping Cough) (cont.)

11. Encourage proper hand washing techniques.

Future Prevention and Education

Pertussis vaccine, given along with diphtheria and tetanus toxoid (Tdap and DTaP) in the recommended schedule, is an effective means of prevention.

Pinworms

Description

Pinworms are a very common condition caused by a small intestinal roundworm. Although some infected individuals have no symptoms, pinworm infestation can include severe anal itching with disturbed sleep, restlessness, and local irritation from scratching. Vaginitis and abdominal pain, in rare instances, are attributed to pinworms. People from all socio-economic and ethnic backgrounds may have pinworms. Diagnosis is made by finding adult worms or eggs in the anal region.

Mode of Transmission

Transmission of pinworms is spread by infective eggs carried from anus to mouth by hands, from articles of bedding or clothing to mouth, or carried in food or by dust. Children who have scratched the anal area can have eggs under their fingernails and transmit to others through shared food.

Incubation Period

The life cycle from egg to adult takes 1–2 months or longer.

Infectious Period

Pinworm eggs are infectious within a few hours after being deposited on the skin. The person is infectious as long as female worms are depositing eggs on skin around the anus. The eggs can survive up to 3 weeks on clothing, bedding, or other objects. Response to specific antihelminth drugs (drugs that kill parasitic worms) is excellent, but re-infestation occurs easily.

School Staff/Nurse Responsibility

1. Reporting to your local health jurisdiction is not necessary.
2. Make referral to licensed health care provider for appropriate diagnosis and treatment of suspected cases.
3. Educate student and family regarding mode of transmission (infectious eggs carried from anus to mouth by hands, from articles of bedding or clothing to mouth, or by food or dust). Teach careful hand washing including careful cleaning of fingernails after using the bathroom and before eating.
4. Encourage good personal hygiene and proper hand washing techniques after going to the bathroom, before eating, and after changing diapers.
5. Maintain and support confidentiality for the student.

Pinworms (cont.)

Control of Spread

1. Utilize standard precautions (see Appendix VIII, *Guidelines for Handling Body Fluids in Schools).*

2. Refer to district infection control program protocols and policy for infectious diseases.

3. If condition is recurrent, all members of household should be treated simultaneously. Risks and benefits of prescribing antihelminth drugs for children younger than 2 years should be reviewed with medical care provider, because of limited experience in using these drugs with children of this age.

4. Surfaces where diapers are changed must be disinfected after each use (see Appendix VIII, *Guidelines for Handling Body Fluids in Schools*).

5. Encourage proper hand washing techniques.

Poliomyelitis (Polio)

Description

Poliomyelitis (polio), formerly called infantile paralysis, is an extremely rare illness that begins with minor symptoms but may become life threatening. The initial symptoms may include fever, tiredness, gastrointestinal upset, headache, and sore throat. The disease may resolve after 24–48 hours and might be classified as “minor.” In some instances, however, it may progress to include marked stiffness of the neck, back, and limbs. When the poliovirus gains access to nerve structures it can cause paralysis of any muscles, even the muscles of respiration. This made the use of iron lungs necessary when severe polio cases were seen in the past. Although wild polio transmission has ceased in most countries as a result of vaccination programs, it remains endemic in a few areas of the world, and importation remains a threat. A single case of polio would be a public health emergency.

Mode of Transmission

Transmission of the virus can occur by contact with pharyngeal (throat) droplets as well as through fecal-oral spread.

Incubation Period

Range 3–35 days. Commonly 7–14 days for the paralytic form.

Infectious Period

Not clearly defined, but transmission can occur as long as the virus is shed in the stool. Polio is most infectious in the few days before and after the onset of clinical symptoms. The virus persists in the throat for 1 week after the onset and in the feces for 3–6 weeks. There is no specific medical treatment for polio.

School Staff/Nurse Responsibility

1. Report to your local health jurisdiction of suspected cases is immediate and mandatory.

2. Exclusion of confirmed cases from school would be as directed by or your local health officer.

3. Check susceptibility of contacts and recommend immunization of contacts as appropriate.

4. Maintain and support confidentiality for the student.

Control of Spread

1. Screen for school vaccine entry requirement.

Poliomyelitis (Polio) (cont.)

2. Utilize standard precautions (see Appendix VIII, *Guidelines for Handling Body Fluids in Schools).*

3. Refer to district infection control program protocol and policy for infectious diseases.

Future Prevention and Education

Polio vaccine is required for school and child care entry. Administration of oral (live virus) polio vaccine was discontinued in the United States in 2000. Only inactivated injectable vaccine is used now.

Internationally, polio control is achieved by immunization of any individual in an epidemic area who is over the age of 6 weeks and who is unvaccinated, incompletely vaccinated, or uncertain of vaccination history.

Ringworm (Tinea)

Description

Ringworm is not caused by a worm, but by various types of fungi. When found on the body it is called *tinea corporis*; when on the scalp, *tinea capitis*; when in the groin, *tinea cruris*; and when on the feet, *tinea pedis.* (see Athlete's Foot section). It is a very common infection.

Ringworm begins as a small, red patch or bump that spreads outward, so that each affected area takes on the appearance of a red, scaly, outer ring with a clear central area. Hair may become brittle and break off in gradually spreading areas. Itching sometimes accompanies the infection.

Mode of Transmission

Transmission of ringworm is generally by person-to-person or contaminated article-to-person contact. Infected animals may be a source for scalp and body infections, although rarely.

Incubation Period

Usually 7–21 days.

Infectious Period

Ringworm is infectious during the duration of skin or scalp lesions and while the fungus persists on contaminated materials.

School Staff/Nurse Responsibility

1. A report to your local health jurisdiction is not necessary.
2. Make referral to licensed health care provider for appropriate diagnosis and treatment of suspected cases.
3. Maintain and support confidentiality for the student.

Control of Spread

1. Utilize standard precautions (see Appendix VIII, *Guidelines for Handling Body Fluids in Schools).*
2. Refer to district infection control program protocols and policy for infectious diseases.
3. Encourage frequent hand washing.
4. The student may stay in school after treatment has been started.

Ringworm (Tinea) (cont.)

5. Encourage the student to keep the affected area covered to minimize transmission.

6. Instruct students not to share combs, hats, towels, and/or other personal articles.

7. Disinfect showers, dressing rooms, and gymnasium (floors, mats, and sports equipment). Follow cleaning and disinfecting guidelines in Appendix VIII.

8. Encourage proper laundering of towels and clothing.

9. Request physical activity clearance from licensed health care provider before student returns to school-related physical activities.

Future Prevention and Education

Ringworm of the body is not particularly dangerous, has no unusual long-term consequences, and can generally be treated quite effectively with locally applied preparations. A prescribed oral medication may be needed for severe or persistent cases of body ringworm and is necessary to treat all ringworm of the scalp.

Instruct students about the causes, means of transmission, and prevention of this condition.

Rubella (Three-Day Measles)

Description

Rubella is a relatively mild viral illness. Its importance lies not in the problems it causes in the person who acquires the disease, but rather in the significant congenital defects it may cause in infants whose mothers contracted rubella during the first 12 weeks of pregnancy. The first signs of rubella in children may be swollen, tender glands, usually at the back of the neck and behind the ears; and a low-grade fever followed by a rash. Adults may experience a 1–5 day prodrome (early signs of onset), consisting of respiratory symptoms. The rash usually consists of pink to red isolated spots that appear first on the face then spread rapidly to the trunk, biceps, and thigh areas of the extremities with large confluent areas of flushing. The rash usually fades within 3 days. Fever is often mild or absent. Some itching may occur. Rubella in adolescents and adults may cause painful or swollen joints (especially in females). Because many other rash illnesses look like rubella, laboratory tests are required to confirm the diagnosis. Up to 50 percent of rubella cases are asymptomatic.

Mode of Transmission

Transmission is from nasopharyngeal secretions of infected persons. It is also transmitted across the placenta to the fetus. Infants with congenital rubella can shed large quantities of the virus from their respiratory secretions and in the urine.

Incubation Period

14–17 days, (range 14–21 days).

Infectious Period

Rubella is infectious for about 1 week before and at least 4 days after the appearance of the rash.

School Staff/Nurse Responsibility

1. Report to your local health jurisdiction of suspected cases is immediate and mandatory.

2. Make referral to licensed health care provider for laboratory tests to establish diagnosis and for necessary follow-up of suspected rubella cases.

3. Maintain and support confidentiality for the student.

Control of Spread

1. Screen for school vaccine entry requirement.

2. Utilize standard precautions (see Appendix VIII, *Guidelines for Handling Body Fluids in Schools).*

Rubella (Three-Day Measles) (cont.)

3. Refer to District infection control program protocols and policy for infectious diseases.

4. Students may return to school on the 5th day after the rash appeared.

5. Pregnant contacts of the student should be notified of their exposure and advised to contact their licensed health care provider immediately to discuss the status of their immunity to rubella.

6. Instruct students never to share items that may be contaminated with saliva such as beverage containers.

Future Prevention and Education

A blood test is available to identify those that lack immunity to rubella. Because of the theoretical risk to the fetus, females of childbearing age should receive vaccine only if they say they are not pregnant and are counseled not to become pregnant for 1 month after vaccination.

Scabies

Description

Scabies is a severe, itchy skin infestation caused by the mite *Sarcoptes scabiei* that burrows in the skin surface. Scabies affects persons from all socio-economic levels without regard to age, sex, or standards of personal hygiene. Although scabies is more prominent in crowded living conditions, everyone is susceptible. It is extremely common among children. The earliest symptoms of scabies are itching, especially at night. Subsequently, little red bumps, like hives, tiny bites, or pimples appear. In more advanced cases, the skin may be crusty or scaly. The female mite prefers warmer sites of the human body. The mite burrows into the outer layer of the skin in tiny red lines about half an inch long and then lays eggs. The parasite tends to be first located in the webs between the fingers or toes, around the wrist, or navel. It can also be commonly found on the backs of elbows, the folds of the armpits, the beltline and abdomen, the creases of the groin, and on the genitalia. In children younger than the age of 2 years, the eruption is generally small vesicles (blisters) and can occur additionally on the head, neck, palms, and soles. Scabies may be severe for immunocompromised persons.

Mode of Transmission

Scabies is transmitted by skin-to-skin contact. Scabies usually is spread by direct, prolonged, skin-to-skin contact with a person who has scabies. Contact generally must be prolonged; a quick handshake or hug usually will not spread scabies. Scabies is spread easily to sexual partners and household members. Persons sharing a bed are also at risk. Child care facilitates are also a common site of scabies infestation. The mites can survive 3–4 days away from human skin.

Incubation Period

Symptoms in persons without previous exposure usually do not occur until 4–6 weeks after exposure to an infected person. Persons who were previously infested are sensitized and, therefore, usually present symptoms 1–4 days after the exposure. Re-infestations are usually milder than the original episode.

Infectious Period

Scabies can be transmitted as long as the person remains infested and untreated, including during the interval before symptoms develop.

School Staff/Nurse Responsibility

1. Suspect scabies in a skin rash that causes intense itching, especially at night. Students with mild cases can be sent home at the end of their school day.

2. Notification to the parent or guardian for appropriate referral to licensed health care provider is made by the school nurse for diagnosis and treatment of suspected cases. Students can be readmitted the following day after overnight treatment with a prescribed topical anti-scabicide cream.

Scabies (cont.)

3. Discreetly manage scabies cases so that the student is not ostracized, isolated, humiliated, or psychologically traumatized.

4. If it is believed that there has been direct, prolonged skin to skin contact in the school setting, the school nurse will inform parents/guardians regarding possible exposure to a student with a confirmed case of scabies. Provide information pertaining to symptoms, treatment, and prevention information as signs of scabies can occur as late as 1–2 months after exposure.

5. If multiple students (10 percent or greater of class or school) are affected:

   a. Seek assistance from your local health jurisdiction in controlling the outbreak.

   b. Inform parent/guardian of the outbreak.

6. Encourage parent/guardian to notify the school, all close contacts, and others who may have had close skin contact with the effected student.

7. Maintain and support confidentiality for the student.

Control of Spread

1. Utilize standard precautions (see Appendix VIII, *Guidelines for Handling Body Fluids in Schools).*

2. Refer to district infection control program protocols and policy for infectious diseases.

3. A prescribed topical medication is recommended for treatment.

4. Because the lesions are the result of a hypersensitive reaction to the mite, itching may continue for 4–6 weeks despite successful treatment. Contact with the licensed health care provider for additional comfort measures may be warranted. More prescriptive scabicide treatment will not relieve the post scabies itch.

Do not attempt to treat scabies with home remedies. Treatment guidelines include:

1. Examining and treating all family members simultaneously to avoid re-infestation.

2. Applying medication appropriately.

3. Washing all personal items. Bedding and clothing worn next to the skin during the 4 days before initiation of therapy should be laundered in a washing machine with hot water and dried using a hot cycle. The mites do not survive more than 3–4 days without skin contact.

Scabies (cont.)

4. Placing items you do not wish to launder in the dryer on the hot cycle for 30 minutes.

5. Dry-cleaning items.

6. Placing items in plastic bags and storing them in the garage for 2 weeks. If the mites do not get a meal within 1 week they will die.

7. Vacuuming the entire house and discarding the used bag. Environmental disinfectants are unnecessary and unwarranted.

Note

Pets do not need to be treated.

Future Prevention and Education

1. Scabies is widespread and transmission usually occurs through prolonged, close personal contact. Education about its symptoms and treatment may help those at risk and eliminate spread. It is usually not serious except that it causes severe itching and secondary infection from scratching. Scabies in students, like lice and pinworms, does not necessarily indicate poor hygiene.

2. If repeated infections occur despite proper treatment, an investigation for unrecognized cases among companions or household members should be undertaken. This should be done in consultation with your local health jurisdiction. The most common cause of treatment failure is inadequate treatment of close personal contacts. All family members should receive prophylactic treatment.

3. The use of chemical sprays or “bug bombs” to treat the environment within the school setting is not recommended due to potential toxicity and harm to humans.

Resources

CDC Scabies frequently asked questions:
http://www.cdc.gov/parasites/scabies/gen_info/faqs.html

Sexually Transmitted Infections (STI)

Sexually transmitted infections (STIs) are transmitted by sexual activity such as vaginal, oral, or anal sex. The STIs that are of the greatest concern include HIV/AIDS, chlamydia, syphilis, Human Papillomavirus (genital warts, HPV), herpes, gonorrhea, and hepatitis B. These diseases occur commonly in persons between the ages of 15–29 years. The number of diseases listed in the sexually transmitted category has climbed sharply in recent years. New tests indicate that an emphasis on symptoms is out of date. Screening for asymptomatic infection is important. Consider child sexual abuse when gonorrhea, chlamydia, or syphilis is present in a student who is not sexually active. Call local child protective services.

Future Prevention and Education

1. For confidential information about STIs, call the national STI Hotline at 1-800-227-8922 or choose the STI option of Washington State's AIDS Hotline at 1-800-272-2437.

2. School nurses can order CDC's STI treatment guidelines from the Washington State Department of Health's Office of STI Services at 360-236-3460, or consult the latest guidelines at http://www.cdc.gov/std/treatment.

3. The address for *The Practitioners Handbook for the Management of STDs* is www.STDhandbook.org.

4. CDC's STI clinical slides in PowerPoint or graphic files are available at http://www.cdc.gov/std/training/clinicalslides/.

5. For a large array of dermatology photographs, go to www.dermis.net/dermisroot/en/home/index.htm.

Sexually Transmitted Infections (STI) (cont.)

Chlamydia

Description

Chlamydia trachomatis is a bacterium that causes infection of the external and internal genital tract. **Most chlamydial infections are asymptomatic—they have no symptoms.** Pain during urination and an opaque discharge from the urethra are the most common symptoms for males, when they do occur. Symptoms for females include mucopurulent cervicitis (inflammation of the cervix), cervical ectopy (redness) and friability (easily induced bleeding) of the cervix. If left untreated, complications may occur, including pelvic inflammatory disease and chronic pelvic pain in females and epididymitis (inflammation of the testes) in males. This may eventually result in infertility for both sexes.

Mode of Transmission

Chlamydia is transmitted by sexual activity involving the penis, vagina, mouth, and/or rectum.

Incubation Period

7–21 days.

Infectious Period

Chlamydia infection may extend for months in untreated cases, especially in asymptomatic cases. Treatment with current CDC-recommended antibiotics ends infectiousness within days.

School Staff/Nurse Responsibility

1. Make referral to licensed health care provider for diagnosis and appropriate therapy. If the referred student is of the age of 14 or older and is otherwise competent, written consent from the student must be obtained prior to disclosing such referral and/or treatment information with the student's parent/guardian (see RCW 70.24.105; RCW 70.24.110, Appendix X).

2. Report of suspected child abuse cases is mandatory.

3. Maintain and enforce confidentiality for the student. The consent to exchange information and medical records is governed by RCW 70.24.105 and Chapter 70.02 RCW.

4. If clinical services to support Chlamydia diagnosis and treatment exist at the school (i.e., school-based health center), reporting of all cases diagnosed on site is mandatory. (See http://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/SexuallyTransmittedDisease/CaseReports.aspx.)

Sexually Transmitted Infections (STI) (cont.)

Control of Spread

1. Control of spread involves an interview with the patient and tracing of sexual contacts by public health personnel. Notification of public health authorities as soon as possible is essential. Rescreening 3–4 months after completion of treatment is recommended.

Future Prevention and Education

Middle school and high school students need accurate information about STIs, their symptoms, causes, treatment, and where treatment can be obtained. The need for referral for interviewing and treating all contacts must be stressed (see RCW 28A.230.020, Appendix XI).

Sexually Transmitted Infections (STI) (cont.)

Gonorrhea (Clap, Strain, Dose)

Description

Gonorrhea is caused by the bacterium *Neisseria gonorrhoeae*. Gonorrhea genital infections differ somewhat in presentation in males and females. In males, pain during urination and purulent (pus-like) discharge from the urethra usually occurs 2–8 days after exposure. **Up to 20 percent of males have no symptoms.** In females, gonorrhea may show up as pain during urination or vaginal discharge. **Most infected females have no symptoms.** Infection can spread to the pelvic areas and even to the joints, heart, brain, and other organs in both males and females. Coexisting chlamydial infection and potential pelvic inflammatory disease should be a concern, along with pharyngeal (throat) and anorectal infections.

Mode of Transmission

Gonorrhea is transmitted by sexual activity involving the penis, vagina, mouth, and/or rectum.

Incubation Period

1–30 days, usually 2–10 days.

Infectious Period

Gonorrhea may extend for months in untreated cases, especially in asymptomatic cases. Treatment with current CDC-recommended antibiotics ends infectiousness within days. *N. gonorrhoeae* changes rapidly so the most up-to-date treatment recommendations should be consulted (www.cdc.gov/std/treatment/default.htm).

School Staff/Nurse Responsibility

1. Make referral to licensed health care provider for diagnosis and appropriate therapy. If the referred student is of the age of 14 or older and is otherwise competent, written consent from the student must be obtained prior to disclosing such referral and/or treatment information with the student's parent/guardian (see RCW 70.24.105; RCW 70.24.110, Appendix X).

2. Report of suspected child abuse cases is mandatory.

3. Maintain and enforce confidentiality for the student. The consent to exchange information and medical records is governed by RCW 70.24.105 and Chapter 70.02 RCW.

Sexually Transmitted Infections (STI) (cont.)

4. If clinical services to support gonorrhea diagnosis and treatment exist at the school (i.e., school-based health center), reporting of all cases diagnosed on site is mandatory. (See http://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/SexuallyTransmittedDisease/CaseReports.aspx.)

Control of Spread

1. Control of spread involves an interview with the patient and tracing of sexual contacts by public health personnel. Notification of public health authorities as soon as possible is essential.

2. No school exclusion is necessary. Patient should receive treatment as soon as diagnosis is confirmed.

3. Report of suspected child abuse cases is mandatory. Consider child sexual abuse when gonorrhea is present in a student who is not sexually active.

Future Prevention and Education

Middle school and high school students need accurate information about STIs, their symptoms, causes, treatment, and where treatment can be obtained. The need for referral for interviewing and treating all contacts must be stressed (see RCW 28A.230.020, Appendix XI).

Antibiotic resistant strains of gonorrhea may increase the risk of spreading this infection. School nurses should work closely with local health jurisdiction staff to better ensure successful treatment and discuss any student who reports his/her symptoms have not resolved.

Sexually Transmitted Infections (STI) (cont.)

Herpes Simplex Virus, Genital Area

Description

Genital herpes is usually caused by Type 2 herpes simplex virus (HSV), though Type 1 infection in the genital area accounts for 30 percent of infections. As with oral herpes infections, this is a recurrent, life-long, viral infection but is asymptomatic or not recognized in at least two-thirds of those infected. New tests, including serologies, enhance diagnosis. Very large national studies indicate that one-fifth of United States residents over the age of 12 years have antibodies to Type 2 HSV. Lesions are most infectious if fluid-filled vesicles (blisters) are present. Infection can be severe in the newborn.

Genital lesions pose no risk to others unless there is direct contact with infected lesions. Genital herpes infection, due to either Type 1 or Type 2 virus, can be sexually transmitted. It is not acquired from nonsexual sources or objects such as toilet seats.

Mode of Transmission

Both Types 1 and 2 HSV are transmitted by direct contact with infected skin and secretions during periods of asymptomatic or symptomatic viral shedding. Sores need not be present. Transmission to the newborn occurs most commonly at delivery.

Incubation Period

2–20 days.

Infectious Period

There is a life-long potential for spread of infection. Skin lesions are infectious until healed. The virus can be shed from the site of infection at any time. Sores need not be present. Intermittent or suppressive therapy with specific antivirals may alleviate outbreaks and viral shedding and have been shown to reduce transmission.

School Staff/Nurse Responsibility

1. Make referral to licensed health care provider for diagnosis and appropriate therapy. If the referred student is of the age of 14 or older and is otherwise competent, written consent from the student must be obtained prior to disclosing such referral and/or treatment information with the student's parent/guardian (see RCW 70.24.105; RCW 70.24.110, Appendix X).

2. Report of suspected cases of child abuse is mandatory.

Sexually Transmitted Diseases (STI) (cont.)

3. Provide education and counseling regarding transmission of disease, recurrence potential, and recommended prevention practices to prevent spread. Further information can be found at www.ashastd.org.

4. If clinical services to support initial herpes diagnosis and treatment exist at the school (i.e. school-based health center), reporting of all cases diagnosed on site is mandatory. http://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/SexuallyTransmittedDisease/CaseReports.aspx).

5. Maintain and enforce confidentiality for the student. The consent to exchange information and medical records is governed by RCW 70.24.105 and Chapter 70.02 RCW.

Future Prevention and Education

Middle school and high school students need accurate information about STIs, their symptoms, causes, treatment, and where treatment can be obtained. The need for referral for interviewing and treating all contacts must be stressed (see RCW 28A.230.020, Appendix XI).

Sexually Transmitted Infection (STI) (cont.)

Human Papillomavirus (HPV, Genital Warts)

Description

HPV is a group of over 100 strains of virus, 40 of which can infect the genitals. Two strains are responsible for approximately 70 percent of cervical cancers and another two strains cause 90 percent of genital warts. HPV has also been implicated in head/neck cancers, esophageal cancers, penile and anal cancers. The strains that cause warts are not associated with cancer. HPV infections are extremely common. Symptoms can vary; some may have no warts, others many. Warts also vary in appearance often depending upon location. Some may appear to be grayish and hard, others may be soft and pink. When they do occur, they are frequently clustered. Fortunately, most HPV infections do not go on to cause cancer and in most cases are cleared from the body within two years

A vaccine that protects against the four most common strains of HPV is available for both males and females between the ages of 9–26.

Mode of Transmission

HPV is transmitted through skin-to-skin contact with an infected individual during sexual activity. Warts do not have to be present for infection to occur due to viral shedding.

Incubation Period

Two weeks to several months.

Infectious Period

HPV is infectious for duration of the viral infection. Most individuals will clear the infection without intervention within two years.

School Staff/Nurse Responsibility

1. Make referral to licensed health care provider for diagnosis and appropriate therapy. If the referred student is of the age of 14 or older and is otherwise competent, written consent from the student must be obtained prior to disclosing such referral and/or treatment information with the student's parent/guardian (see RCW 70.24.105; RCW 70.24.110, Appendix X).

2. Report of suspected cases of child abuse is mandatory.

3. Provide education and counseling regarding transmission of disease, and recommended prevention practices to prevent spread.

Sexually Transmitted Infections (STI) (cont.)

4. Maintain and enforce confidentiality for the student. The consent to exchange information and medical records is governed by RCW 70.24.105 and Chapter 70.02 RCW.

5. There is no reporting requirement for HPV.

Future Prevention and Education

Middle school and high school students need accurate information about STIs, their symptoms, causes, treatment, and where treatment can be obtained (see RCW 28A.230.020, Appendix XI).

Both males and females can be vaccinated against the most common strains of HPV.

Beginning with sixth grade entry, every public school in the state shall provide parents and guardians with information about human papillomavirus disease and the HPV vaccine at the beginning of every school year (RCW 28A.210.080).

Sexually Transmitted Infections (STI) (cont.)

Non-Gonococcal Urethritis (NGU)

Description

Non-gonococcal urethritis (NGU) is a condition that is caused by a variety of bacteria. In males it is more common than gonorrhea. While chlamydia is the most frequent isolated agent, other agents are involved in a significant number of cases. *Ureaplasma urealyticum, Trichomonas vaginalis,* and herpes cause approximately 10–15 percent of NGU cases.

Symptoms are very similar to gonorrhea, with pain and a pus-like to mucous-like discharge from the urethra. Many infected persons have no symptoms. Diagnosis is based on symptoms, laboratory studies, and negative cultures for gonorrhea.

Mode of Transmission

NGU is transmitted by sexual contact.

Incubation Period

Generally 2–21 days or more.

Infectious Period

NGU is infectious for the duration of bacterial infection. Viral causes such as herpes, may mean long-term infectiousness potential.

School Staff/Nurse Responsibility

1. Make referral to licensed health care provider for diagnosis and appropriate therapy. If the referred student is of the age of 14 or older and is otherwise competent, written consent from the student must be obtained prior to disclosing such referral and/or treatment information with the student's parent/guardian (see RCW 70.24.105; RCW 70.24.110, Appendix X).

2. Report of suspected cases of child abuse is mandatory.

3. Maintain and enforce confidentiality for the student. The consent to exchange information and medical records is governed by RCW 70.24.105 and Chapter 70.02 RCW.

Control of Spread

1. Control of spread involves an interview with the patient and referral of sexual contacts for medical examination and treatment. Schools are required to cooperate with their local health jurisdiction staff in the process of investigation.

Sexually Transmitted Diseases (STI) (cont.)

2. Recurrent NGU may be due to lack of compliance with treatment, failure to treat sexual partners, or reinfection.

Future Prevention and Education

Middle school and high school students need accurate information about STIs, their symptoms, causes, treatment, and where treatment can be obtained (see RCW 28A.230.020, Appendix XI).

Sexually Transmitted Diseases (STI) (cont.)

Syphilis

Description

Syphilis is an acute and chronic, potentially life-threatening disease caused by the bacterium *Treponema pallidum*. Infection is characterized first by a local lesion, then a secondary rash, followed by a period of latency (no symptoms), and much later by possible involvement of the nervous system, heart, skin, and bone. The most distinctive early sign is called a chancre (a shallow, painless ulcer with a firm border that is usually located on genital surfaces, but possibly on other areas of the body). Within 1–5 weeks (even without treatment) the chancre will usually disappear. A skin rash and/or patches in the mouth/throat may then appear and may last 2–6 weeks. At this secondary stage, blood tests for syphilis are always positive (unlike the primary stage that can have negative serologic tests). A period of latency then occurs. Patients may remain asymptomatic throughout life or may progress to the late destructive stages of the disease. In an untreated female, syphilis may be transmitted to a fetus regardless of the stage of the disease.

Mode of Transmission

With the exception of congenital infection, syphilis is transmitted through direct contact with an infectious lesion or rash occurring in primary and secondary stages, typically by sexual contact.

Incubation Period

10–90 days, usually 21 days.

Infectious Period

Appropriate antibiotic treatment ends infectiousness within 24 hours. Isolation of appropriately treated patients from school is not required.

School Staff/Nurse Responsibility

1. Make referral to licensed health care provider for diagnosis and appropriate therapy. If the referred student is of the age of 14 or older and is otherwise competent, written consent from the student must be obtained prior to disclosing such referral and/or treatment information with the student's parent/guardian (see RCW 70.24.105; RCW 70.24.110, Appendix X).

2. Report of suspected child abuse cases is mandatory.

3. If clinical services to support syphilis diagnosis and treatment exist at the school (i.e. school-based health center), reporting of all cases diagnosed on site is mandatory.

Sexually Transmitted Infections (STI) (cont.)

http://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/SexuallyTransmittedDisease/CaseReports.aspx

4. Maintain and enforce confidentiality for the student. The consent to exchange information and medical records is governed by RCW 70.24.105 and Chapter 70.02 RCW.

Control of Spread

1. Control of spread involves an interview with the patient and tracing of all sexual contacts by public health officials for medical examination and treatment. Schools are required to cooperate with their local health jurisdiction staff in the process of investigation.

2. Adequate treatment will limit spread from the primary site to other organs and from one individual to another.

Future Prevention and Education

Middle school and high school students need accurate information about STIs, their symptoms, causes, treatment, and where treatment can be obtained (see RCW 28A.230.020, Appendix XI).

No vaccine is available. Simultaneous infection with syphilis and other STIs is common. The untreated disease may become a very significant health problem in the years ahead. Congenital syphilis such as the infection of a newborn with syphilis contracted from the mother, is a serious and unnecessary tragedy since this disease can be diagnosed and treated effectively.

Sexually Transmitted Infections (STI) (cont.)

Trichomoniasis ("Trich")

Description

Trichomoniasis is caused by a parasitic protozoa called *Trichomonas vaginalis* and is considered one of the most common sexually transmitted infections.

While trichomoniasis infects both males and females, males seldom have any symptoms. Symptoms for females include abnormal vaginal discharge, itching, burning, and vaginal odor. Diagnosis is confirmed by laboratory smear, culture, or other test. There is evidence linking trichomoniasis infection to low birth weight babies and premature births.

Mode of Transmission

Trichomoniasis is transmitted through penile-vaginal intercourse.

Incubation Period

5–28 days.

Infectious Period

Trichomoniasis is infectious for the duration of the infection.

School Staff/Nurse Responsibility

1. Report to your local health jurisdiction is not required.

2. Make referral to licensed health care provider for diagnosis and appropriate therapy. If the referred student is of the age of 14 or older and is otherwise competent, written consent from the student must be obtained prior to disclosing such referral and/or treatment information with the student's parent/guardian (see RCW 70.24.105; RCW 70.24.110, Appendix X).

3. Report of suspected child abuse cases is mandatory.

4. Maintain and enforce confidentiality for the student. The consent to exchange information and medical records is governed by RCW 70.24.105 and Chapter 70.02 RCW.

Control of Spread

Although the male is seldom symptomatic with trichomoniasis, control of spread and reinfection usually involves concurrent referral of male sexual contacts for medical examination and treatment. Only in this way can the female partner avoid reinfection once therapy is completed.

Sexually Transmitted Infections (STI) (cont.)

Future Prevention and Education

Middle school and high school students need accurate information about STIs, their symptoms, causes, treatment, and where treatment can be obtained (see RCW 28A.230.020, Appendix XI).

Sexually Transmitted Infections (STI) (cont.)

Vaginitis

Description

Vaginitis is an inflammation of the vagina and is considered the most common infection of the female genital organs.

The most prevalent types of vaginitis are trichomoniasis (trich), candidiasis (yeast), and bacterial vaginosis (Gardnerella vaginitis, nonspecific vaginitis). Symptoms include abnormal vaginal discharge, itching, burning, and vaginal odor. Diagnosis is confirmed by laboratory smear, culture, or other test.

Mode of Transmission

Vaginal infections may be transmitted by intimate sexual contact but symptoms also may originate from excessive douching, use of birth control pills, certain antibiotics, and other sources such as allergic reactions to vaginal products.

Incubation Period

Variable depending on the type of vaginitis.

Infectious Period

Vaginitis caused by microorganisms is infectious for the duration of infection.

School/Nurse Responsibility

1. Report to your local health jurisdiction is not required.

2. Make referral to licensed health care provider for diagnosis and appropriate therapy. If the referred student is of the age of 14 or older and is otherwise competent, written consent from the student must be obtained prior to disclosing such referral and/or treatment information with the student's parent/guardian. (see RCW 70.24.105; RCW 70.24.110, Appendix X).

3. Report of suspected child abuse cases is mandatory.

4. Maintain and enforce confidentiality for the student. The consent to exchange information and medical records is governed by RCW 70.24.105 and Chapter 70.02 RCW.

Control of Spread

Although the male is seldom symptomatic with these infections, control of spread and reinfection usually involves concurrent referral of male sexual contacts for medical

Sexually Transmitted Infections (STI) (cont.)

examination and treatment if the diagnosis is trichomoniasis. Only in this way can the female partner avoid reinfection once therapy is completed.

Future Prevention and Education

Middle school and high school students need accurate information about STIs, their symptoms, causes, treatment, and where treatment can be obtained (see RCW 28A.230.020, Appendix XI).

Smallpox

Description

The last case of wild-virus smallpox in the world occurred in 1977 in Somalia. There has not been a case of smallpox disease in the United States since 1949. Routine vaccination for smallpox is no longer done. A single case of smallpox would be a public health emergency.

Smallpox is an acute infectious viral disease characterized by sudden onset of fever greater than 101ºF, fatigue, headache, muscle pain, nausea, vomiting, and backache for 1–4 days before the onset of rash. Lesions begin as raised red spots (papules) and become firm vesicles (blisters) often with a central dimple. Unlike chickenpox, lesions are at the same stage of development at the same time no matter where they are on the body. Crusts begin to form in about 14 days and begin to separate during the third week.

Smallpox vaccine is used in special circumstances to vaccinate some military personnel and laboratory workers. The vaccine is created using a different but related virus that causes the same kind of lesion but in a limited area (e.g., site of inoculation).

Mode of Transmission

Most transmission of smallpox resulted from direct face-to-face contact with an infected person, usually within a distance of 6 feet, from physical contact with a person with smallpox, or with contaminated articles. Vaccine virus can be spread from the vaccine inoculation site or from fresh scabs to another person by hands or skin contact.

Incubation Period

7–19 days, usually 12 days.

Infectious Period

Lesions are infectious until the dry scab crusts have separated. The scabs should be considered infectious. A person with smallpox is sometimes contagious with onset of fever, but the person becomes most contagious with the onset of rash.

School Staff/Nurse Responsibility

1. Immediately report to your local health jurisdiction by telephone a suspected case of smallpox or smallpox vaccine rash.
2. Make referral to licensed health care provider of any suspected cases.
3. Your local health jurisdiction will determine disease control measures.
4. Maintain and support confidentiality for the student.

Smallpox (cont.)

Control of Spread

1. Utilize standard precautions (see Appendix VIII, *Guidelines for Handling Body Fluids in Schools).*

2. Refer to district infection control program protocols and policy for infectious diseases.

3. Only persons with up-to-date vaccination for smallpox should examine a potential case.

4. Maintain respiratory isolation of the case if smallpox is suspected. Cover lesions from smallpox vaccine, which is a different virus that is also contagious.

5. Use standard precautions including gloves for any contact with dressings or with articles soiled with fluid or scabs from skin lesions.

6. Dispose of all dressings in biohazard bags or disinfect dressings with 1:10 bleach and water solution.

7. Follow recommendations from your local health jurisdiction about exclusion from school.

Future Prevention and Education

In the event of an intentional release of smallpox virus, vaccination would be recommended for those exposed to the initial release, contacts of people with smallpox, and others at risk of exposure.

Vaccination of contacts within 4 days of exposure is protective.

Resources

- In order for school nurses to stay informed on breaking issues related to smallpox and bioterrorism diseases and conditions, the following Web sites are recommended:

- The Washington State Department of Health: http://www.doh.wa.gov.

- The latest information for clinicians and the public on smallpox: http://www.bt.cdc.gov/agent/smallpox/index.asp. This site includes question and answer sheets in languages other than English.

- The United States Army Medical Research Institute of Infectious Diseases: http://www.usamriid.army.mil/education/index.cfm. This site includes updates, links, and education options along with general information.

Smallpox (cont.)

- The Harborview Medical Center Web site provides background material for clinicians dealing with families from other countries including traumatic stress related to conflicts in the United States and abroad: http://ethnomed.org/.

Streptococcal Infections (Sore Throat, Scarlet Fever, Necrotizing Fasciitis)

Description

Streptococcal sore throat (pharyngitis) is an acute bacterial infection characterized by sore throat, fever, large tonsils with pus on them, or an inflamed pharynx (throat) and tender nodes in the neck. Streptococcal sore throat can occur with very few symptoms. All sore throats resembling strep throat are not due to strep. For example, infectious mononucleosis can cause a similar sore throat. Students may carry streptococci in their throats but not have symptoms.

Scarlet fever involves a streptococcal sore throat and a skin rash caused by a toxin produced by certain strains of streptococci. The rash usually appears on the neck, chest, groin, and axilla (armpits). It usually does not involve the face. Characteristically, the rash spares the area around the mouth and inside of the elbow. Peeling of the skin, especially of the fingers and toes, may follow the rash.

Impetigo is a superficial skin infection with streptococci or other bacteria. Symptoms include red sores or blisters, often on the face or areas that are scratched like an insect bite (see Impetigo).

Necrotizing fasciitis (flesh-eating bacteria) is caused by Group A strep, the same bacteria that causes strep throat and impetigo. Unlike strep throat and impetigo, which are common and easy to treat, necrotizing fasciitis is very rare and more difficult to treat. The infection occurs between the skin (in the fascia) and eventually results in tissue damage to the skin and underlying muscle. The signs and symptoms are fever with severe pain, followed by swelling and redness at a wound site. As with all unidentified rashes, especially those accompanied by fever or illness, make referral to a licensed health care provider. Treatment is early antibiotic therapy. Prevention is practicing proper handwashing techniques and keeping all wounds clean.

Antibiotics can treat streptococcal infections. Untreated milder streptococcal infections can lead to serious complications (rheumatic fever and kidney disease [glomerulonephritis]).

Mode of Transmission

Streptococcal infection is usually transmitted by airborne droplets or direct skin contact with an infected person. A person can move the infection from one part of the body to another by scratching. Necrotizing fasciitis is spread through direct contact with infected persons through an open sore or wound on the skin. The wound site may be minor.

Incubation Period

From 2–5 days.

Streptococcal Infections (Sore Throat, Scarlet Fever, Necrotizing Fasciitis) (cont.)

Infectious Period

Streptococcal disease is most infectious in the acute phase. Untreated, it may be infectious for several weeks. However, if treated with antibiotics, the infectious period can last less than 24 hours. Some individuals can remain carriers for prolonged periods.

School Staff/Nurse Responsibility

1. Report to your local health jurisdiction suspected or confirmed outbreaks associated with a school.
2. Refer students with a symptomatic sore throat and/or unexplained fever to a health care provider.
3. Notify parent/guardian of students with history of rheumatic fever or kidney infection (glomerulonephritis) if there is a cluster of streptococcal pharyngitis at school.
4. Maintain and support confidentiality for the student.

Control of Spread

1. Utilize standard precautions (see Appendix VIII, *Guidelines for Handling Body Fluids in Schools)*.
2. Refer to district infection control program protocols and policy for infectious diseases.
3. Students with sore throat and fever should be cultured and, if culture-positive, treated appropriately by a licensed health care provider. Those with a positive throat culture should be excluded until at least 24 hours after antimicrobial treatment is initiated. They should be able to return to school after 24 hours of appropriate treatment, when they have no fever, and when physically well enough to attend. No follow-up throat culture is necessary after treatment.
4. When throat cultures are done on a cluster of students to check for strep, there will almost always be some who test positive but are without any symptoms. These students need not be excluded from school nor do they require treatment.
5. Significant increases in the number of sore throats or increases above normal in school absenteeism (above 10 percent) should be referred to your local health jurisdiction for epidemiologic investigation.
6. The culturing of asymptomatic contacts of a strep case is not generally done except in facility outbreaks (e.g., long term residence facility). Some licensed health care providers will wish to treat these contacts while some will observe for a period of time before treating.

Streptococcal Infections (Sore Throat, Scarlet Fever, Necrotizing Fasciitis) (cont.)

7. No vaccines are available for general use at this time to prevent strep throat.

8. Instruct students not to share items that may be contaminated with saliva such as beverage containers.

9. Clean or dispose of articles soiled with nose and throat discharges.

10. Cover mouth with tissue when coughing or sneezing. If no tissue is available, encourage students to “catch your cold in your elbow” by covering their mouth and nose with the crook of their arm and coughing or sneezing into their shirt or coat sleeve.

11. Encourage proper hand washing techniques.

Future Prevention and Education

As with all antibiotic prescriptions, the family should be encouraged to take (or administer to their child) the full course of prescribed treatment, even if the symptoms disappear before all of the medication is taken. Years of prescribing antibiotics for nonbacterial infections and failing to complete the full courses of treatment have promoted the development of antibiotic-resistant bacteria. Antibiotic resistance occurs when bacteria change in some way that reduces or eliminates the effectiveness of drugs designed to cure infections.

Routine classroom or school culture surveys to find strep carriers are not justified unless local public health officials determine an unusual prevalence of streptococcal disease or its complications (rheumatic fever and kidney disease [glomerulonephritis]).

Tetanus (Lockjaw)

Description

Tetanus is now a very rare bacterial disease in the United States because of routine immunization with vaccines containing tetanus toxoid. Tetanus growth in a deep wound produces a toxin that can cause localized spasm and pain in the muscles at the site of injury, or severe generalized muscle spasms most marked in the jaw and neck, generalized pain, even seizures, and death. Tetanus has not been reported in the United States in individuals who received an adequate primary immunization series.

Mode of Transmission

Transmission is through contamination of a wound by soil, dust, water, or articles, especially those that have been contaminated with animal feces or manure. The entry wound may or may not be apparent. Deep puncture wounds are a particular risk because the bacteria grows in a low-oxygen or oxygen-free environment.

Incubation Period

Usually 3–21 days, but it may range from 1 day to several months, depending on the character and extent of the wound. The average is 10 days.

Infectious Period

None.

School Staff/Nurse Responsibility

1. Provide basic first aid to wounds immediately, washing thoroughly with soap and water using standard precautions (see Appendix VIII, *Guidelines for Handling Body Fluids in Schools).*

2. Make referral to licensed health care provider for evaluation of the wound for additional medical care if needed and a tetanus booster, if needed.

3. Notify parent/guardian of the wound.

4. Maintain and support confidentiality for the student.

5. Refer to district infection control program protocols and policy for infectious diseases.

Control of Spread

1. Screen for school vaccine entry requirement.

Tetanus (Lockjaw) (cont.)

Future Prevention and Education

Tetanus vaccine is required for school entry. Surveillance and education to ensure adequate immunization levels is essential. School immunization requirements for Kindergarten and Grade 6 provide adequate immunization levels. Adults who have not received a Tdap booster should get one, then a booster dose of Td every ten years during their lifetime.

Ticks

Description

Ticks are eight-legged arthropods that feed on blood from humans and other animals such as rodents and birds. The more familiar hard ticks are found in woody, brushy, or grassy areas. Hard ticks have hard coverings and are usually dark and patterned. Soft ticks lack the hard covering and may be pale to brown. Tick size varies depending on its developmental stage and recent feeding, varying from 1/8 to 1/2 inches in length.

Different species of hard ticks can carry several infectious diseases in the western United States. Diseases and symptoms include:

Lyme disease typically starts with an expanding circular target-shape rash. There may be fever, headache, muscle aches, and joint pain. Rare late symptoms include recurring joint pain, heart disease, and nervous system disorders. The affected ticks are in western Washington.

Babesiosis causes fever, chills, muscle aches, and anemia. The rare cases are from western Washington.

Anaplasmosis causes headache, fever, chills, and muscle aches. The affected ticks are in western Washington.

Rocky Mountain spotted fever typically starts with fever, vomiting, muscle aches, and headache. There may be a rash several days later. Some cases have abdominal pain, diarrhea, and joint pain. The affected ticks are mainly in eastern Washington.

Tularemia can be spread in several ways including tick bite. Symptoms are fever, headache, swollen lymph nodes, and a skin ulcer near the bite. Cases occur throughout the state although tularemia is usually not tick-associated.

Tick paralysis involves progressive paralysis starting in the legs resulting in weakness, numbness, and difficulty walking. If the tick is not removed, breathing muscles may be paralyzed. Cases occur in eastern Washington.

Soft ticks carry relapsing fever that causes fevers which come and go over several weeks or longer. The infection is usually not severe but can cause loss of a pregnancy. Cases occur mainly in eastern Washington. Relapsing fever is the most common tick-borne infection reported in Washington.

In Washington there are reports every year of locally-acquired cases of Lyme disease, tularemia, and relapsing fever. These include rare reports of babesiosis, anaplasmosis, Rocky Mountain spotted fever, and tick paralysis.

Mode of Transmission

Ticks can spread an infection when they attach and bite to get a blood meal.

Ticks (cont.)

Incubation Period

Varies by disease.

Infectious Period

Tick-borne diseases are not spread directly among people. The infections can be spread during pregnancy or by blood transfusion.

School Staff/Nurse Responsibility

1. Safe tick removal is described in *How to Respond: Illness and Injury at School (2010)* page 26, and at: http://here.doh.wa.gov/materials/how-to-respond-injury-and-illness-at-school or on the DOH Ticks Web page: http://www.doh.wa.gov/CommunityandEnvironment/Pests/Ticks.aspx

   Notify parents and recommend they contact their health care provider with questions or concerns. Save the tick, if possible, for identification.

2. Advise students not to handle, crush, or attempt to remove ticks.

3. If the student reports a known tick bite and the tick is no longer attached, wash the bite site thoroughly with soap and water.

4. Utilize standard precautions (see Appendix VIII, *Guidelines for Handling Body Fluids in Schools).*

5. Refer to district infection control program protocols and policy for infectious diseases.

6. Inform parent of all tick bites and the importance of monitoring the site and any early symptoms of tick-borne illness, particularly "flu-like" symptoms or rash over the next month or so. If symptoms develop, the student should be evaluated by his/her health care provider. Be sure the parent informs the provider about the recent tick bite, when the bite occurred, and where the student most likely acquired the tick.

7. Refer suspected cases of any tick-borne illness to a licensed health care provider.

8. Maintain and support confidentiality for the student.

Control of Spread

Tick-borne diseases are not expected to be spread in schools.

Ticks (cont.)

Future Prevention and Education

Students taking field trips or staying in wood cabins could be at risk for tick exposures. If spending time outdoors in risk areas (woody, brushy, or grassy) students and staff should be instructed to:

1. Wear long pants and a long-sleeved shirt. Tuck pant legs into socks or boots and tuck shirt into pants. Ticks on the clothing can be more easily seen and removed.

2. Wear light colored, tightly woven clothing. The light color will allow the dark tick to be seen more easily. The tight weave makes it harder for the tick to attach itself.

3. If staying overnight in wood cabins or structures in rural or wilderness areas, be sure that the cabins are not infested with rodents that could bring in soft ticks.

4. Cabins should be rodent-proofed. Seal all openings in the foundation and walls. Use heavy screen on windows, vents, and other openings. Keep a cleared area of at least 18 inches around the cabin to discourage rodent entry.

5. Inspect the cabins for rodent activity

6. Securely store and minimize food and snacks within the cabin. Get rid of food wastes away from the cabin to prevent attracting rodents.

7. Check thoroughly for ticks after the activity. Inspect areas around the head, neck, and ears. Report presence of tick to school nurse if available or parent.

Resources

Centers for Disease Control and Prevention Web site, Ticks: http://www.cdc.gov/ticks/.

Washington State Department of Health, Ticks: http://www.doh.wa.gov/CommunityandEnvironment/Pests/Ticks.aspx.

Tuberculosis (TB)

Description

Tuberculosis (TB) is a chronic bacterial disease caused by *Mycobacterium tuberculosis* that may affect any part of the body but most commonly attacks the lungs. In children under the age of 15 years, TB frequently settles in other high oxygen-tension areas of the body (bones, joints, brain, spinal tissue, and lymph nodes). The initial infection with TB is systemic and silent, causing no noticeable symptoms. In most healthy children and adults, initial infection does not immediately develop into disease and the individual is not infectious. This condition is known as latent TB infection. Infants, however, are particularly susceptible to rapidly developing disease at the time of initial infection.

Mode of Transmission

Transmission is generally from the inhalation of droplets expelled from a person with pulmonary disease by sneezing, coughing, and even talking. The bacteria are spread through airborne transmission from diseased to susceptible individuals.

Incubation Period

Variable, about 2–10 weeks. From the time the TB bacilli enter the body and begin the infection process, it may take 2–10 weeks to develop a positive TB test using a purified protein derivative (PPD) solution. Most cases of untreated infection (90 percent) become dormant and never progress to active disease. This percentage is notably lower in young children.

Infectious Period

Students with latent TB infection or uncomplicated primary TB are noninfectious and may remain in school or play groups as long as their general health is good. When the TB lesions have broken down in the lungs and have become infectious, infectiousness persists as long as living bacteria are discharged through the bronchi. Specific drug treatment will usually diminish the infectiousness within weeks. Your local health jurisdiction staff will advise when treated student or staff members may return to school.

Treatment

All individuals who react significantly to the PPD skin test should have an initial chest x-ray to rule out the presence of any active pulmonary disease process. Most infected individuals with latent TB infection will benefit from preventive antibiotic therapy. All diseased individuals are treated typically with a minimum of four antituberculous antibiotics for a minimum of six months. Your local health jurisdiction TB control office must be consulted regarding specifics of individual cases.

Tuberculosis (TB) (cont.)

School Staff/Nurse Responsibility

1. Report to your local health jurisdiction for suspected or known cases is mandatory (see Chapter 246-101 WAC, Appendix V, or go to http://www.doh.wa.gov/PublicHealthandHealthcareProviders/NotifiableConditions.aspx).

2. Make referral to licensed health care provider of any student identified with TB symptoms for TB assessment. Use of the student's existing licensed health care provider is preferable. Consult with your local health jurisdiction as needed.

3. Assist your local health jurisdiction with contact investigations when an active TB case has been identified in the school. Assist your local health jurisdiction in TB testing of school contacts when indicated.

4. Assist staff to dispel anxiety related to noninfectious cases. Promote understanding within the student and faculty populations regarding TB disease versus TB infection. Consult with your local health jurisdiction TB program for assistance.

5. Do not report positive TB tests to your local health jurisdiction unless TB testing was performed as part of a contact investigation. Do not exclude students, or staff because of a positive TB test reaction.

6. Maintain and support confidentiality for the student.

Control of Spread

1. Utilize standard precautions (see Appendix VIII, *Guidelines for Handling Body Fluids in Schools).*

2. Refer to district infection control program protocols and policy for infectious diseases.

3. Active cases must be under treatment with anti-TB drugs.

4. Local health officials must clear treated individuals for return to school.

5. Recent TB skin test converters should have a chest x-ray and medical consultation regarding indication for TB-preventive medication.

6. Students or staff without symptoms are not excluded from school on the basis of a positive TB test indicating latent TB infection alone.

Cover mouth with tissue when coughing or sneezing. If no tissue is available, encourage students to "catch your cold in your elbow" by covering their mouth

Tuberculosis (TB) (cont.)

and nose with the crook of their arm and coughing or sneezing into their shirt or coat sleeve. Clean or dispose of articles soiled with nose or throat discharges.

7. Instruct students not to share items that may be contaminated with saliva, such as beverage containers.

Future Prevention and Education

1. No immunization is recommended in the United States. In some countries Bacillus Calmette-Guerin (BCG) vaccine is given. It is not recommended in countries like the United States where the incidence of TB is low.

2. Routine TB testing of students is no longer recommended in Washington State. However, in specific situations or populations, the risk of exposure may be greater than normal (recent studies have shown a higher prevalence of TB in newly-arrived immigrants). In such cases, schools should consult with their local health jurisdictions.

3. Since TB is a potentially serious disease with special problems and concerns relating to its historical significance in the United States, questions should be directed to your local health jurisdiction.

Resources

The following books are good references for schools: *Tuberculosis Handbook for School Nurses* (revised 2011) and *Guidelines for Initiating A School-based Directly Observed Therapy Program* (revised 2002).

Available online and in print from:
New Jersey Medical School Global Tuberculosis Institute (GTBI)
225 Warren Street
P.O. Box 1709
Newark, NJ 07101-1709

Washington State Department of Health TB manual:
http://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/Tuberculosis/ProviderMaterials/TBServicesManual.aspx.

Warts (Verrucae)

Description

Warts are caused by more than 125 viral types that are the source of skin-colored growths on exposed areas of the skin and mucous membranes. Warts are usually self limited. Their names and appearance depends on the part of the body affected. Some warts are called genital, plantar, oral, flat, facial or filiform, common, and periungual warts. They may be smooth and flat (as plantar warts on the soles of the feet), raised (as on fingers, knees, and hands), or elongated (as on face and neck). Warts usually do not hurt, but occasionally can be very painful, especially if secondary infections occur as a result of scratching. New warts may occur in an individual from picking or scratching the initial wart.

Mode of Transmission

Warts are usually transmitted by direct skin-to-skin contact with a person who is shedding the virus. The transmitter may or may not have symptoms. Contaminated floors and other objects may cause spread of the wart virus. Genital warts are usually sexually transmitted.

Incubation Period

Variable, ranging from 1–8 months but may be as long as several years.

Infectious Period

The infectious period of warts is unknown. The virus is shed at least as long as visible lesions persist and shedding continues intermittently when warts are not present.

School Staff/Nurse Responsibility

1. Make referral to licensed health care provider when warts are extensive and bothersome to the student or parent/guardian. Most warts will disappear spontaneously. Warts may fail to disappear even with repeated treatment and they may recur after an apparent cure. They may be treated with locally applied chemicals, surgery, cautery, or freezing with liquid nitrogen.

2. Clean and disinfect floors, mats, and other equipment if a large number of cases of plantar warts are present. Students with plantar warts should be urged to wear thongs on their feet for showering or be excused from showering until warts disappear.

3. Utilize standard precautions (see Appendix VIII, *Guidelines for Handling Body Fluids in Schools).*

4. Refer to district infection control program protocols and policy for infectious diseases.

Warts (Verrucae) (cont.)

5. Sexual abuse must be considered if genital warts are found in children who are beyond infancy and pre-pubital. Report of suspected child abuse cases is mandatory.

6. Maintain and support confidentiality for the student.

Future Prevention and Education

Inform students and staff that transmission may be by direct person-to-person contact.

APPENDIX I

RCW 28A.210.060-170 Immunization Law

RCW 28A.210.060

Immunization program—Purpose.

In enacting RCW 28A.210.060 through 28A.210.170, it is the judgment of the legislature that it is necessary to protect the health of the public and individuals by providing a means for the eventual achievement of full immunization of school-age children against certain vaccine-preventable diseases.
[1990 c 33 § 190; 1984 c 40 § 3; 1979 ex.s. c 118 § 1. Formerly RCW 28A.31.100.]

NOTES

Severability—1984 c 40: See note following RCW 28A.195.050.

Effective date—1979 ex.s. c 118: "This act is necessary for the immediate preservation of the public peace, health, and safety, the support of the state government and its existing public institutions, and shall take effect on September 1, 1979." [1979 ex.s. c 118 § 13.]

Severability—1979 ex.s. c 118: "If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected." [1979 ex.s. c 118 § 16.]

Immunization plan: RCW 43.70.525.

APPENDIX II

RCW 28A.210.010 Contagious Diseases, Limiting Contact—Rules and Regulations

RCW 28A.210.010

Contagious diseases, limiting contact—Rules and regulations.

The state board of health, after consultation with the superintendent of public instruction, shall adopt reasonable rules regarding the presence of persons on or about any school premises who have, or who have been exposed to, contagious diseases deemed by the state board of health as dangerous to the public health. Such rules shall specify reasonable and precautionary procedures as to such presence and/or readmission of such persons and may include the requirement for a certificate from a licensed physician that there is no danger of contagion. The superintendent of public instruction shall provide to appropriate school officials and personnel, access and notice of these rules of the state board of health. Providing online access to these rules satisfies the requirements of this section. The superintendent of public instruction is required to provide this notice only when there are significant changes to the rules.

[2009 c 556 § 3; 1971 c 32 § 1; 1969 ex.s. c 223 § 28A.31.010. Prior: 1909 c 97 p 262 § 5; RRS § 4689; prior: 1897 c 118 § 68; 1890 p 372 § 47. Formerly RCW 28A.31.010, 28.31.010.]

Link – Washington State Legislature
http://apps.leg.wa.gov/rcw/default.aspx?cite=28A.210.010

APPENDIX III

Chapter 246-110 WAC Contagious Disease—School Districts and Day Care Centers

WAC 246-110-001 Purpose

WAC 246-110-010 Definitions

WAC 246-110-020 Control of Communicable (Contagious) Disease

WAC 246-101-415 Responsibilities of Child Day Care Facilities

WAC 246-101-420 Responsibilities of Schools

WAC 246-110-001—Purpose. The following regulations are adopted by the board of health for the purpose of governing the presence on or about any school or day care center premises of susceptible persons who have, or have been exposed to, a communicable disease. These regulations are in addition to other requirements imposed by chapter 246-100 WAC.

In furtherance of the purpose and intent of the law and these regulations, it is recommended that parents of students whose medical supervision seems inadequate should be encouraged to obtain the services of a physician for the child. When the economic situation warrants, the parents should be guided to the appropriate source of community-sponsored medical care. These regulations are not intended to imply that any diagnosis or treatment will be performed by school or day care center personnel.

[Statutory Authority: RCW 43.20.050. 92-02-019 (Order 225B), § 246-110-001, filed 12/23/91, effective 1/23/92; 91-02-051 (Order 124B), recodified as § 246-110-001, filed 12/27/90, effective 1/31/91; 90-21-056 (Order 095), § 248-101-011, filed 10/15/90, effective 10/15/90.]

WAC 246-110-010—Definition. As used in this portion of these regulations, these terms shall mean:

(1) "Contact" means a person exposed to an infected person, animal, or contaminated environment which might provide an opportunity to acquire the infection.

(2) "Exposure" means such association with a person or animal in the infectious stage of a disease, or with a contaminated environment, as to provide the opportunity to acquire the infection.

(3) "Susceptible" means a person who does not possess sufficient resistance, whether natural or induced, to a pathogenic agent or disease to prevent contracting that disease when exposed thereto.

(4) "Communicable disease (contagious disease)" means an illness caused by an infectious agent which can be transmitted from one person, animal, or object to another person by direct or indirect means including transmission via an intermediate host or vector, food, water, or air. Communicable (contagious) diseases include, but are not limited to:

(a) Chickenpox

(b) Conjunctivitis (bacterial)

(c) Diphtheria

(d) Giardiasis

(e) Hepatitis A

(f) Invasive Haemophilus influenza disease (excluding otitis media)

(g) Measles

(h) Meningitis (bacterial)

(i) Mumps

(j) Pediculosis

(k) Pertussis

(l) Rubella

(m) Salmonellosis

(n) Shigellosis

(o) Tuberculosis

(5) "School" means each building, facility, and location at or within which any or all portions of a preschool, kindergarten and grades one through twelve program of education and related activities are conducted for two or more children by or in behalf of any public school district and by or in behalf of any private school or private institution subject to approval by the state board of education.

(6) "Day care center" means an agency which regularly provides care for a group of children for periods of less than twenty-four hours and is licensed pursuant to chapter 74.15 RCW.

(7) "Outbreak" means the occurrence of cases of a disease or condition in any area over a given period of time in excess of the expected number of cases.

[Statutory Authority: RCW 43.20.050. 91-02-051 (Order 124B), recodified as § 246-110-010, filed 12/27/90, effective 1/31/91; 90-21-056 (Order 095), § 248-101-021, filed 10/15/90, effective 10/15/90.]

WAC 246-110-020—Control of communicable (contagious) disease.

(1) When there is an outbreak of a contagious disease, as defined in WAC 246-110-010, such that there is the potential for a case or cases within a school or day care center, the local health officer, if appropriate, after consultation with the secretary of health or designee shall take all

medically appropriate actions deemed to be necessary to control or eliminate the spread of the disease, including, but not limited to:

(a) Closing the affected school(s) or day care center(s), or part(s) thereof;

(b) Closing other schools or day care centers in the local health officer's jurisdiction;

(c) Causing the cessation of selected school or day care center activities or functions;

(d) Excluding from schools or day care centers in the local health officer's jurisdiction any students, staff, and volunteers who are infected with, or deemed to be susceptible to, the disease.

(2) Prior to taking action the health officer shall:

(a) Consult with and discuss the ramifications of action with the superintendent of the school district, or the chief administrator of the day care center or their designees on the proposed action; and

(b) Provide the board of directors and the superintendent of the school district or the chief administrator of the day care center a written decision in the form and substance of an order directing them to take action;

(3) Where these actions have been taken, the local health officer shall, in addition:

(a) Set the terms and conditions permitting schools or day care centers to reopen; activities and functions to resume; and excluded students, staff and volunteers to be readmitted; and

(b) Pursue, in consultation with the secretary of health or designee and school and/or day care officials, the investigation of the source of disease, or order those actions necessary to the ultimate control of the disease.

[Statutory Authority: RCW 43.20.050. 92-02-019 (Order 225B), § 246-110-020, filed 12/23/91, effective 1/23/92; 91-02-051 (Order 124B), recodified as § 246-110-020, filed 12/27/90, effective 1/31/91; 90-21-056 (Order 095), § 248-101-221, filed 10/15/90, effective 10/15/90.]

WAC 246-101-415—Responsibilities of child day care facilities.

Child day care facilities shall:

(1) Notify the local health department of cases, suspected cases, outbreaks, and suspected outbreaks of notifiable conditions that may be associated with the child day care facility.

(2) Consult with a health care provider or the local health department for information about the control and prevention of infectious or communicable disease, as necessary.

(3) Cooperate with public health authorities in the investigation of cases, suspected cases, outbreaks, and suspected outbreaks of disease that may be associated with the child day care facility.

(4) Establish and implement policies and procedures to maintain confidentiality related to medical information in their possession.

[Statutory Authority: RCW 43.20.050. 11-02-065, § 246-101-415, filed 1/4/11, effective 2/4/11; 00-23-120, § 246-101-415, filed 11/22/00, effective 12/23/00.]

Link - Washington State Legislature
http://apps.leg.wa.gov/wac/default.aspx?cite=246-101-415

WAC 246-101-420—Responsibilities of schools.

Schools shall:

(1) Notify the local health department of cases, suspected cases, outbreaks, and suspected outbreaks of disease that may be associated with the school.

(2) Cooperate with the local health department in monitoring influenza.

(3) Consult with a health care provider or the local health department for information about the control and prevention of infectious or communicable disease, as necessary.

(4) Cooperate with public health authorities in the investigation of cases, suspected cases, outbreaks, and suspected outbreaks of disease that may be associated with the school.

(5) Release identifying information only to other individuals responsible for protecting the health and well-being of the public through control of disease.

(6) Schools shall establish and implement policies and procedures to maintain confidentiality related to medical information in their possession.

[Statutory Authority: RCW 43.20.050. 11-02-065, § 246-101-420, filed 1/4/11, effective 2/4/11; 00-23-120, § 246-101-420, filed 11/22/00, effective 12/23/00.]

Link - Washington State Legislature
http://apps.leg.wa.gov/wac/default.aspx?cite=246-101-420

APPENDIX IV

Chapter 246-100 WAC Communicable and Certain Other Diseases

WAC 246-100-006 Purpose

WAC 246-100-011 Definitions

WAC 246-100-021 Responsibilities and Duties—Health Care Providers

WAC 246-100-006—Purpose. The following rules and regulations are adopted under the authority of chapter 43.20 RCW to protect the health and well-being of the public by controlling communicable and certain other diseases.

[Statutory Authority: RCW 43.20.050. 91-02-051 (Order 124B), recodified as § 246-100-006, filed 12/27/90, effective 1/31/91; 87-11-047 (Order 302), § 248-100-006, filed 5/19/87.]

Link - Washington State Legislature
http://apps.leg.wa.gov/WAC/default.aspx?cite=246-100-006

WAC 246-100-011—Definitions.

The following definitions shall apply in the interpretation and enforcement of chapter 246-100 WAC:

(1) "Acquired immunodeficiency syndrome (AIDS)" means illness, disease, or conditions defined and described by the Centers for Disease Control, U.S. Public Health Service, Morbidity and Mortality Weekly Report (MMWR), December 18, 1992, Volume 41, Number RR-17. A copy of this publication is available for review at the department and at each local health department.

(2) "AIDS counseling" means counseling directed toward:

(a) Increasing the individual's understanding of acquired immunodeficiency syndrome; and

(b) Assessing the individual's risk of HIV acquisition and transmission; and

(c) Affecting the individual's behavior in ways to reduce the risk of acquiring and transmitting HIV infection.

(3) "Anonymous HIV testing" means that the name or identity of the individual tested for HIV will not be recorded or linked to the HIV test result. However, once the individual testing positive receives HIV health care or treatment services, reporting of the identity of the individual to the state or local public health officer is required.

(4) "Board" means the Washington state board of health.

(5) "Case" means a person, alive or dead, having been diagnosed to have a particular disease or condition by a health care provider with diagnosis based on clinical or laboratory criteria or both.

(6) "Child day care facility" means an agency regularly providing care for a group of children for less than twenty-four hours a day and subject to licensing under chapter 74.15 RCW.

(7) "Communicable disease" means an illness caused by an infectious agent which can be transmitted from one person, animal, or object to another person by direct or indirect means including transmission via an intermediate host or vector, food, water, or air.

(8) "Confidential HIV testing" means that the name or identity of the individual tested for HIV will be recorded and linked to the HIV test result, and that the name of the individual testing positive for HIV will be reported to the state or local health officer in a private manner.

(9) "Contaminated" or "contamination" means containing or having contact with infectious agents or chemical or radiological materials that pose an immediate threat to present or future public health.

(10) "Contamination control measures" means the management of persons, animals, goods, and facilities that are contaminated, or suspected to be contaminated, in a manner to avoid human exposure to the contaminant, prevent the contaminant from spreading, and/or effect decontamination.

(11) "Department" means the Washington state department of health.

(12) "Detention" or "detainment" means physical restriction of activities of an individual by confinement for the purpose of controlling or preventing a serious and imminent threat to public health and may include physical plant, facilities, equipment, and/or personnel to physically restrict activities of the individual to accomplish such purposes.

(13) "Disease control measures" means the management of persons, animals, goods, and facilities that are infected with, suspected to be infected with, exposed to, or suspected to be exposed to an infectious agent in a manner to prevent transmission of the infectious agent to humans.

(14) "Health care facility" means:

(a) Any facility or institution licensed under chapter 18.20 RCW, boarding home, chapter 18.46 RCW, birthing centers, chapter 18.51 RCW, nursing homes, chapter 70.41 RCW, hospitals, or chapter 71.12 RCW, private establishments, clinics, or other settings where one or more health care providers practice; and

(b) In reference to a sexually transmitted disease, other settings as defined in chapter 70.24 RCW.

(15) "Health care provider" means any person having direct or supervisory responsibility for the delivery of health care who is:

(a) Licensed or certified in this state under Title 18 RCW; or

(b) Is military personnel providing health care within the state regardless of licensure.

(16) "HIV testing" means conducting a laboratory test or sequence of tests to detect the human immunodeficiency virus (HIV) or antibodies to HIV performed in accordance with requirements to WAC 246-100-207. To assure that the protection, including but not limited to, pre- and post-test counseling, consent, and confidentiality afforded to HIV testing as described in chapter 246-100 WAC also applies to the enumeration of CD4 + (T4) lymphocyte counts (CD4 + counts) and CD4 + (T4) percent of total lymphocytes (CD4 + percent) when used to diagnose HIV infection, CD4 + counts and CD4 + percent will be presumed HIV testing except when shown by clear and convincing evidence to be for use in the following circumstances:

(a) Monitoring previously diagnosed infection with HIV;

(b) Monitoring organ or bone marrow transplants;

(c) Monitoring chemotherapy;

(d) Medical research; or

(e) Diagnosis or monitoring of congenital immunodeficiency states or autoimmune states not related to HIV.

The burden of proving the existence of one or more of the circumstances identified in (a) through (e) of this subsection shall be on the person asserting such existence.

(17) "Infectious agent" means an organism such as a virus, rickettsia, bacteria, fungus, protozoan, or helminth that is capable of producing infection or infectious disease.

(18) "Isolation" means the separation, for the period of communicability or contamination, of infected or contaminated persons or animals from others in such places and under such conditions as to prevent or limit the direct or indirect transmission of the infectious agent or contaminant from those infected or contaminated to those who are susceptible or who may spread the agent or contaminant to others.

(19) "Local health department" means the city, town, county, or district agency providing public health services to persons within the area, as provided in chapter 70.05 RCW and chapter 70.08 RCW.

(20) "Local health officer" means the individual having been appointed under chapter 70.05 RCW as the health officer for the local health department, or having been appointed under chapter 70.08 RCW as the director of

public health of a combined city-county health department, or his or her delegee appointed by the local board of health.

(21) "Nosocomial infection" means an infection acquired in a hospital or other health care facility.

(22) "Outbreak" means the occurrence of cases of a disease or condition in any area over a given period of time in excess of the expected number of cases.

(23) "Post-test counseling" means counseling after the HIV test when results are provided and directed toward:

(a) Increasing the individual's understanding of human immunodeficiency virus (HIV) infection;

(b) Affecting the individual's behavior in ways to reduce the risk of acquiring and transmitting HIV infection;

(c) Encouraging the individual testing positive to notify persons with whom there has been contact capable of spreading HIV;

(d) Assessing emotional impact of HIV test results; and

(e) Appropriate referral for other community support services.

(24) "Pretest counseling" means counseling provided prior to HIV testing and aimed at:

(a) Helping an individual to understand:

(i) Ways to reduce the risk of human immunodeficiency virus (HIV) transmission;

(ii) The nature, purpose, and potential ramifications of HIV testing;

(iii) The significance of the results of HIV testing; and

(iv) The dangers of HIV infection; and

(b) Assessing the individual's ability to cope with the results of HIV testing.

(25) "Principal health care provider" means the attending physician or other health care provider recognized as primarily responsible for diagnosis and treatment of a patient or, in the absence of such, the health care provider initiating diagnostic testing or therapy for a patient.

(26) "Quarantine" means the limitation of freedom of movement of such well persons or domestic animals as have been exposed to, or are suspected

to have been exposed to, an infectious agent, for a period of time not longer than the longest usual incubation period of the infectious agent, in such manner as to prevent effective contact with those not so exposed.

(27) "School" means a facility for programs of education as defined in RCW 28A.210.070 (preschool and kindergarten through grade twelve).

(28) "Sexually transmitted disease (STD)" means a bacterial, viral, fungal, or parasitic disease or condition which is usually transmitted through sexual contact, including:

(a) Acute pelvic inflammatory disease;

(b) Chancroid;

(c) Chlamydia trachomatis infection;

(d) Genital and neonatal herpes simplex;

(e) Genital human papilloma virus infection;

(f) Gonorrhea;

(g) Granuloma inguinale;

(h) Hepatitis B infection;

(i) Human immunodeficiency virus infection (HIV) and acquired immunodeficiency syndrome (AIDS);

(j) Lymphogranuloma venereum;

(k) Nongonococcal urethritis (NGU); and

(l) Syphilis.

(29) "Spouse" means any individual who is the marriage partner of an HIV-infected individual, or who has been the marriage partner of the HIV-infected individual within the ten-year period prior to the diagnosis of HIV-infection, and evidence exists of possible exposure to HIV.

(30) "State health officer" means the person designated by the secretary of the department to serve as statewide health officer, or, in the absence of such designation, the person having primary responsibility for public health matters in the state.

(31) "Suspected case" or "suspected to be infected" means the local health officer, in his or her professional judgment, reasonably believes that infection with a particular infectious agent is likely based on signs and

symptoms, laboratory evidence, or contact with an infected individual, animal, or contaminated environment.

(32) "Veterinarian" means an individual licensed under provisions of chapter 18.92 RCW, veterinary medicine, surgery, and dentistry and practicing animal health care.

[Statutory Authority: RCW 70.24.130 and 70.24.380. 05-11-110, § 246-100-011, filed 5/18/05, effective 6/18/05. Statutory Authority: RCW 43.20.050 (2)(d), 70.05.050 and70.05.060 . 03-06-003, § 246-100-011, filed 2/19/03, effective 2/19/03. Statutory Authority: RCW 43.20.050. 00-23-120, § 246-100-011, filed 11/22/00, effective 12/23/00. Statutory Authority: RCW 70.24.022, 70.24.340 and Public Law 104-146. 97-15-099, § 246-100-011, filed 7/21/97, effective 7/21/97. Statutory Authority: Chapter 70.24 RCW. 93-08-036 (Order 354B), § 246-100-011, filed 4/1/93, effective 5/2/93. Statutory Authority: RCW 43.20.050 and 70.24.130. 92-02-019 (Order 225B), § 246-100-011, filed 12/23/91, effective 1/23/92. Statutory Authority: RCW 43.20.050. 91-02-051 (Order 124B), recodified as § 246-100-011, filed 12/27/90, effective 1/31/91. Statutory Authority: Chapter 70.24 RCW. 89-07-095 (Order 325), § 248-100-011, filed 3/22/89; 88-17-057 (Order 317), § 248-100-011, filed 8/17/88. Statutory Authority: RCW 43.20.050. 88-07-063 (Order 308), § 248-100-011, filed 3/16/88; 87-11-047 (Order 302), § 248-100-011, filed 5/19/87.]

Link - Washington State Legislature
http://apps.leg.wa.gov/WAC/default.aspx?cite=246-100-011

WAC 246-100-021—Responsibilities and duties—Health care providers.

Every health care provider, as defined in chapter 246-100 WAC, shall:

(1) Provide adequate, understandable instruction in control measures designed to prevent the spread of disease to:

(a) Each patient with a communicable disease under his or her care; and

(b) Others as appropriate to prevent spread of disease.

(2) Cooperate with public health authorities during investigation of:

(a) Circumstances of a case or suspected case of a notifiable condition or other communicable disease; and

(b) An outbreak or suspected outbreak of illness.

Comply with requirements in WAC 246-100-206, 246-100-211, and chapter 24 6-101 WAC.

(3) Use protocols established in *Communicable Diseases Manual,* seventeenth edition, James Chin, MD, MPH, editor, 2000, when treating wounds caused by animal bites. A copy of this publication is available for review at the department and at each local health department.

[Statutory Authority: RCW 43.20.050. 00-23-120, § 246-100-021, filed 11/22/00, effective 12/23/00. Statutory Authority: RCW 43.20.050, 70.24.130 and 70.104.055. 92-02-019 (Order 225B), § 246-100-021, filed 12/23/91, effective 1/23/92. Statutory Authority: RCW 43.20.050. 91-02-051 (Order 124B), recodified as § 246-100-021, filed 12/27/90, effective 1/31/91. Statutory Authority: Chapter 70.104 RCW. 90-10-036 (Order 049), § 248-100-021, filed 4/26/90, effective 5/27/90. Statutory Authority: RCW 43.20.050. 87-11-047 (Order 302), § 248-100-021, filed 5/19/87.]

Link - Washington State Legislature
http://apps.leg.wa.gov/WAC/default.aspx?cite=246-100-021

Note

The Washington State Department of Health currently uses protocols from: Heymann, D. (2008). *Control of Communicable Diseases Manual,* 19th ed., American Public Health Association, Washington, D.C.

APPENDIX V

Chapter 246-101 WAC Notifiable Conditions

WAC 246-101-101 Notifiable Conditions and the Health Care Provider

WAC 246-101-105 Duties of the Health Care Provider

WAC 246-101-110 Means of Notification

WAC 246-101-115 Content of Notification

WAC 246-101-120 Handling of Case Reports and Medical Information

WAC 246-101-101—Notifiable conditions and the health care provider.

This section describes the conditions that Washington's health care providers must notify public health authorities of on a statewide basis. The board finds that the conditions in Table HC-1 of this section are notifiable for the prevention and control of communicable and noninfectious diseases and conditions in Washington.

(1) Principal health care providers shall notify public health authorities of the conditions identified in Table HC-1 of this section as individual case reports following the requirements in WAC 246-101-105, 246-101-110, 246-101-115, and 246-101-120.

(2) Other health care providers in attendance, other than the principal health care provider, shall notify public health authorities of the conditions identified in Table HC-1 of this section unless the condition notification has already been made.

(3) Local health officers may require additional conditions to be notifiable within the local health officer's jurisdiction.

Link - Washington State Legislature
http://apps.leg.wa.gov/WAC/default.aspx?cite=246-101-101

(This link includes Table HC-1 Conditions Notifiable by Health Care Providers)

WAC 246-101-105—Duties of the health care provider.

Health care providers shall:

(1) Notify the local health department where the patient resides, or, in the event that patient residence cannot be determined, the local health department in which the health care providers practice, regarding:

(a) Cases or suspected cases of notifiable conditions specified as notifiable to local health departments in Table HC-1 of WAC 246-101-101;

(b) Cases of conditions designated as notifiable by the local health officer within that health officer's jurisdiction;

(c) Outbreaks or suspected outbreaks of disease including, but not limited to, suspected or confirmed outbreaks of varicella, influenza, viral meningitis, health care-associated infection suspected due to contaminated food products or devices, or environmentally related disease;

(d) Known barriers which might impede or prevent compliance with orders for infection control or quarantine; and

(e) Name, address, and other pertinent information for any case, suspected case or carrier refusing to comply with prescribed infection control measures.

(2) Notify the department of conditions designated as notifiable to the local health department when:

(a) A local health department is closed or representatives of the local health department are unavailable at the time a case or suspected case of an immediately notifiable condition occurs;

(b) A local health department is closed or representatives of the local health department are unavailable at the time an outbreak or suspected outbreak of communicable disease occurs.

(3) Notify the department of pesticide poisoning that is fatal, causes hospitalization or occurs in a cluster.

(4) Notify the department regarding cases of notifiable conditions specified as notifiable to the department in Table HC-1 of WAC 246-101-101.

(5) Assure that positive preliminary test results and positive final test results for notifiable conditions of specimens referred to laboratories outside of Washington for testing are correctly notified to the local health department of the patient's residence or the department as specified in Table Lab-1 of WAC 246-101-201. This requirement can be satisfied by:

(a) Arranging for the referral laboratory to notify either the local health department, the department, or both; or

(b) Forwarding the notification of the test result from the referral laboratory to the local health department, the department, or both.

(6) Cooperate with public health authorities during investigation of:

(a) Circumstances of a case or suspected case of a notifiable condition or other communicable disease; and

(b) An outbreak or suspected outbreak of disease.

(7) Provide adequate and understandable instruction in disease control measures to each patient who has been diagnosed with a case of a communicable disease, and to contacts who may have been exposed to the disease.

(8) Maintain responsibility for deciding date of discharge for hospitalized tuberculosis patients.

(9) Notify the local health officer of intended discharge of tuberculosis patients in order to assure appropriate outpatient arrangements are arranged.

(10) By July 1, 2011, when ordering a laboratory test for a notifiable condition as identified in Table HC-1 of WAC 246-101-101, providers must provide the laboratory with the following information for each test order:

(a) Patient name;

(b) Patient address including zip code;

(c) Patient date of birth;

(d) Patient sex;

(e) Name of the principal health care provider;

(f) Telephone number of the principal health care provider;

(g) Type of test requested;

(h) Type of specimen;

(i) Date of ordering specimen collection.

[Statutory Authority: RCW 43.20.050. 11-02-065, § 246-101-105, filed 1/4/11, effective 2/4/11. Statutory Authority: RCW 43.20.050 and 70.104.030. 00-23-120, § 246-101-105, filed 11/22/00, effective 12/23/00.]

Link - Washington State Legislature
http://apps.leg.wa.gov/WAC/default.aspx?cite=246-101-105

WAC 246-101-110—Means of notification.

Health care providers shall adhere to the following timelines and procedures:

(1) Conditions designated as immediately notifiable must be reported to the local health officer or the department, as specified in Table HC-1 of WAC 246-101-101, immediately at the time of diagnosis or suspected diagnosis. This applies twenty-four hours a day, seven days a week. Each local health jurisdiction, as well as the department, maintains after-hours emergency phone contacts for this purpose. A party sending a report by secure facsimile copy or secure electronic transmission during normal business hours must confirm immediate receipt by a live person.

(2) Conditions designated as notifiable within twenty-four hours must be reported to the local health officer or the department, as specified in Table HC-1 of WAC 246-101-101, within twenty-four hours of diagnosis or suspected diagnosis, seven days a week. Reports during normal public health business hours may be sent by secure electronic transmission, telephone, or secure facsimile copy of a case report. A party sending a report outside of normal public health business hours must use the after-hours emergency phone contact for the appropriate jurisdiction.

(3) Conditions designated as notifiable within three business days must be reported to the local health officer or department, as specified in Table HC-1 of WAC 246-101-101, within three business days. Notification may be sent by written case report, secure electronic transmission, telephone, or secure facsimile copy of a case report; and

(4) Conditions designated as notifiable on a monthly basis must be reported to the local health officer or the department, as specified in Table HC-1 of WAC 246-101-101, on a monthly basis. Notification may be sent by written case report, secure electronic transmission, telephone, or secure facsimile copy of a case report.

[Statutory Authority: RCW 43.20.050. 11-02-065, § 246-101-110, filed 1/4/11, effective 2/4/11. Statutory Authority: RCW 43.20.050, 70.24.125, 70.28.010 and 70.104.030. 00-23-120, § 246-101-110, filed 11/22/00, effective 12/23/00.]

Link - Washington State Legislature
http://apps.leg.wa.gov/WAC/default.aspx?cite=246-101-110

WAC 246-101-115—Content of notifications.

(1) For each condition listed in Table HC-1 of WAC 246-101-101, health care providers shall provide the following information for each case or suspected case:

(a) Patient name;

(b) Patient address;

(c) Patient telephone number;

(d) Patient date of birth;

(e) Patient sex;

(f) Diagnosis or suspected diagnosis of disease or condition;

(g) Pertinent laboratory data, if available;

(h) Name of the principal health care provider;

(i) Telephone number of the principal health care provider;

(j) Address of the principal health care provider;

(k) Name and telephone number of the person providing the report; and

(l) Other information as the department may require on forms generated by the department.

(2) The local health officer or state health officer may require other information of epidemiological or public health value.

[Statutory Authority: RCW 43.20.050. 11-02-065, § 246-101-115, filed 1/4/11, effective 2/4/11. Statutory Authority:
RCW 43.20.050, 43.70.545, 70.24.125, 70.28.010 and 70.104.030. 00-23-120, § 246-101-115, filed 11/22/00, effective 12/23/00.]

Link - Washington State Legislature
http://apps.leg.wa.gov/WAC/default.aspx?cite=246-101-115

WAC 246-101-120—Handling of case reports and medical information.

(1) All records and specimens containing or accompanied by patient identifying information are confidential.

(2) Health care providers who know of a person with a notifiable condition, other than a sexually transmitted disease, shall release identifying information only to other individuals responsible for protecting the health and well-being of the public through control of disease, including the local health department.

(3) Health care providers with knowledge of a person with sexually transmitted disease, and following the basic principles of health care providers, which respect the human dignity and confidentiality of patients:

(a) May disclose the identity of a person or release identifying information only as specified in RCW 70.24.105; and

(b) Shall under RCW 70.24.105(6), use only the following customary methods for exchange of medical information:

(i) Health care providers may exchange medical information related to HIV testing, HIV test results, and confirmed HIV or confirmed STD diagnosis and treatment in order to provide health care services to the patient. This means that information shared impacts the care or treatment decisions concerning the patient; and the health care provider requires the information for the patient's benefit.

(ii) Health care providers responsible for office management are authorized to permit access to a patient's medical information and medical record by medical staff or office staff to carry out duties required for care and treatment of a patient and the management of medical information and the patient's medical record.

(c) Health care providers conducting a clinical HIV research project shall report the identity of an individual participating in the project unless:

(i) The project has been approved by an institutional review board; and

(ii) The project has a system in place to remind referring health care providers of their reporting obligations under this chapter.

(4) Health care providers shall establish and implement policies and procedures to maintain confidentiality related to a patient's medical information.

[Statutory Authority: RCW 43.20.050. 11-02-065, § 246-101-120, filed 1/4/11, effective 2/4/11. Statutory Authority: RCW 43.20.050 and 70.104.030. 00-23-120, § 246-101-120, filed 11/22/00, effective 12/23/00.]

Link - Washington State Legislature
http://apps.leg.wa.gov/WAC/default.aspx?cite=246-101-120

APPENDIX VI

Washington State School Directors' Association (WSSDA)
Policy 3414—Infectious Disease
Procedure 3414P—Infectious Disease

Infectious Diseases

In order to safeguard the school community from the spread of certain communicable diseases the superintendent will implement procedures assuring that all school buildings are in compliance with State Board of Health rules and regulations regarding the presence of persons who have or have been exposed to infectious diseases deemed dangerous to the public health. Such procedures will also prescribe the steps that will be taken to remove the danger to others.

The district will require that the parents or guardian complete a medical history form at the beginning of each school year. The nurse or school physician may use such reports to advise the parent of the need for further medical attention and to plan for potential health problems in school.

The board authorizes the school principal to exclude a student who has been diagnosed by a physician or is suspected of having an infectious disease in accordance with the regulations within the most current Infectious Disease Control Guide, provided by the State Department of Health and the Office of the Superintendent of Public Instruction. The principal and/or school nurse will report the presence of suspected case or cases of reportable communicable disease to the appropriate local health authority as required by the State Board of Health. Such information concerning a student's present and past health condition will be treated as confidential. The principal will cooperate with the local health officials in the investigation of the source of the disease.

The fact that a student has been tested for a sexually transmitted disease, the test result, any information relating to the diagnosis or treatment of a sexually transmitted disease, and any information regarding drug or alcohol treatment for a student must be kept strictly confidential. If the district has a release, the information may be disclosed pursuant to the restrictions in the release.

A school principal or designee has the authority to send an ill child home without the concurrence of the local health officer, but if the disease is reportable, the local health officer must be notified. The local health officer is the primary resource in the identification and control of infectious disease in community and school. The local health officer, in consultation with the superintendent can take whatever action deemed necessary to control or eliminate the spread of disease, including closing a school.

Legal References:	Chapter 70.02 RCW	Medical records—health care information access and disclosure
	RCW 28A.210.010	Contagious diseases, limiting contact—Rules

Chapter 246-110 WAC Contagious diseases—School districts and day care centers

Management References:

Policy & Legal News, February 2013—Policy Revisions

Adoption Date:
School District Name:
Revised: 08.07; 12.11; 02.13
Classification: Priority

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Infectious Diseases

An infectious disease is caused by the presence of certain microorganisms in the body. Infectious diseases may or may not be communicable or in a contagious state.

Diseases in a contagious state may be controlled by excluding the student from the classroom or by referring the student for medical attention. Staff members of a school must advise the school nurse and principal or designee when a student exhibits symptoms of an infectious disease based on the criteria outlined in this procedure. The school nurse and principal or designee must be provided with as much health information as is known about the case in a timely manner so that appropriate action can be initiated. (See Infectious Disease Control Guide for School Staff).

List of Reportable Diseases

In consultation with the school nurse, the district will report suspected disease or disease with known diagnosis to the local health department as indicated on the Notifiable Conditions page of the Washington Department of Health's website.

Cluster of Cases

The occurrence of any generalized (covering greater than 75 percent of the body) rash with or without fever, cough, runny nose, and reddened eyes in a school MUST be reported IMMEDIATELY to the school nurse who will in turn report as necessary to the local health department. Localized rash cases diagnosed as unrelated to a contagious disease, such as diaper rash, poison oak, etc. need not be reported. In addition to rash illnesses, any unusual cluster of infectious disease must be reported to the school nurse.

Identification and Follow-Up

A. The length of absence from school for a student ill from a contagious disease is determined by the directions given in the Infectious Disease Control Guide or instructions provided by the health care provider, or instructions from the local health officer.
B. The principal has the final responsibility for enforcing all exclusions.
C. Follow-up of suspected communicable disease cases should be carried out in order to determine any action necessary to prevent the spread of the disease to additional children.

Reporting At Building Level

A student with a diagnosed reportable condition will be reported by the school principal or designee to the local health officer (or state health officer if local health officer is not available) as per schedule.

When symptoms of communicable disease are detected in a student who is at school, the regular procedure for the disposition of ill or injured students will be followed unless the student is fourteen years or older and the symptoms are of a sexually transmitted disease. In those instances the student has confidentiality

rights that prohibit notification of anyone but the health department. In all other instances, the principal or designee will:

1. Call the parent, guardian or emergency phone number to advise him/her of the signs and symptoms;
2. Determine when the parent or guardian will pick up the student;
3. Keep the student isolated but observed until the parent or guardian arrives; and
4. Notify the teacher of the arrangements that have been made prior to removing the student from school**;**
5. Notify the school nurse to ensure appropriate health-related interventions are in place.

First Aid Procedures

A. Students should be asked to wash their own minor wound areas with soap and water under staff guidance when practicable. If performed by staff, wound cleansing should be conducted in the following manner:
   1. Soap and water are recommended for washing wounds. Individual packets with cleansing solutions or saline can also be used;
   2. Gloves must be worn when cleansing wounds which may put the staff member in contact with wound secretions or when contact with any bodily fluids is possible;
   3. Gloves and any cleansing materials will be discarded in a lined trash container that is disposed of daily according to WAC 296-823—Occupational exposure to bloodborne pathogens and included in the most recent OSPI Infectious Disease Control Guide;
   4. Hands must be washed before and after treating the student and after removing the gloves; and
   5. Treatment must be documented in a health log program.

B. Thermometers will be handled in the following manner:
   1. Only disposable thermometers or non-mercury thermometers with disposable sheath covers and/or temporal scan thermometers should be used when taking student's temperatures; and
   2. Disposable sheath covers will be discarded in a lined trash container that is secured and disposed of daily. Temporal scan thermometers will be disinfected after each use.

Handling Of Body Fluids

A. Body fluids of all persons should be considered to contain potentially infectious agents (germs). Body fluids include blood, semen, vaginal secretions, drainage from scrapes and cuts, feces, urine, vomitus, saliva, and respiratory secretions;
B. Gloves must be worn when direct hand contact with body fluids is anticipated (e.g., treating nose bleeds, bleeding abrasions), when handling clothes soiled by body fluids (e.g., urine and/or feces), when diapering children, and when sanitizing spaces used for diapering. Hand washing is the most important intervention for preventing the spread of disease and

C. must take place after gloves are removed and between care of multiple students;
D. Used gloves must be discarded in a secured lined trash container and disposed of daily according to WAC 296-823 - Bloodborne Pathogens and included in the most recent OSPI Infectious Disease Control Guide. Hands must then be washed thoroughly; and
E. Self-treatment of minor injury, when reasonable, will be encouraged;
F. Sharps will be disposed in an approved container. Sharps containers must be maintained upright throughout use, be tamper-proof and safely out of students' reach, be replaced routinely and not be allowed to overfill.
G. General cleaning procedures will include use of a 10 percent bleach solution to kill norovirus and *C.difficile* spores.

For other universal precautions, the district will comply with WAC 296-823-Bloodborne Pathogens and the OSPI Infectious Disease Control Guideline.

Treatment of Students with Chronic Medical Conditions (e.g., HIV; AIDS; Hepatitis)

On the disclosure that a student has been identified as having Human Immunodeficiency Virus (HIV) or Acquired Immunodeficiency Syndrome (AIDS) or Infectious Hepatitis, the superintendent, principal, parent, local health officer, school nurse and the student's licensed healthcare provider will confer as necessary and determine the appropriate placement of the student. The student will be accommodated in a least restrictive manner, free of discrimination, without endangering the other students or staff. The student may only be excluded from school on the written concurrence of the public health officer and the student's licensed healthcare provider, that remaining or returning to school would constitute a risk either to the student or to employees or other students.
All discussions and records will be treated as confidential, consistent with RCW 70.24.105.

Release of information regarding the testing, test result, diagnosis or treatment of a student for a sexually transmitted disease, HIV, drug or alcohol or mental health treatment or family planning or abortion may only be made pursuant to an effective release and only to the degree permitted by the release. To be effective, a release must be signed and dated, must specify to whom the release may be made and the time period for which the release is effective. Students fourteen and older must authorize disclosure regarding HIV, sexually transmitted diseases, or reproductive healthcare issues. Students thirteen and older must authorize disclosure regarding drug or alcohol treatment or mental health treatment. Students of any age must authorize disclosure regarding family planning or abortion. Parents must authorize disclosure pertaining to younger students.

Any disclosure made pursuant to a release regarding reproductive healthcare, including sexually transmitted diseases, HIV/AIDS or drug or alcohol treatment must be accompanied by the following statement:

> “This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by state law. A general authorization for the release of medical or other information is not sufficient for this purpose.”

The district will ensure that newly hired school district employees receive the HIV/AIDS training regarding:

A. History and epidemiology of HIV/AIDS;
B. Methods of transmission of HIV;
C. Methods of prevention of HIV including universal precautions for handling of body fluids;
D. Current treatment for symptoms of AIDS and prognosis of disease progression;
E. State and federal laws governing discrimination of persons with HIV/AIDS; and
F. State and federal laws regulating confidentiality of a person’s HIV antibody status.

New employee training will be provided within six months from the first day of employment in the district.
Continuing employees will receive information, within one year of district receipt from OSPI, on new discoveries or changes in accepted knowledge of transmission, prevention, and treatment for HIV/AIDS.

Date: 08.07; 02.13; 09.13

APPENDIX VII

Chapter 246-366 WAC Primary and Secondary Schools

WAC 246-366-001 Introduction

WAC 246-366-010 Definitions

WAC 246-366-050 Buildings

WAC 246-366-060 Plumbing, Water Supply and Fixtures

WAC 246-366-070 Sewage Disposal

WAC 246-366-130 Food Handling

WAC 246-366-150 Exemption

Note

Additional environmental health and safety standards for primary and secondary school facilities can be found at the following link: http://apps.leg.wa.gov/wac/default.aspx?cite=246-366

WAC 246-366-001—Introduction. These rules and regulations are established as minimum environmental standards for educational facilities and do not necessarily reflect optimum standards for facility planning and operation.

[Statutory Authority: RCW 43.20.050. 91-02-051 (Order 124B), recodified as § 246-366-001, filed 12/27/90, effective 1/31/91; Order 55, § 248-64-210, filed 6/8/71.]

Link - Washington State Legislature
http://apps.leg.wa.gov/WAC/default.aspx?cite=246-366-001

WAC 246-366-010—Definitions. The following definitions shall apply in the interpretation and the enforcement of these rules and regulations:

(1) "School" - Shall mean any publicly financed or private or parochial school or facility used for the purpose of school instruction, from the kindergarten through twelfth grade. This definition does not include a private residence in which parents teach their own natural or legally adopted children.

(2) "Board of education" - An appointive or elective board whose primary responsibility is to operate public or private or parochial schools or to contract for school services.

(3) "Instructional areas" - Space intended or used for instructional purposes.

(4) "New construction" - Shall include the following:

(a) New school building.

(b) Additions to existing schools.

(c) Renovation, other than minor repair, of existing schools.

(d) Schools established in all or part of any existing structures, previously designed or utilized for other purposes.

(e) Installation or alteration of any equipment or systems, subject to these regulations, in schools.

(f) Portables constructed after the effective date of these regulations.

(5) "Occupied zone" - Is that volume of space from the floor to 6 feet above the floor when determining temperature and air movement, exclusive of the 3 foot perimeter on the outside wall.

(6) "Site" - Shall include the areas used for buildings, playgrounds and other school functions.

(7) "Portables" - Any structure that is transported to a school site where it is placed or assembled for use as part of a school facility.

(8) "Health officer" - Legally qualified physician who has been appointed as the health officer for the city, town, county or district public health department as defined in RCW 70.05.010 (2), or his authorized representative.

(9) "Secretary" - Means secretary of the Washington state department of health or the secretary's designee.

(10) "Department" - Means Washington state department of health.

[Statutory Authority: RCW 43.20.050. 92-02-019 (Order 225B), § 246-366-010, filed 12/23/91, effective 1/23/92; 91-02-051 (Order 124B), recodified as § 246-366-010, filed 12/27/90, effective 1/31/91; 82-07-015 (Order 225), § 248-64-220, filed 3/9/82; Order 131, § 248-64-220, filed 8/5/76; Order 55, § 248-64-220, filed 6/8/71.]

Link - Washington State Legislature
http://apps.leg.wa.gov/WAC/default.aspx?cite=246-366-010

WAC 246-366-050—Buildings.

(1) Buildings shall be kept clean and in good repair.

(2) Instructional areas shall have a minimum average ceiling height of 8 feet. Ceiling height shall be the clear vertical distance from the finished floor to the finished ceiling. No projections from the finished ceiling shall be less than 7 feet vertical distance from the finished floor, e.g., beams, lighting fixtures, sprinklers, pipe work.

(3) All stairway[s] and steps shall have handrails and nonslip treads.

(4) The floors shall have an easily cleanable surface.

(5) The premises and all buildings shall be free of insects and rodents of public health significance and conditions which attract, provide harborage and promote propagation of vermin.

(6) All poisonous compounds shall be easily identified, used with extreme caution and stored in such a manner as to prevent unauthorized use or possible contamination of food and drink.

(7) There shall be sufficient space provided for the storage of outdoor clothing, play equipment and instructional equipment. The space shall be easily accessible, well lighted, heated and ventilated.

(8) Schools shall be provided with windows sufficient in number, size and location to permit students to see to the outside. Windows are optional in special purpose instructional areas including, but not limited to, little theaters, music areas, multipurpose areas, gymnasiums, auditoriums,

shops, libraries and seminar areas. No student shall occupy an instructional area without windows more than 50 percent of the school day.

(9) Exterior sun control shall be provided to exclude direct sunlight from window areas and skylights of instructional areas, assembly rooms and meeting rooms during at least 80 percent of the normal school hours. Each area shall be considered as an individual case. Sun control is not required for sun angles less than 42 degrees up from the horizontal. Exterior sun control is not required if air conditioning is provided, or special glass installed having a total solar energy transmission factor less than 60 percent.

[Statutory Authority: RCW 43.20.050. 91-02-051 (Order 124B), recodified as § 246-366-050, filed 12/27/90, effective 1/31/91; 82-07-015 (Order 225), § 248-64-260, filed 3/9/82; 79-08-078 (Order 183), § 248-64-260, filed 7/26/79; Order 124, § 248-64-260, filed 3/18/76; Order 55, § 248-64-260, filed 6/8/71.]

Link - Washington State Legislature
http://apps.leg.wa.gov/WAC/default.aspx?cite=246-366-050

WAC 246-366-060- Plumbing, water supply and fixtures.

(1) Plumbing: Plumbing shall be sized, installed, and maintained in accordance with the state building code. However, local code requirements shall prevail, when these requirements are more stringent or in excess of the state building code.

(2) Water supply: The water supply system for a school shall be designed, constructed, maintained and operated in accordance with chapter 246-290 WAC.

(3) Toilet and handwashing facilities:

(a) Adequate, conveniently located toilet and handwashing facilities shall be provided for students and employees. At handwashing facilities soap and single-service towels shall be provided. Common use towels are prohibited. Warm air dryers may be used in place of single-service towels. Toilet paper shall be available, conveniently located adjacent to each toilet fixture.

(b) The number of toilet and handwashing fixtures in schools established in existing structures, previously designed or utilized for other purposes shall be in accordance with the state building code. However, local code requirements shall prevail, when these requirements are more stringent or in excess of the state building code.

(c) Toilet and handwashing facilities must be accessible for use during school hours and scheduled events.

(d) Handwashing facilities shall be provided with hot water at a maximum temperature of 120 degrees Fahrenheit. If hand operated self-closing faucets are used, they must be of a metering type capable of providing at least ten seconds of running water.

(4) Showers:

(a) Showers shall be provided for classes in physical education, at grades 9 and above. An automatically controlled hot water supply of 100 to 120 degrees Fahrenheit shall be provided. Showers with cold water only shall not be permitted.

(b) Drying areas, if provided, shall be adjacent to the showers and adjacent to locker rooms. Shower and drying areas shall have water impervious nonskid floors. Walls shall be water impervious up to showerhead heights. Upper walls and ceiling shall be of smooth, easily washable construction.

(c) Locker and/or dressing room floors shall have a water impervious surface. Walls shall have a washable surface. In new construction, floor drains shall be provided in locker and dressing areas.

(d) If towels are supplied by the school, they shall be for individual use only and shall be laundered after each use.

[Statutory Authority: RCW 43.20.050. 92-02-019 (Order 225B), § 246-366-060, filed 12/23/91, effective 1/23/92; 91-02-051 (Order 124B), recodified as § 246-366-060, filed 12/27/90, effective 1/31/91; 82-07-015 (Order 225), § 248-64-270, filed 3/9/82; 79-08-078 (Order 183), § 248-64-270, filed 7/26/79; Order 124, § 248-64-270, filed 3/18/76; Order 55, § 248-64-270, filed 6/8/71.]

Link - Washington State Legislature
http://apps.leg.wa.gov/WAC/default.aspx?cite=246-366-060

WAC 246-366-070 – Sewage disposal.

All sewage and waste water from a school shall be drained to a sewerage disposal system which is approved by the jurisdictional agency. On-site sewage disposal systems shall be designed, constructed and maintained in accordance with chapters 246-272 and 173-240 WAC.

[Statutory Authority: RCW 43.20.050. 92-02-019 (Order 225B), § 246-366-070, filed 12/23/91, effective 1/23/92; 91-02-051 (Order 124B), recodified as § 246-366-070, filed 12/27/90, effective 1/31/91; 82-07-015 (Order 225),

Link - Washington State Legislature
http://apps.leg.wa.gov/WAC/default.aspx?cite=246-366-070

WAC 246-366-130—Food handling.

(1) Food storage, preparation, and service facilities shall be constructed and maintained and operated in accordance with chapters 246-215 and 246-217 WAC.

(2) When central kitchens are used, food shall be transported in tightly covered containers. Only closed vehicles shall be used in transporting foods from central kitchens to other schools.

[Statutory Authority: RCW 43.20.050. 92-02-019 (Order 225B), § 246-366-130, filed 12/23/91, effective 1/23/92; 91-02-051 (Order 124B), recodified as § 246-366-130, filed 12/27/90, effective 1/31/91; Order 55, § 248-64-340, filed 6/8/71.]

Link - Washington State Legislature
http://apps.leg.wa.gov/WAC/default.aspx?cite=246-366-130

WAC 246-366-150—Exemption.

The board of health may, at its discretion, exempt a school from complying with parts of these regulations when it has been found after thorough investigation and consideration that such exemption may be made in an individual case without placing the health or safety of the students or staff of the school in danger and that strict enforcement of the regulation would create an undue hardship upon the school.

[Statutory Authority: RCW 43.20.050. 91-02-051 (Order 124B), recodified as § 246-366-150, filed 12/27/90, effective 1/31/91; 82-07-015 (Order 225), § 248-64-360, filed 3/9/82; Order 55, § 248-64-360, filed 6/8/71.]

Link - Washington State Legislature
http://apps.leg.wa.gov/WAC/default.aspx?cite=246-366-150

For additional WACs in Chapter 246-366 related to building safety in primary and secondary schools please use the following link:
http://apps.leg.wa.gov/WAC/default.aspx?cite=246-366

Appendix VIII

Guidelines for Handling Body Fluids in School

Guidelines for Handling Body Fluids in School

The following guidelines are meant to provide simple and effective precautions against transmission of disease for all persons potentially exposed to the blood or body fluids of any student. No distinction is made between body fluids from students with a known disease or those from students without symptoms or with an undiagnosed or unreported disease.

Handling Body Fluids In Schools

A. Standard Precautions (includes universal precautions)

Standard precautions are a newer approach to infection control. Broader than universal precautions (many state laws refer to this term), standard precautions are recommended practice for protection against transmission of bloodborne pathogens and other infectious diseases in the workplace. They combine the major features of universal precautions, and body substance isolation, and are based on the principle that all blood, body fluids, secretions (including respiratory secretions), excretions (except sweat), non-intact skin, and mucous membranes may contain transmissible infectious agents. Standard precautions include a group of infection prevention practices that apply to all persons, regardless of suspected or confirmed infection status, in any setting with delivery of healthcare, including first aid. These precautions address hand hygiene, use of personal protective equipment depending on the anticipated exposure, and safe injection practices. Also, equipment or items in the environment likely to have been contaminated with infectious body fluids must be handled in a manner to prevent transmission of infectious agents (e.g., wear gloves for direct contact, contain heavily soiled equipment, properly clean and disinfect or sterilize reusable equipment).

NOTE: In its 2007 update, Centers for Disease Control and Prevention (CDC) added respiratory hygiene/cough etiquette to their standard precautions. Respiratory hygiene has become a standard practice in school and community influenza control plans. This includes use of masks when providing healthcare to a person with a potential respiratory infection as well as everybody covering coughs and sneezes.

(Excerpted from Centers for Disease Control and Prevention (CDC), 2007 Guideline for Isolation Precautions in Hospitals.)
http://www.cdc.gov/hicpac/2007IP/2007isolationPrecautions.html

The key steps to preventing spread of disease related to body fluids at school include:

- Frequent hand washing;
- Using gloves when providing direct health care;

- Washing hands after removing gloves and before working with the next person.

B. General Precautions

- Eating, drinking, smoking, applying cosmetics or lip balm, and handling contact lenses are prohibited in work areas where there is a reasonable likelihood of occupational body fluid exposure.

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

C. Hand Washing Procedures

- Recommend hand washing procedure:

  - Use a plain (non-antimicrobial) liquid soap for routine hand washing with temperate (warm) water, scrub vigorously for at least 15 seconds and then rinse under a stream of warm water. Soap suspends soil and microorganisms, allowing them to be washed off. Running water is necessary to carry away dirt and debris.

  - Use an antimicrobial agent or waterless antiseptic agent for specific circumstances, e.g., control of outbreaks or infections when soap and water are not available.

  - Use paper towels to turn off the water faucet.

  - Use fresh paper towels to thoroughly dry hands.

  - Use paper towels to open any exit door.

  - Use paper towels to turn off bathroom lights.

  - Wash hands after touching any body fluid or contaminated object.

  - Wash hands after gloves are removed and between patients.

  - Take means to avoid chapped or cracked skin on hands if providing healthcare.

  - Facilities must provide an adequate supply of running potable water at a temperate temperature (85^{o}–110^{o}F), soap, and single-use towels or hot-air drying machines http://apps.leg.wa.gov/WAC/default.aspx?cite=246-366-060.

- Bar soap should not be used. Disposable, non-refillable liquid soap dispensers are preferred. Antimicrobial soaps have no benefit over plain

soaps and are linked to antibiotic resistance development, endocrine disruption, and environmental problems. Fragrance-free soaps are less sensitizing.

- Hand sanitizers should never replace standard hand washing with soap and water; however, when hand washing facilities are not available an ethanol alcohol-based (minimum 62 percent) hand sanitizer can be used, preferably in fragrance-free gel or foaming form. Enough sanitizer should be used to wet the hands for at least 15 seconds or longer if indicated by the manufacturer. Remember, alcohol hand sanitizers have not been shown to be effective against norovirus or *Clostridium difficile* spores or for soiled hands. Hands must be washed with soap and running water as soon as feasible. Take precautions to avoid accidental ingestion or abuse by students.

D. Use of Gloves

- When possible, direct skin contact with body fluids should be avoided.

- Disposable non-latex gloves should be available in the offices of coaches, custodians, nurses, principals, and staff in school settings such as the gymnasium, play fields, preschool, and health room where contact with blood or other body fluids is likely to occur. All other personnel should have access to first aid supplies, which includes gloves.

- Gloves should be worn when direct hand contact with body fluids is anticipated (treating bloody noses, handling clothes soiled by incontinence, cleaning small spills by hand).

- Disposable (single use) non-latex gloves must be replaced as soon as possible when contaminated, or immediately if they are torn, punctured, or when their ability to function as a barrier is compromised.

- Gloves, after use involving contact with body fluids, should be placed in a plastic bag or lined trash can, secured, and disposed of daily.

- Because of the increasing incidence of allergic reactions to latex, only non-latex gloves should be used.

- General-purpose utility gloves may be cleaned and disinfected for reuse if they show no signs of deterioration. However, utility gloves must be discarded if they are cracked, peeling, torn, punctured, or exhibit other signs of deterioration, or when their ability to function as a barrier is compromised.

- Unbroken skin is an excellent barrier to infectious agents. Staff with sores or cuts on their hands (non-intact skin) having contact with blood or body fluids should always double glove if lesions are extensive.

- Instruction to staff who are at risk for exposure to body fluids should include:

    - Staff should change gloves between tasks on the same student/staff person after contact with material which may have a high concentration of microbes.

    - Staff, including bus drivers/monitors and trip sponsors, should be taught how to properly remove gloves.

    - Gloves need not be worn when feeding students, or when wiping saliva from skin, unless blood is present or the caregiver has cuts or wounds on their hands.

    - Staff should always wash hands with soap and water after removing gloves.

    - Unanticipated skin contact with body fluids may occur in situations where gloves may not be immediately available (when wiping a runny nose, applying pressure to a bleeding injury outside of the classroom, helping a student in the bathroom). In these instances, hands and other affected skin areas of all exposed persons should be thoroughly washed with soap and water as soon as possible.

    - As much as possible, have the injured student provide direct care for the wound (applying pressure, washing).

    - If contact with contaminated body fluids by non-intact skin or mucous membranes does occur, the staff member should follow the school's policy for post-exposure management and seek medical evaluation of the need for post-exposure prophylaxis.

E. Contaminated Sharps

- Students should be advised to report found needles, broken glass, or other sharps, but not touch them.

- Staff and students should be reminded to take care to prevent injuries when using needles and other sharps.

- Broken glassware, discarded needles, and other sharps must not be picked up directly with the hands. Cleanup must be accomplished using mechanical means such as a brush and dustpan, tongs, or forceps, by staff wearing appropriate protective gloves. Broken glass should be disposed of in a container which keeps others from being cut.

- Contaminated, reusable sharps must not be stored or processed in a manner which requires employees to reach by hand into the containers where these sharps have been placed.

- Contaminated needles and other contaminated sharps must not be bent, recapped, or removed.

- Shearing or breaking of contaminated needles is prohibited.

- Contaminated sharps must be discarded immediately in containers which are closable, puncture resistant, leak proof on sides and bottom, and labeled or color-coded.

- Containers for contaminated sharps must be easily accessible to personnel and located as close as possible to the immediate area where sharps are used (health rooms, science classrooms).

- Sharps containers must be maintained upright throughout use, replaced routinely, and not be allowed to overfill.

- When moving containers of contaminated sharps from the area of use, they must be closed immediately prior to removal or replacement to prevent spillage or protrusion of contents during handling, storage, transport, or shipping. They must be placed in a secondary container if leakage is possible. The secondary container must be closable, constructed to contain all contents, and prevent leakage during handling, storage, transport, or shipping. The secondary container must also be labeled and color-coded.

- Containers for contaminated *reusable* sharps must meet all of the qualifications for disposable containers, except they do not need to be closeable, since devices will be removed from these containers.

- Puncture resistant sharps containers should be provided if contaminated sharps (needles) are in the workplace.

- Disposal of these containers depends on local waste management programs. Check with the environmental health office of your local health jurisdiction for any additional local infectious waste disposal requirements and for information in the absence of a local infectious waste management program. (See Appendix XII).

F. Cardiopulmonary Resuscitation (CPR)

- Use resuscitation shields with one-way valve (mouth-to-mouth, mouth-to-nose, mouth-to-nose and mouth) during CPR.

G. General Housekeeping Practices

- The employer must ensure that the worksite is maintained in a clean and sanitary condition and determine and implement an appropriate cleaning schedule for rooms where body fluids are present.

- Housekeeping workers must wear appropriate personal protective equipment, including general-purpose utility gloves, during all cleaning of blood or other potentially infectious materials.

- Cleaning schedules must be as frequent as necessary, depending on the area of the school, the type of surface to be cleaned, and the amount and type of contamination present. High-use surfaces should be cleaned more frequently.

- General cleaning involves soap/detergent and water. Cleaning with soap and water with wiping, particularly with microfiber cloths, will remove dirt and organic matter and the majority of microorganisms. In cases of contamination with body fluids, bathrooms, and high-touch surfaces, registered disinfectants or appropriate bleach solutions will kill most of the organisms which are left. Floors and walls do not need to be disinfected.

- Encourage frequent hand-washing to reduce general contamination. It is recommended that students wash their hands before and after computer use.

H. Disinfectants

- Disinfectants are U.S. Environmental Protection Agency (EPA) registered antimicrobials that are recommended for use on hard inanimate surfaces and objects to kill or inactivate infectious organisms, though not necessarily their spores. Disinfectants do not sterilize a surface. Sterilizers destroy or eliminate all forms of microbial life including fungi, viruses, and all forms of bacteria and their spores. Sanitizers reduce the level of microorganisms to levels considered safe for general purposes.

- There are several classes of disinfectants which are registered by their effectiveness against specific microorganisms as well as their effectiveness on types of hard surfaces. Many of the active ingredients in disinfectant products are skin, eye, and respiratory irritants. Schools must have a Material Safety Data Sheet (MSDS) on hand for each chemical purchased. Manufacturer label instructions must be followed, including those for personal protective equipment.

- Label instructions on cleaning products and disinfectants must be followed. Wash surfaces with a soap or detergent product to remove debris and microorganisms, rinse with water, and follow with an EPA-registered disinfectant or appropriate bleach solution to kill microorganisms. The area to be disinfected must stay wet for the length of time indicated on the label to kill the microorganisms.

- If a surface is *not* visibly dirty, it can be cleaned and disinfected with an EPA registered product that combines cleaner and disinfectant. The label instructions must be followed.

- If a surface is visibly dirty, it should be cleaned first (using friction) with an EPA registered product that combines cleaner and disinfectant *or* it must be cleaned with a cleaner first, then rinsed, then disinfected with an EPA-registered disinfectant.

- When choosing a disinfectant, determine what microorganisms you want to protect against and the area it is to be used in. For general disinfection, choose a product that is effective against most bacteria and viruses and lists schools as a recommended site. Methicillin-resistant *Staphylococcus aureus* (MRSA) and influenza viruses are killed by several types of disinfectants. Nonenveloped viruses such as noroviruses are more difficult to kill than vegetative (growing) bacteria and enveloped viruses such as influenzas. A 1:10 bleach solution of household (5-6 percent) bleach with a one minute wet time is necessary to kill noroviruses. Some bacteria, such as *Clostridium difficile*, form reproductive spores. While the vegetative forms of bacteria are killed by a range of disinfectants, bacterial spores are not. A 1:10 bleach solution of household (5-6%) bleach with a minimum five-minute wet contact time is necessary to kill *C. difficile* spores. EPA has also registered at least three cleaner/disinfectant wipe products with 1:10 bleach which are effective against *C. difficile* (vegetative and spores) and noroviruses, when used as directed. Never mix cleaners and disinfectants, or any other chemicals, unless the labels indicate it is safe to do so. Never soak wipe cloths or mops in a class of disinfectant that is different from the disinfectant you were using on the cloth or mop to clean a surface or item. For example, chlorine bleach must never be mixed with ammonia or acids such as vinegar. (Do not mop with a quaternary ammonia compound and then soak the mop in a bleach solution.)

- Eye protection, in addition to gloves, may be necessary when mixing or diluting chemicals – read and follow the labels.

- Disinfectants should be used in well *ventilated areas. Ne*ver use disinfectant or pesticide foggers in schools or spray disinfectants into the air. They are to be used on hard surfaces and should be breathed as little as possible.

- Product shelf life for disinfectants and expiration dates should be followed.

- Disinfecting wipes, particularly alcohol wipes, are recommended for electronic items that are touched often. Make sure the wipe is suitable for the surface and the surface will stay wet the required contact time.

- Bleach solutions:

    - Sodium hypochlorite (bleach) is a common and effective sanitizer, disinfectant, and sporicide, depending on the concentration and the “kill” time – the time the surface stays wet with the bleach solution.

- Bleach used as a disinfectant must be regular strength (5.25 percent) or ultra (6.0 percent), plain, unscented liquid sodium hypochlorite. Do not use scented, powdered, splash-less, or color-safe “bleach.” Check the label.

- Bleach solutions for disinfection or sanitizing must be prepared fresh daily. Add the required amount of bleach to cool water to reduce fumes. Eye protection and gloves should be used when diluting full strength bleach. The Department of Labor and Industries Core Safety Rules, WAC 296-800-15030, require an emergency eye wash within 50 feet or 10 seconds of full strength bleach being used. See DOSH Directive 13.0 for details.

- Bleach is a disinfectant, not a cleaner. Surfaces must be cleaned with soap and water before the bleach solution is used. Bleach rapidly loses efficacy in the presence of organic material. Do not mix soap/detergent in with bleach.

- After application of the bleach solution, the surface does not need to be rinsed, but does need to be dry before using.

- Bleach dilutions:

    - Sanitizing (food contact surfaces, bottles, mouthed toys, etc.) (50-100 ppm)

        - 1/16 tsp bleach/1 cup water
        - 1 tsp bleach/1 gallon water
        - Immerse for at least 2 minutes
        - Air dry

    - Disinfecting (diaper area, bathrooms, non-diarrheal stools) (500-600 ppm)

        - ¾ tsp bleach/1 cup water
        - 1 TBSP bleach/1 quart water
        - ¼ cup bleach/1 gallon water
        - Area must stay wet at least 2 minutes.

    - Sporicide/Noroviruses/Hanta viruses (5000+ ppm)

        - 1 part bleach to 9 parts water1½ cups bleach/1 gallon water

- Wet contact time for sporicide: 5+ minutes
- Wet contact time for Noroviruses: 1+ minute
- Wet contact time for rodent droppings: 10 minutes
- See DOH Hantavirus webpage for specifics: http://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/Hantavirus.aspx
- This is an extremely concentrated bleach solution. Protect eyes, skin, and clothing during preparation and use. Keep the area well ventilated.

- Bleach wipes and stable bleach solutions
  - *Bleach wipes*-There are at least two EPA registered 1:10 bleach wipes on the market that also contain a detergent and are registered for use against *C. difficile* spores and noroviruses in addition to being effective against several types of vegetative bacteria.
  - *Stable bleach solutions* – There is at least one EPA registered 1:10 bleach solution available that contains a detergent and is registered for use against *C. difficile* spores and noroviruses in addition to being effective against several types of vegetative bacteria.
  - Use of these stabilized commercial products would address many of the safety concerns with mixing and using strong bleach solutions.

I. Procedures for Cleaning and Disinfection of Hard Surfaces

- The employer must ensure those who are cleaning wear non-latex or utility gloves or other protective equipment. There should not be exposure of open skin or mucous membranes to blood or body fluids being cleaned.
- Disposable towels or tissues should be used whenever possible, and mops should be cleaned and soaked in disinfectant after use, following label instructions. Microfiber clothes and mops can be machine washed and dried.
- Contaminated disposable items (tissues, paper towels, diapers) should be handled with disposable gloves and disposed of properly.
- Cleaning and disinfection of hard surfaces, including sporting equipment such as wrestling and gymnastic mats, as well as desk and tabletops used for eating, should be done routinely at the conclusion of each day. (Some products clean and disinfect in one application, if the surface is not noticeably dirty.)

- Following an outbreak of an infectious disease, sanitize all toys and educational materials with hard surfaces in pre-school and kindergarten classes.

- When surfaces are noticeably dirty, clean immediately, or as soon as feasibly possible, with soap and water, followed by an appropriate disinfectant after completion of cleaning procedures. When products contain both detergents and disinfectants, you can clean first with the product; then use a fresh wipe or cloth to disinfect the surface.

- Surfaces where diapers are changed must be cleaned and disinfected after each use. If a surface is visibly dirty, a cleaner or detergent must be used first, then the surface disinfected.

- Diaper changing areas or other surfaces/items contaminated with diarrheal stool must be cleaned then disinfected with EPA-registered disinfectants that kill *Clostridium difficile* spores or a 1:10 household chlorine bleach solution, freshly made up daily. A 1:10 bleach solution is necessary to kill either *C. difficile* spores (five minute wet contact time) or norovirus (one minute wet contact time).

- Surfaces must be intact to be cleaned and disinfected. Ripped or torn equipment must be repaired or replaced.

J. Blood or Body Fluid Spills

- Many schools stock sanitary absorbent agents specifically intended for cleaning body fluid spills. The dry material is applied to the area, left for a few minutes to absorb the fluid. Carefully collect the absorbent material without causing dust or aerosolization. Clean and disinfect the area. Soiled surfaces should be promptly cleaned with soap and water. After cleaning a spill, apply an appropriate disinfectant to the area and allow to remain wet for at least the minimum time specified by the manufacturer. Use an EPA registered hospital disinfectant, which is either tuberculosis (TB) effective or HIV and HBV effective. A solution of six percent sodium hypochlorite (unscented household bleach) diluted 1:10 with water may also be used.

- Diarrheal stools must be assumed to be potentially contaminated with *Clostridium difficile* or noroviruses, requiring cleaning, followed by disinfection with a 1:10 bleach solution or EPA registered 1:10 bleach solution or wipe.

- Dispose of non-reusable cleaning equipment.

- Wash hands with soap and water after removing gloves.

K. Cleaning up vomit

- Vomit should be presumed to be contaminated with noroviruses, which are highly infective. Clear individuals from the area. Cover the vomit with a disposable cloth to reduce potential airborne contamination. Soak with soap and water over the cloth.

- Use face masks with eye protection or a face shield, gloves, and aprons when cleaning up vomit. Paper towels or other towels used to clean-up vomit should be immediately placed in a sealed trash bag for disposal.

- Discard any uncovered food in the area.

- Clean contaminated surfaces with soap and water. Then disinfect with a fresh 1:10 bleach solution or EPA-registered 1:10 bleach wipe, with at least a one minute contact time. EPA registered disinfectants for noroviruses can also be used.

- Any food contact surfaces must then receive a clear water rinse and a final wipe down with a regular *sanitizing* bleach solution.

L. Athletics

- During athletic contests or practice, an ample supply of towels should be available. Disposable towels and tissues are recommended for clean-up, cloth towels for showering or bathing.

- Disposable towels must be used for one individual only and then disposed of in an appropriate receptacle.

- Gloves must be worn when handling blood or objects contaminated with blood.

- During sporting events or practice, competitors who are bleeding, have an open wound, or blood on the uniform shall not participate in an event until proper treatment is administered and contaminated surfaces cleaned and disinfected. This may mean the player may be kept out of play.

- The bloodied portion of a uniform must be properly disinfected or the uniform changed before the athlete may participate. (See Laundry below.)

- Mats should be cleaned and disinfected before and after practice and matches and immediately following any release of bodily fluids. When mats are rolled up, all sides of mats should be cleaned before they are rolled up.

- Mats must be smooth and intact to be cleaned and disinfected effectively. Repair or dispose of torn or eroded mats.

- Disinfectants for athletic mats must be EPA registered for the purpose and effective against at least MRSA, herpes, ringworm, and impetigo. Label instructions must be followed.

- Mops, buckets, and cleaning clothes should be designated for athletic areas. Microfiber clothes and mops have been shown to be more effective, easier to clean, and use, than the old cloth ones. Mop heads should be laundered at least weekly.

- Those who are cleaning should wear non-latex or utility gloves or other protective equipment and should avoid exposure of open skin or mucous membranes to blood or body fluids.

- Wet contact time must be met for adequate disinfection.

- Excess dust, dirt, hair, and particulates must be removed with designated push brooms or dust mops prior to cleaning, looking for tears or loose tape.

- At least every two weeks, tape on floors or surfaces should be removed to allow thorough cleaning underneath.

- Bleach disinfection solution must be made fresh daily.

- All equipment and mats, including wall mats, where athletes have skin contact, must be cleaned and disinfected.

M. Procedures for Cleaning and Disinfection of Carpets/Rugs

- The employer must ensure that those who are cleaning wear non-latex or utility gloves or other protective equipment and avoid exposure of open skin or mucous membranes to blood or body fluids.
- Soiled rugs or carpets should be cleaned and disinfected promptly after a blood or body fluid spill. Feces-contaminated carpet should be disposed of.

- If necessary, mechanically remove body fluid with disposable towels or an appropriate wet vacuum extractor. Avoid aerosolization of material.

- Apply a sanitary absorbent agent on soiled area (follow manufacturer's directions). Let dry and re-vacuum.

- Spray with white vinegar solution (one ounce vinegar to one quart cool water).

- Blot area with paper towels.

- The area should then be disinfected with an EPA approved disinfectant followed by an application of bacteriostatic rug shampoo.

- The vacuum bag or sweepings should be disposed of in a plastic bag.
- Disinfect vacuuming and other equipment used in clean up.
- Dispose of non-reusable cleaning equipment.

N. Disposal of Blood-Containing Materials

- The employer must ensure school custodians wear utility gloves for disposing of soiled items, plastic bags containing soiled items, and whenever there is a risk of puncture.
- If a towel, cloth, or item of clothing is so saturated with blood it would drip blood if compressed, then it should be disposed of in a biohazard bag or container.
- Place other items which contain bodily fluids or excretions in a plastic bag, tie it, and place it in a second plastic bag. The second bag should then be tied.
- Double bagging prior to handling, storing, and/or transporting infectious waste is necessary if the outside of a bag is contaminated with blood or other potentially infectious materials.
- Equipment contaminated with blood or other potentially infectious materials must be checked and decontaminated, if possible, prior to servicing or shipping.
- Equipment which cannot be effectively disinfected must be labeled with the international biohazard symbol and contaminated parts documented.
- Waste, such as bloody tissues (not saturated with blood), should be disposed of properly in a plastic-lined trash can. It is not considered hazardous material, so it can be thrown away in the school dumpster.
- Dispose of all regulated waste according to applicable state and county regulations.

O. Procedures for Cleaning and Disinfection of Cleaning Equipment

- The employer must ensure employees who have contact with cleaning equipment wear protective gloves.
- Soak mops in disinfectant after use and rinse thoroughly, or wash in a hot water cycle before rinsing.
- Place disposable cleaning equipment in a plastic bag as appropriate.
- Dispose of water down the sewer system.

- Rinse non-disposable cleaning equipment (such as buckets) thoroughly in disinfectant.

- All bins, pails, cans, and similar receptacles intended for reuse and have a reasonable likelihood of becoming contaminated with blood or other potentially infectious materials, must be inspected and decontaminated on a regularly scheduled basis and cleaned and decontaminated immediately, or as soon as feasible, upon visible contamination.

- Dispose of used disinfectant solution down the sewer system.

- Promptly remove gloves and discard in appropriate receptacles.

- Wash hands.

P. Procedures for Cleaning and Disinfection of Clothing and Linens soiled with Body Fluids

- Soiled linens should be handled as little as possible and with minimal agitation.

- The employer must ensure employees who have contact with contaminated laundry wear protective gloves and other appropriate personal protective equipment (PPE).

- All soiled linens should be placed in plastic bags at the location where they were used.

- Whenever contaminated laundry is wet and presents a reasonable likelihood of soak-through or leakage from the bag or container, the laundry must be placed and transported in bags or containers, which prevent soak-through and/or leakage of fluids to the exterior.

- Reusable PPE and other non-disposable items (towels used to wipe up body fluid, etc.) soaked through with body fluids should be placed in plastic bags labeled with the international biohazard symbol or color-code.

- Required labels are to be affixed as close as feasible to the container by string, wire, adhesive, or other method, which prevents their loss or unintentional removal. Red bags or containers may be substituted for labels.

- If the school does its own laundry (gym towels, sports uniforms, etc.) or sends it out, the goal is to remove infectious agents by the use of soap and water (140-160 degrees F) AND dry bleach (which will not affect fabric colors). To work effectively, the washing machine must not be overloaded. Clothing soaked with body fluids should be washed separately from other items. Pre-soaking may be required for heavily soiled clothes.

- Student clothing that is soiled with body fluid, including feces, should be bagged and sent home for washing with appropriate directions to the parent/guardian.

- Clean laundry should never be placed in baskets or other receptacles that have held dirty laundry unless they are cleaned and disinfected between dirty and clean use.

Q. Signs and Labels

- Warning labels must be affixed to containers of regulated waste. Labels should be fluorescent orange or orange-red with contrasting color writing. Red bags may be substituted for labels.

- WAC 299-823-14060—Handle regulated waste properly and safely, from the Bloodborne Pathogens Standard chapter 296-823 WAC uses the term "regulated waste," to refer to the following categories of waste:

    - liquid or semi-liquid blood or other potentially infectious materials (OPIM);

    - items contaminated with blood or OPIM and which would release these substances in a liquid or semi-liquid state if compressed;

    - items that are caked with dried blood or OPIM and are capable of releasing these materials during handling;
    - contaminated sharps; and

    - pathological and microbiological wastes containing blood or OPIM.

Link – Washington State Legislature, Handle regulated waste properly and safely http://apps.leg.wa.gov/wac/default.aspx?cite=296-823-14060

According to the Occupational Safety and Health Administration (OSHA), http://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=INTERPRETATIONS&p_id=27092.

It is the employer's responsibility to determine the existence of regulated waste. This determination should not be based on actual volume of blood, but rather on the potential to release blood, (e.g., when compacted in the waste container).

Bandages that are not saturated to the point of releasing blood or OPIM if compressed, would not be considered regulated waste. Similarly, discarded feminine hygiene products do not normally meet the criteria for regulated waste as defined by the Bloodborne Pathogens Standard. Beyond these guidelines, it is the employer's responsibility to determine the existence of regulated waste.

Table 1
Potential Transmission of Infectious Agents in a School Setting

Body Fluid/Source	Potential Infectious Agent	Potential Route of Transmission
Blood • cuts/abrasions • nosebleeds • menses • contaminated needle	Hepatitis B virus Hepatitis C virus HIV Cytomegalovirus	Percutaneous inoculation (needlestick) Inoculation of cuts, abrasions, dermatitis, or mucous membranes
Feces • incontinence • diarrhea	Bacteria—*Campylobacter, Salmonella, Shigella, E coli* O157:H7 and related *E. coli*, *Clostridium difficile* Parasites—*Giardia, Cryptosporidium, Cyclospora* Viruses—Noroviruses, rotavirus, enteroviruses, hepatitis A virus	Oral ingestion from contaminated hands, objects
Fluid from Skin or Mucous Membrane Lesions	Herpes *Varicella* *Staphylococcus*, methicillin-resistant *Staphylococcus aureus* (MRSA) *Streptococcus* (impetigo)	Inoculation of cuts, abrasions, dermatitis, or mucous membranes Direct contact of contaminated articles with intact skin or mucous membranes.
Semen/Vaginal Fluid	Hepatitis B virus Hepatitis C virus HIV Gonorrhea Syphilis Chlamydia Other sexually transmitted infections	Sexual contact including by mucous membranes or contact with nonintact skin
Urine • incontinence	Cytomegalovirus Rubella	Oral or percutaneous inoculation from contaminated hands, objects
Vomitus	Norovirus Rotavirus	Oral inoculation from contaminated hands, objects Respiratory inoculation from respiratory droplets

Resources

Guidelines for Handling Body Fluids in School are based on OSPI's *Guidelines for Implementation of School Employee Training on HIV/AIDS and Other Bloodborne Pathogens*, April 2011, pages 13-21
http://www.k12.wa.us/HealthServices/pubdocs/GuidelinesHIVBloodborne.pdf

State of Washington Department of Labor and Industry Administrative Policy Number ES.C.4.2 - Minors and Blood borne Pathogens in Non-medical Settings. http://www.lni.wa.gov/WorkplaceRights/files/policies/esc42.pdf

WAC 296-125-030 (24) Prohibited and hazardous employment — All minors.
http://apps.leg.wa.gov/wac/default.aspx?cite=296-125-030

Washington State Department of Labor and Industries
Bloodborne Pathogens WAC 296-823
http://www.lni.wa.gov/wisha/rules/bbpathogens/default.htm

APPENDIX IX

Guidelines for the Placement of Children and Adolescents Infected with the Human Immunodeficiency Virus (HIV)

WASHINGTON STATE DEPARTMENT OF HEALTH

Guidelines for the Placement of Children and Adolescents Infected with the Human Immunodeficiency Virus (HIV)

Problem Statement

In order to ensure that the rights of all children in Washington to public education are protected and to provide clarity regarding standard health practices, this statewide guidance on school placement of children and adolescents infected with HIV in schools has been developed. These recommendations apply to all children and adolescents from preschool through Grade 12 and address child care settings as well. They are based on the most recent scientific data available and will be revised as appropriate.

From 2006-2010 newly, diagnosed cases of Human Immunodeficiency Virus (HIV) infection in persons under the age of 20 years accounted for three percent of the total number of cases reported in Washington State. Acquired Immune Deficiency Syndrome (AIDS) is a late stage of HIV infection that is life threatening. The rate of newly diagnosed children and adolescents has remained stable since HIV became a reportable condition in Washington. The Washington State Department of Health (DOH) anticipates children and adolescents will continue to be diagnosed in the future.

In spite of years of education about HIV/AIDS, both children and adults who are infected with HIV still suffer from significant societal stigma. As treatment options improve and become more accessible, HIV positive children and youth generally experience better health and quality of life, thereby increasing the number of children and youth with HIV who are able to and interested in participating in regular school programs.

Access to a quality education free from harassment is a right for all children, including those living with HIV. The rights of HIV-positive students, as well as staff members, in school environments are governed by several laws, including the Rehabilitation Act of 1973, the Americans with Disabilities Act (ADA), the Individuals with Disabilities Education Act (IDEA), the Family Educational Rights and Privacy Act (FERPA), and numerous state laws. (Center for HIV Law and Policy, 2012).

Background

HIV, the virus that causes AIDS, is spread from an infected person to an uninfected person by unprotected sexual intercourse, sharing needles or injection equipment, transfusion or accidental exposure to infected blood or blood products, and from mother to child during the perinatal period. Although HIV can be isolated from other body fluids, it is found in quantity only in blood, semen, and vaginal fluids. Transmission has been documented from blood, semen, vaginal fluids, and rarely, breast milk.

HIV is NOT transmitted by casual person-to-person contact (as would normally occur among children) or exposure to saliva, tears or sweat. None of the identified cases of HIV infection or AIDS in the United States is known to have been transmitted in a school setting or while playing sports.

According to the Washington State Department of Health, from 2002 to 2007 there were 34 new cases of HIV infection reported among youth below the age of 20, representing 1 percent of the total number of new cases in Washington. Only 4 cases of pediatric HIV infection were reported during that time period.
The Center for Disease Control and Prevention (CDC) provides the following information about HIV infection among young Americans.

- In 2009, young persons accounted for 39 percent of all new HIV infections in the United States. For comparison's sake, persons aged 15–29 comprised 21 percent of the United States population in 2010.

- Young men who have sex with men (MSM), especially those of minority races and ethnicities, are at increased risk for HIV infection. In 2009, young MSM accounted for 27 percent of new HIV infections in the US and 69 percent of new HIV infections among persons aged 13–29. Among young black MSM, new HIV infections increased 48 percent from 2006 through 2009.

- In 2009, young blacks accounted for 65 percent (5,404) of diagnoses of HIV infection reported among persons aged 13–24 years.

- In 2008, an estimated 22 percent of persons aged 13–24 living with diagnosed HIV infection were infected through hemophilia, blood transfusion, birth, or unknown transmission mode, with the majority being infected parentally.

Guidelines for the Placement of HIV-Positive Children and Adolescents

The following guidelines are based on recommendations developed by the CDC and the National Association of State Boards of Education (NASBE) 2001, published in *Someone in School Has AIDS: A Complete Guide to Education Policies Concerning HIV Infection, 2nd Edition* and in NASBE Policy Update from *Updating State Policies for Students with HIV Infection, 2001.*

Children and adolescents through Grade 12 are referred to as “children” in the following:

1. Discrimination based on HIV status is explicitly barred, in accordance with the federal American with Disabilities Act.
2. Mandatory screening of students for HIV infection, as a condition of school or child care entry, is prohibited by law.

3. Children infected with HIV, except for those subject to conditions described in No. 6 below, should be allowed to attend school and before

4. and after school care in an unrestricted manner. The student should be considered eligible for all rights, privileges, and services provided by law and local policy of the school districts or child care settings. The mere presence of HIV-infected students in these settings does not pose a risk to other students or to child care or school employees.

5. Those involved in the care and education of children should respect the individual's right to privacy and the confidentiality of school and medical records. Law prohibits unauthorized disclosure of a person's status with regard to any sexually transmitted disease. RCW 70.24.105 describes to whom and under which circumstances the disclosure of a person's HIV status may occur. Chapter 70.02 governs the exchange of health care information among providers.

   Students are not required to disclose their HIV status to school staff. It is possible that a parent could request a 504 accommodation or Individual Education Plan (IEP); however, signed consent from the parent/guardian or student over the age of 14 years is required before health care information can be shared. The nurse might further protect the confidentiality of this information by using broad language when describing the need for the accommodation rather than providing a specific diagnosis.

6. For most HIV-infected children, the benefits of a normal school setting would outweigh the risks of their acquiring potentially serious infections in that setting. Assessment of the risk to the immunosuppressed student of attending school (Grades K–12) in an unrestricted setting is best made by the student's licensed health care provider who is aware of the student's immune status.

7. All children who display aggressive behavior such as biting, and those who have other medical conditions such as un-coverable oozing lesions, may require a more restrictive environment regardless of their HIV infection status. Individual judgments need to be made regarding the placement of children with questionable behavior, impaired neurologic development, or other medical conditions in the typical school or child care setting. These decisions, for children Grades K–12, are best made at the local school district level using the team approach.

8. All schools and child care facilities should utilize standard precautions and adopt infection control procedures for handling blood or body fluids. School nurses, teachers, other school or child care employees, and children Grades K–12 should be appropriately educated regarding these procedures (see Appendix VIII).

HIV/AIDS Training for School Employees

Chapter 392-198 WAC, Training—School employees—HIV/AIDS requires:

1. Mandatory and supplemental course content for training school district employees regarding the transmission, prevention, and treatment of HIV/AIDS.

2. Significant new discoveries or changes in accepted knowledge of transmission, prevention, and treatment for HIV/AIDS be provided to all public school employees as directed by DOH.

3. All newly hired employees shall receive HIV/AIDS training as described in this WAC within 6 months from the first day of employment in the district.

APPENDIX X

RCW 70.24.110

Minors—Treatment, Consent, Liability for Payment for Care

RCW 70.24.110

Minors—Treatment, consent, liability for payment for care.

A minor fourteen years of age or older who may have come in contact with any sexually transmitted disease or suspected sexually transmitted disease may give consent to the furnishing of hospital, medical and surgical care related to the diagnosis or treatment of such disease. Such consent shall not be subject to disaffirmance because of minority. The consent of the parent, parents, or legal guardian of such minor shall not be necessary to authorize hospital, medical and surgical care related to such disease and such parent, parents, or legal guardian shall not be liable for payment for any care rendered pursuant to this section.

[1988 c 206 § 912; 1969 ex.s. c 164 § 1.]

Link - Washington State Legislature
http://apps.leg.wa.gov/rcw/default.aspx?cite=70.24.110

Resources:

- *Providing Health Care to Minors under Washington Law*
- *Age of Consent*

APPENDIX XI

RCW 28A.230.020

Common School Curriculum—Fundamentals in Conduct

RCW 28A.230.020

Common school curriculum—Fundamentals in conduct.

All common schools shall give instruction in reading, penmanship, orthography, written and mental arithmetic, geography, the history of the United States, English grammar, physiology and hygiene with special reference to the effects of alcohol and drug abuse on the human system, science with special reference to the environment, and such other studies as may be prescribed by rule or regulation of the state board of education. All teachers shall stress the importance of the cultivation of manners, the fundamental principles of honesty, honor, industry and economy, the minimum requisites for good health including the beneficial effect of physical exercise and methods to prevent exposure to and transmission of sexually transmitted diseases, and the worth of kindness to all living creatures and the land. The prevention of child abuse may be offered as part of the curriculum in the common schools.

[1991 c 116 § 6; 1988 c 206 § 403; 1987 c 232 § 1; 1986 c 149 § 4; 1969 c 71 § 3; 1969 ex.s. c 223 § 28A.05.010. Prior: 1909 p 262 § 2; RRS § 4681; prior: 1897 c 118 § 65; 1895 c 5 § 1; 1890 p 372 § 45; 1886 p 19 § 52. Formerly RCW 28A.05.010, 28.05.010, and 28.05.020.]

NOTES

Effective date—1988 c 206 §§ 402, 403: See note following RCW 28A.230.070.

Severability—1988 c 206: See RCW 70.24.900.

Child abuse and neglect—Development of primary prevention program: RCW 28A.300.160.

Districts to develop programs and establish programs regarding child abuse and neglect prevention: RCW 28A.230.080.

Link - Washington State Legislature
http://apps.leg.wa.gov/rcw/default.aspx?cite=28A.230.020

APPENDIX XII

Washington State
Local Health Jurisdictions

Local Health Jurisdictions	Phone
Adams County Health District Environmental Health (Othello) http://www.co.adams.wa.us/departments/default.asp?DeptID=10	509-659-3315 509-488-2031
Asotin County Health District Environmental Health http://ac-hd.org/	509-758-3344
Benton-Franklin Health District Environmental Health http://www.bfhd.wa.gov	509-460-4200 509-460-4205 509-786-1633
Chelan-Douglas Health District Environmental Health http://www.cdhd.wa.gov	509-886-6400 509-886-6450
Clallam County Department of Health and Human Services Environmental Health http://www.clallam.net/healthservices/	360-417-2200 360-417-2258
Clark County Public Health Environmental Health http://www.clark.wa.gov/public-health/index.asp	360-397-8000 360-397-8428
Columbia County Public Health District Environmental Health http://www.columbiaco.com/	509-382-2181 509-382-2181
Cowlitz County Health Department Environmental Health http://www.co.cowlitz.wa.us/health	360-414-5599 360-414-5592
Garfield County Health District Environmental Health http://co.garfield.wa.us/health	509-843-3412
Grant County Health District Environmental Health http://www.granthealth.org	509-754-6060 509-754-6060

Local Health Jurisdictions (cont.)

	Phone
Grays Harbor County Public Health and Social Services Environmental Health http://www.co.grays-harbor.wa.us/info/pub_svcs/envhealth.html	360-532-8631 360-249-4413
Island County Health Department Environmental Health http://www.islandcounty.net/health/	360-679-7351 360-679-7350
Jefferson County Health and Human Services Environmental Health http://www.jeffersoncountypublichealth.org/	360-385-9400 360-385-9444
Kitsap County Health District Environmental Health http://www.kitsappublichealth.org/	360-337-5235 360-337-5235
Kittitas County Health Department Environmental Health http://www.co.Kittitas.wa.us/health/	509-962-7515 509-933-7515
Klickitat County Health Department Environmental Health http://www.klickitatcounty.org/health/	509-493-5058 509-773-4565
Lincoln County Health Department Environmental Health http://www.co.lincoln.wa.us/Health%20Department/	509-725-1001 509-725-2501
Mason County Department of Health Services Environmental Health http://www.co.mason.wa.us/health/index.php	360-427-9670 360-482-5269 ext. 274
Northeast Tri-County Health District Environmental Health http://www.netchd.org/	509-684-5048 509-684-2262
Okanogan County Health District Environmental Health http://www.okanogancounty.org/ochd/	509-422-7140 509-422-7144
Pacific County Health and Human Services Department Environmental Health http://www.co.pacific.wa.us/health/index.htm	360-875-9343 360-875-9356

Local Health Jurisdictions (cont.)	Phone
Public Health – Seattle and King County Environmental Health http://www.kingcounty.gov/healthservices/health.aspx	206-296-4600 206-205-4394
San Juan County Department of Health and Community Services Environmental Health http://sanjuanco.com/health/default.aspx	360-378-4474 360-378-4474
Skagit County Department of Health Environmental Health http://www.skagitcounty.net/Common/asp/default.asp?d=Health&c=General&p=main.htm	360-336-9380 360-336-9380
Skamania County Health Department Environmental Health http://www.skamaniacounty.org/community-health/	509-427-3881 509-427-3881
Snohomish Health District Environmental Health http://www.snohd.org	425-339-5200 425-339-5250
Spokane Regional Health District Environmental Health http://www.srhd.org	509-324-1500 509-324-1560
Tacoma-Pierce County Health Department Environmental Health http://www.tpchd.org	253-798-6410 253-798-6470
Thurston County Public Health and Social Services Department Environmental Health http://www.co.Thurston.wa.us/health	360-867-2500 360-867-2667
Wahkiakum County Department of Health and Human Services Environmental Health http://www.co.wahkiakum.wa.us/depts/health/	360-795-6207 360-795-6207
Walla Walla County-City Health Department Environmental Health http://www.co.walla-walla.wa.us/departments/phd/index.shtml	509-524-2650 509-524-2662

Local Health Jurisdictions (cont.)

	Phone
Whatcom County Health Department Environmental Health http://www.co.whatcom.wa.us/health/index.jsp	360-676-6724 360-676-6724
Whitman County Health Department Environmental Health http://www.whitmancounty.org/PubHealth	509-397-6280 509-397-6280
Yakima Health District Environmental Health http://yakimahealthdistrict.org/w/	509-575-4040 509-575-4040

APPENDIX XIII

Resources

Resources

A. References

ACIP immunization recommendations available at:
http://www.cdc.gov/vaccines/pubs/ACIP-list.htm

American Academy of Pediatrics (2012). *Red Book: Report of the Committee on Infectious Diseases,* 29th ed., Elk Grove Village, IL.

American Academy of Pediatrics (2009). *School Infectious Disease Guidance, Infection Control Measures.* Elk Grove Village, IL, pages 19-29.

American Academy of Pediatrics (2004). *School Health: Policy and Practice,* 6th ed., Elk Grove Village, IL.

Centers for Disease Control and Prevention (2007), *Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings.* http://www.cdc.gov/hicpac/2007IP/2007isolationPrecautions.html

Champion, C. (2005). *Occupational Exposure to Bloodborne Pathogens*, National Association of School Nurses, Inc., Silver Spring, MD.

Guidelines for Handling Body Fluids in School are based on OSPI's *Guidelines for Implementation of School Employee Training on HIV/AIDS and Other Bloodborne Pathogens* (2011) pages 13-21.
http://www.k12.wa.us/HealthServices/pubdocs/GuidelinesHIVBloodborne.pdf

Heymann, D. (2008). *Control of Communicable Diseases Manual,* 19th ed., American Public Health Association, Washington, D.C.

MMWR Recommendations and Reports(2011). *Immunization of Health-Care Personnel*. 60(RR07); 1-45.
http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6007a1.htm?s_cid=rr6007a1_e

Immunization Manual for Schools, Preschool and Child Care Facilities (2012).
Available from:
Washington State Department of Health
Web
site: http://www.doh.wa.gov/CommunityandEnvironment/Schools/Immunization/SchoolManual.aspx

National Association of State Boards of Education (NASBE) 2001. *Someone at School has AIDS: A Complete Guide to Education Policies Concerning HIV Infection*. Alexandria, VA:
NASBE. http://nasbe.org/index.php?option=com_content&view=article&id=120:policies-concerning-students-and-staff-with-hiv-infection&catid=78:model-policies&Itemid=372

Resources (cont.)

Siegel, JD., Rhinehart, E., Jackson, M., Chiarello, L.,& the Healthcare Infection Control Practices Advisory Committee (2007). *Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings.* http://www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf

State of Washington Department of Labor and Industry Administrative Policy Number ES.C.4.2 - Minors and Blood borne Pathogens in Non-medical Settings. http://www.lni.wa.gov/WorkplaceRights/files/policies/esc42.pdf

Tacoma Pierce County Heath Department – School MRSA guidelines http://www.tpchd.org/health-wellness-1/diseases-conditions/methicillin-resistant-staphylococcus-aureus-mrsa/

WAC 296-125-030 (24) Prohibited and hazardous employment — All minors. http://apps.leg.wa.gov/wac/default.aspx?cite=296-125-030

B. Videos, DVD's, Curriculum, Reference Books, and other Materials

1. Office of Superintendent of Public Instruction (OSPI)

   Health Services A–Z Index of Health Topics
   http://www.k12.wa.us/HealthServices/Resources.aspx

   HIV and Sexual Health Education
   http://www.k12.wa.us/HIVSexualhealth/default.aspx

2. Washington State Department of Health—Immunization and Child Profile Office

   Forms and Publications (flyers, fact sheets, brochures, letters) http://www.doh.wa.gov/YouandYourFamily/Immunization/FormsandPublications/Forms.aspx

   Posters

   A poster depicting proper handwashing techniques is available in multiple languages. The poster is titled, "BE A GERM BUSTER WASH YOUR HANDS" and is available at: http://here.doh.wa.gov/materials/be-a-germ-buster

   A poster encouraging handwashing is available in several sizes in both English and Spanish. The poster is titled, "WashYourHandsingTon" and is available at: http://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/Flu/WashYourHandsingTon.aspx

   A poster promoting respiratory hygiene is available in multiple languages. The poster is titled, "Cover Your Cough" and is available at: http://here.doh.wa.gov/materials/cover-your-cough

3. Washington State School Nurse Corps Resources:
    - Online School Nurse Resource Guide: https://library.nwesd.org/snc/school-nurse-resource-guide
    - *School Health Services—A Guide Book for School Administrators, Nurses and School Personnel* http://www.esd105.org/index.php/educational-services/learning-support/school-nurse-corps
    - Lending libraries - for individual listings of available resources please see the links below to the 9 Educational Service District (ESD) School Nurse Corp Program Web sites:

ESD School Nurse Corps (SNC) Lending Libraries	Contact/Phone Number
ESD 101— http://www.esd101.net/site/Default.aspx?PageID=743 Link to Lending Library materials list: https://library.nwesd.org/sites/library.nwesd.org/files/images/users/u24/Section_14/ESD_101_Library_WebPg_2.doc	SNC Administrator, Team Leader, or SNC Administrative Assistant (509) 789-3538
ESD 105—http://www.esd105.org/index.php/educational-services/learning-support/school-nurse-corps Library is not online, call SNC Administrator or assistant for items that are available for loan	SNC Administrator 509.455.3129 Admin. Asst. 509.454.5304
ESD 112—http://esd112.org/nursecorps/ Library currently being updated, please contact SNC Administrator or assistant for further information regarding resources.	SNC Administrator 360.750.7500 x 215 Program Secretary 360.750.7500 x 335
ESD 113—http://esd113.org/domain/45 Resource Library – http://esd113.org/Page/322	SNC Director 360.464.6866 SNC Admin. Secretary 360.464.6865
Olympic ESD 114— http://www.oesd.wednet.edu/Page/398 Contact SNC Nurse Specialist or SNC secretary for items that are available for loan	SNC Nurse Specialist 360.478.6871 SNC Secretary 360.337.5438
ESD 123—http://www.esd123.org/schoolhealthservices Resource Library – Contact Administrator or Assistant	School Health Services Administrator - 509.544.5715 School Health Services Assistant - 509.544.5721
North Central ESD 171—http://www.ncesd.org/page/443 North Central ESD Libraries – http://media.dymaxion.ca/ncesd/ School Nursing Materials– http://media.dymaxion.ca/display/077?kw=%2A&md=807	SNC Administrator (509)665-2625 SNC administrative assistant (509) 665-2639

Resources (cont.)

NWESD 189—http://www.nwesd.org/nurse SNC Lending Library – https://library.nwesd.org/snc/lending-library	SNC Administrator 360.299.4013 SNC Administrative Assistant 360.299.4073
Puget Sound ESD— http://psesd.org/index.php?option=com_content&task=view&id=128&Itemid=675 Resource Library – http://www.psesd.org/index.php?option=com_content&task=view&id=629&Itemid=294	SNC Administrator Seattle Area – 425.917.7796 Tacoma Area – 253.778.7796

D. Web sites

American Academy of Pediatrics (AAP)
Web site: http://www.aap.org

California Department of Education
Web site: http://www.cde.ca.gov/index.asp
2010 Educational Resources
Catalog: http://www.cde.ca.gov/re/pn/rc/documents/catalog2010.pdf#search=online%20video%20catalogue&view=FitH&pagemode=none

Centers for Disease Control and Prevention (CDC)
Web site: http://www.cdc.gov/
Index to specific disease
information: http://www.cdc.gov/health/default.htm
Influenza Information
Web site: http://www.cdc.gov/germstopper
National Immunization Program
Web site: http://www.cdc.gov/vaccines/
Emerging Diseases
Web site: http://www.cdc.gov/ncidod/eid/

Dermatology Online Atlas (includes pictures and rashes)
Web site: http://www.dermis.net

Emergency Contraception
Web site: http://ec.Princeton.edu

Food and Drug Administration (FDA)
Web site: http://www.fda.gov

Immunization Action Coalition
Web site: http://www.immunize.org

Resources (cont.)

Medline
Web site: http://www.nlm.nih.gov/medlineplus

National Association of School Nurses (NASN)
Web site: http://www.nasn.org

Occupational Safety and Health Administration (OSHA)
Web site: http://www.osha.gov

Seattle Children's
Web site: http://www.seattlechildrens.org/
Center for Children with Special Health Needs
Web site: http://www.cshcn.org

School Nurse Organization of Washington (SNOW)
Web site: http://www.schoolnurseorganizationofwashington.org/

Washington State Department of Health (DOH)
Web site: http://www.doh.wa.gov

Communicable Disease Web site:
http://www.doh.wa.gov/AboutUs/ProgramsandServices/DiseaseControlandHealthStatistics/CommunicableDiseaseEpidemiology.aspx

Communicable Disease reporting Web site:
http://www.doh.wa.gov/PublicHealthandHealthcareProviders/NotifiableConditions/ListofNotifiableConditions.aspx

Epidemiology Web site:
http://www.doh.wa.gov/AboutUs/ProgramsandServices/DiseaseControlandHealthStatistics.aspx

HIV/AIDS Web site:
http://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/HIVAIDS/Prevention.aspx

How to Respond: Injury and Illness at School (2010)
http://here.doh.wa.gov/materials/how-to-respond-injury-and-illness-at-school

STD Web site:
http://www.doh.wa.gov/PublicHealthandHealthcareProviders/PublicHealthLaboratories/CommunicableDiseaseMicrobiology/SexuallyTransmittedDiseases.aspx

Viral hepatitis (adult):
http://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/Hepatitis.aspx

Resources (cont.)

Washington State Department of Health Resources (cont.)

Immunization and Child Profile Program Web site:
http://www.doh.wa.gov/YouandYourFamily/Immunization/Vaccines.

School Environmental Health and Safety Web site: http://www.doh.wa.gov/CommunityandEnvironment/Schools/EnvironmentalHealth.aspx

Pests Web site: http://www.doh.wa.gov/CommunityandEnvironment/Pests.aspx

Immunization Forms:
http://www.doh.wa.gov/YouandYourFamily/Immunization/FormsandPublications/Forms.aspx
Fax to order materials: 360-236-3481
E-mail to order materials: immunematerial@doh.wa.gov

School Immunizations Web site:
http://www.doh.wa.gov/YouandYourFamily/Immunization.aspx

School Environmental Health and Safety Program Web site:
http://www.doh.wa.gov/AboutUs/ProgramsandServices/EnvironmentalPublicHealth/EnvironmentalHealthSafetyandToxicology/Schools.aspx
Health Education Resource Exchange (H.E.R.E)
Web site: http://here.doh.wa.gov/

Washington Industrial Safety and Health Act
Web site: http://www.lni.wa.gov/wisha/

Washington State Department of Labor and Industries
Bloodborne Pathogens WAC 296-823
http://www.lni.wa.gov/wisha/rules/bbpathogens/default.htm

Washington State Legislature
Web site for information on WACs and RCWs: http://search.leg.wa.gov/pub/textsearch/default.asp

Washington State Risk Management Pool
http://www.wsrmp.com/

Washington State School Directors Association
http://www.wssda.org/

Questions about the *Infectious Disease Control Guide for School Staff* should be directed to:

Health Services Program Supervisor
Office of Superintendent of Public Instruction
Old Capitol Building
PO Box 47200
Olympia, WA 98504-7200

Phone: 360-725-6040
TTY: 360-664-3631
Fax: 360-664-3028

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Index (cont.)

U

V

W

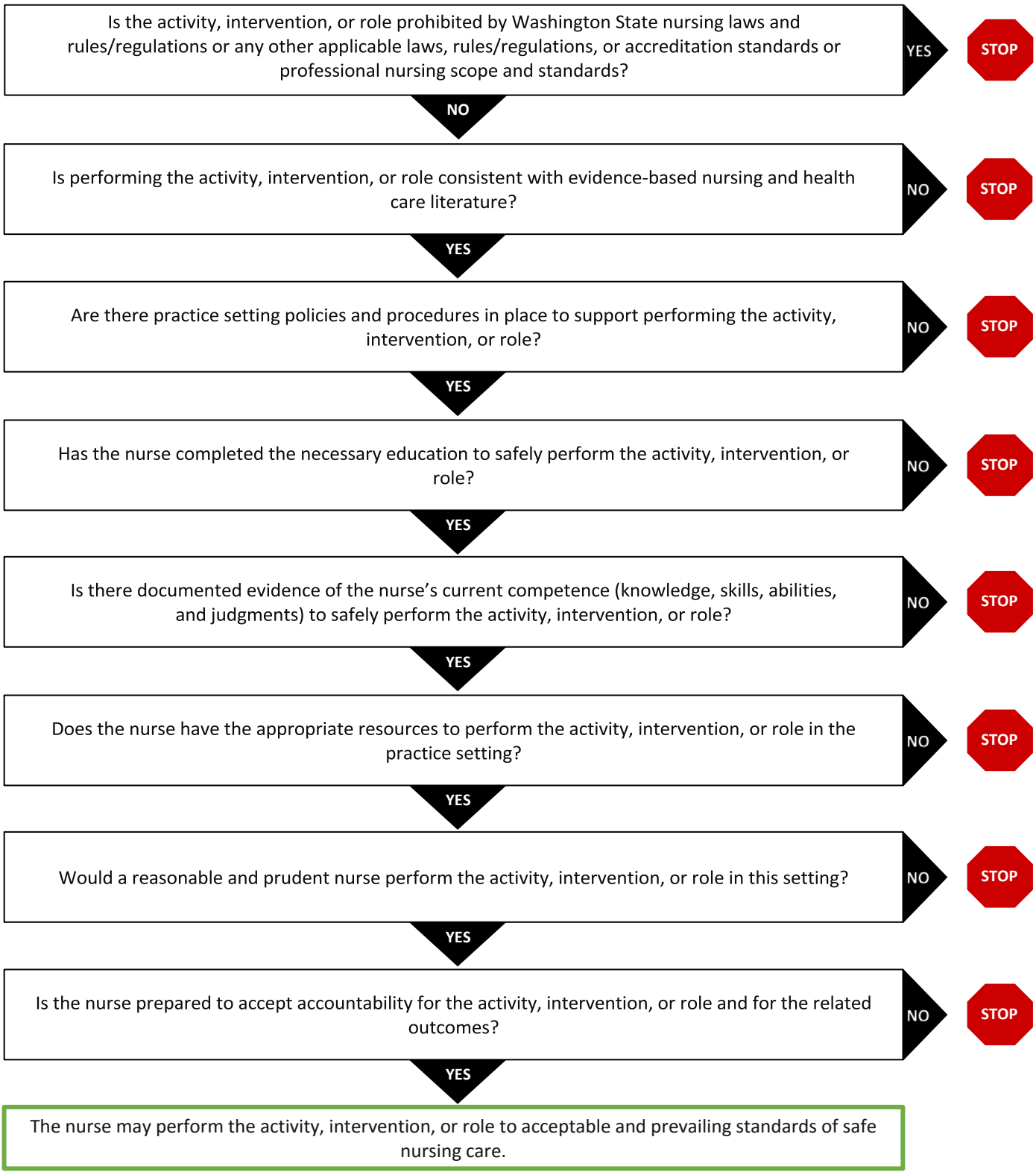
Randy I. Dorn • State Superintendent
Office of Superintendent of Public Instruction
Old Capitol Building • P.O. Box 47200
Olympia, WA 98504-7200

Download this material in PDF at http://www.k12.wa.us/HealthServices/Resources.aspx. This material is available in alternative format upon request. Contact the Resource Center at (888) 595-3276, TTY (360) 664-3631.Please refer to this document number for quicker service: 14-0012.

Randy I. Dorn • State Superintendent
Office of Superintendent of Public Instruction
Old Capitol Building • P.O. Box 47200
Olympia, WA 98504-7200

Scope of Practice Decision Tree

Identify, describe, or clarify the activity, intervention, or role under consideration.



Used with Permission from National Council State Boards of Nursing: Scope of Nursing Practice Decision-Making Framework, Journal of Nursing Regulation, Volume 7, Issue 3, October 2016.

Chapter 18.79 RCW Nursing Care • Standards of Nursing Conduct or Practice WAC 246-840-700

Contact Us: NursingPracticeConsultation.ncqac@doh.wa.gov or 360-236-4725

DOH 609-305 March, 3 2017

Department of Health
Nursing Care Quality Assurance Commission

Advisory Opinion

The Nursing Care Quality Assurance Commission (NCQAC) issues this advisory opinion in accordance with WAC 246-840-800. An advisory opinion adopted by the NCQAC is an official opinion about safe nursing practice. The opinion is not legally binding and does not have the force and effect of a duly promulgated regulation or a declaratory ruling by the NCQAC. Institutional policies may restrict practice further in their setting and/or require additional expectations to assure the safety of their patient and//or decrease risk.

Title:	Registered Nurse Delegation in School Settings	*Number:* NCAO 4.0
References:	RCW 18.79 Nursing Care WAC 246-840 Practical and Registered Nursing Nursing Scope of Practice Decision Tree RCW 18A.210 Delivery of Medications and Services by Unlicensed School Employees Senate Bill 6128 RCW 72.40 State Schools for Blind, Deaf and Sensory Handicapped	
Contact:	Deborah Carlson, MSN, RN	
Phone:	360-236-4725	
Email:	Debbie.carlson@doh.wa.gov	
Effective Date:	July 11, 2014	
Supersedes:	Not Applicable	
Approved By:	Nursing Care Quality Assurance Commission	

Conclusion Statement

The purpose of this advisory opinion is to ensure that nursing care has a consistent standard of practice upon which the profession, school administrators, teachers, parents, other school staff and the public may rely, to safeguard the authority of the registered nurse (RN) to make independent professional decisions regarding delegation of nursing tasks, and to protect students' safety. Nursing delegation is defined as transferring a nursing task to another individual who would not normally be allowed to perform the task (WAC 246-840). Student health and safety must be the primary consideration in the RN's decision to delegate a nursing task to unlicensed assistive personnel (UAP) in public schools, private schools, charter schools, and any entity that considers itself an educational institution or school. Licensed practical nurses (LPNs) may not delegate nursing care in this setting. The RN delegating the care retains accountability and responsibility for the delegation. Delegation of nursing care is not within the authority of school administrators, principals, teachers, office staff, coaches, bus drivers, other health care professionals, or other school employees. RNs cannot delegate to volunteers, parents, or non-school employees during school or during school-sponsored events. Nursing delegation is not appropriate for all students, all nursing tasks, all school settings, or all circumstances. The RN delegating the care must have the education, knowledge, skills, and abilities to delegate nursing tasks competently and safely. No person may coerce a RN into compromising student safety by requiring delegation if the RN determines it is inappropriate to do so.

Background and Analysis

Nurses, school administrators, and the general public frequently seek guidance from the NCQAC about delegation in school settings. Growing numbers of Washington State students with acute or chronic health care needs depend on help with nursing tasks during the school day. Students must have access to health care during school and extra-curricular school-sponsored events to enable them to participate fully. Many school districts in Washington State do not have a full-time school nurse. To meet student needs, Washington State law allows school RNs to delegate certain nursing tasks to UAP in routine and emergency situations.

Providing nursing care and delegation in school settings is uniquely challenging since a school's primary mission is education, not health care. It is not a traditional health care setting where advanced emergency equipment and other licensed health care providers are readily available. Another challenge is that school administrators, staff, parents, and other health care professionals may not understand the legal and regulatory parameters that guide nursing delegation nor the complexity of delegating care in this setting.

Nurses may be confronted with pressure from school administrators or others to delegate inappropriately, which might extend to threatening their jobs if they refuse to do so. At the same time, they may face disciplinary action if delegation does not follow nursing standards and regulatory practices.

State law stipulates that delegation can only be done if a student's condition is stable and predictable. Legal exceptions exist for emergencies limited to delegating injectable epinephrine for students with known anaphylaxis and intranasal medications for seizures (RCW 18.79.240, RCW 28A.210.330).

Laws allow a parent designated adult (PDA) to give care for students with seizures and diabetes. The RN does not delegate care to a PDA (RCW 28A.210.330). The RN may delegate administration of nasal sprays. Intranasal legend drugs (including controlled substances) may be delegated only if a licensed nurse is not on the premises (RCW 28A.210.260). The law requires a school employee (non-nurse) that administers a legend drug (intranasal) to summon emergency medical assistance as soon as practicable.

The RN assigned to a student, or with a student caseload, is solely responsible for the decision to delegate. No one else has the authority to delegate nursing care activities. The law provides protection from coercion from others (such as administrators, teachers, parents, or other health care providers) if the nurse determines it is inappropriate to delegate a task (RCW 18.79.260). This includes protection from employer reprisal or disciplinary action by the NCQAC if delegation could compromise student safety.

Questions often arise regarding the concepts of supervision and delegation in schools. In this context, supervision is defined as, "providing guidance and evaluation for the specific task including the initial direction of the task, periodic inspection of the actual act of accomplishing the task, and the authority to require corrective action." (WAC 246-840-010). This definition is different from the overall act of supervision of general performance as an employee. RNs may perform nursing care independently and carry out medical regimens interdependently under the direction of an authorized provider (RCW 18.79.260) without supervision. LPNs may carry out medical regimens under the direction and

supervision of an authorized provider (physician and surgeon, dentist, osteopathic physician and surgeon, physician assistant, osteopathic physician assistant, podiatric physician and surgeon, advanced registered nurse practitioner, or midwife (RCW 18.79.060). LPNs may carry out nursing regimens under the direction and supervision of a RN. LPNs may assist RNs in carrying out complex activities. The act of delegation does not apply to LPNs based on the definition previously provided. When supervising UAP or LPNs, the act of supervision does not necessarily mean the RN delegating the care has to be on the premises. The law does not allow LPNs may not delegate to UAP in the school.

As of July 1, 2014, in order to carry out delegated tasks, school district employees who are UAP must first submit letters indicating their willingness to give medications or perform nursing care not previously recognized in law (SB 6128). School district employees may decline to file letters and are protected from coercion, employer reprisal, or disciplinary action. Employees, school districts or schools, governing board members, and chief administrator are protected from liability if the UAP performs the task in substantial compliance with NCQAC rules, follows the RN's instructions, and follows written school or district policies. School boards must designate a school RN or ARNP to consult and coordinate care with parents and health care providers as well as train and supervise the school UAP to ensure a safe, therapeutic learning environment. This includes ongoing training for tasks performed infrequently. Volunteers and school district UAP are immune from civil damages when they provide emergency medical services (or transport for emergency medical treatment) at a school-sponsored event. This excludes licensed health care providers.

The majority of laws and rules about nursing delegation in schools apply to public school settings. RCW 28A.210.260 addresses delegation of medication administration in public and private schools but does not address delegation of other care that students might require. There is no explicit guidance for nurse delegation in other school-based entities such as private schools; charter schools; tribal schools; state schools such as the schools for the blind, deaf, and sensory handicapped, and juvenile residential schools (RCW 72.40).

Recommendations

Principles of Delegation

The Nursing Commission adopts the following principles for RNs from the *American Nurses Association and National Council of State Boards of Nursing Joint Statement on Delegation*. A RN delegating in a school setting:

- Takes responsibility and is accountable for providing nursing care
- Directs the care and determines whether delegation is appropriate
- Delegates specific tasks but not the nursing process
- Uses nursing judgment concerning a student's condition, the competence of the UAP, and the degree of supervision required prior to delegation
- Delegates only those tasks where the UAP has the knowledge, skill, and ability to perform the task safely (considering training, cultural competence, experience, regulations, and institutional policies and procedures)
- Communicates and verifies comprehension and acceptance of delegation and responsibility (consider a letter of intent to accept delegation based on law and school policy in instances where the task is not previously recognized in law)

- Provides opportunities for the UAP to ask questions and clarify expectations
- Uses critical thinking and professional judgment when following the *Five Rights of Delegation* (National Council of State Boards of Nursing):
    - Right task – task is appropriate to be delegated
    - Right circumstances – appropriate setting and necessary resources
    - Right person – right task for the right student
    - Right directions and communication – clear, culturally appropriate and concise training of the tasks (objectives, limits, expectations and skills competency demonstration)
    - Right supervision and evaluation – appropriate monitoring, evaluation, intervention, supervision, feedback, and documentation
- Should be involved in establishing systems to assess, monitor, verify, and communicate ongoing competency requirements in areas related to delegation

Delegation Process

1. Use the *School RN Delegation Decision Tree* to determine whether delegation of a nursing task is appropriate
2. Perform nursing assessment of the student's health care needs; consider available resources and unique factors that could make outcomes of the delegated task unpredictable, such as:
    - Whether there is a nurse available or able to provide care on a regular basis
    - Whether the student's health care needs are stable, uncomplicated, routine, and predictable
    - Whether the environment is conducive to delegation
    - Whether the student is unable to provide self-care
    - Whether the task does not require use of nursing judgment
3. Develop a plan to provide periodic re-training and re-demonstration of competency
4. Perform periodic inspection and evaluation and take corrective action as needed
5. Delegate only in accordance with the RN's education, training, knowledge, skills, and experience (seek consultation from another RN if necessary)
6. Assess the UAP's willingness and potential ability to perform the task for the individual student:
    - Consider psychomotor and cognitive skills required to perform the nursing task
    - Verify that the UAP is willing to perform the task in the absence of direct or immediate nurse supervision and has signed the letter of intent (if applicable)
    - Analyze the complexity of the nursing task to determine required or additional training needed by the UAP to competently accomplish the task
    - Assess the level of interaction required, considering language or cultural diversity, that may affect communication or the ability to accomplish the task to be delegated, as well as methods to facilitate the interaction
7. Provide or verify training and competency assessment for the UAP (consider using standardized training modules and assessment processes)
8. Provide clear and specific instructions to the UAP including when and how to contact the RN delegating the care or back-up RN
9. Implement and evaluate delegation
    - Supervise and evaluate the UAP's performance on a periodic basis (The method and frequency of supervision and evaluation is at the discretion of the RN delegating the care)
10. Document the delegation process and adherence according to school or school district policies

11. Notify district administration if it is not safe to delegate a particular nursing task and of the potential need for the district to provide nursing services rather than providing the care through delegation to a UAP

Implementing Changes in Delegated Tasks

The assigned RN retains authority to decide if a new or altered task can be delegated immediately:

1. Review the criteria and process for delegation prior to delegating the new or revised task
2. Provide training or re-training and competency assessment as appropriate
3. Document changes in delegation of the new or altered task

Rescinding Delegation

School RNs delegating care retain the authority to rescind delegation when the following occur:

1. A significant change or decline in the student's health status that would make delegation unsafe
2. The UAP lacks sufficient training, knowledge, skills, or ability to perform a task safely and competently
3. A determination that the specific task requires nursing judgment
4. There is a change in school nurse assignment or school nurse turnover
5. The school nurse is no longer employed by the school or school district or there is a change in the school nurse's assignment
6. The school nurse is no longer under contract (for example, during summer vacation)

In such cases, the delegating RN should initiate and participate in developing an alternative plan to ensure continuity. Rescission of delegation and actions taken should be documented.

Transferring Delegation

Delegation authority cannot be transferred from one RN to another. If the delegating RN is no longer assigned to a student or group of students, the RN assuming authority must undertake new delegation to the UAP.

Documentation

The delegating RN should document the delegation process regardless of the documentation system used by the school or school district using the fundamental principles of nursing documentation:

- Instructions for the task should be specific and broken into individual components
- Document specific steps for the delegated task
- Consider using a system where the RN and UAP initial each step in the document for complicated tasks
- Document date(s), training, and competency assessment including RN and UAP signatures

Supervision

RNs may have a non-nursing supervisor for general employment purposes. Performance evaluation specific to nursing care should only be done by a RN with the education, knowledge, skills, and abilities specific to school nursing. RNs delegating care must assess students prior to delegation and should determine the appropriate level of supervision of the UAP based on the task and student-specific circumstances:

- Indirect supervision: the RN gives written or oral instructions for the care and treatment and is not on the premises
- Immediate supervision: the RN provides guidance and evaluation, is on the premises within audible and visual range of the student
- Direct supervision: the RN provides guidance and evaluation based on assessment, is on the premises and quickly and easily available

Policies and Procedures

School nurses should follow professional practice standards within the legal framework and individual scope of practice. The school or school district should have policies and procedures based on regulations, scope of practice, and nursing care standards relevant to delegation. School RNs should be involved in developing these.

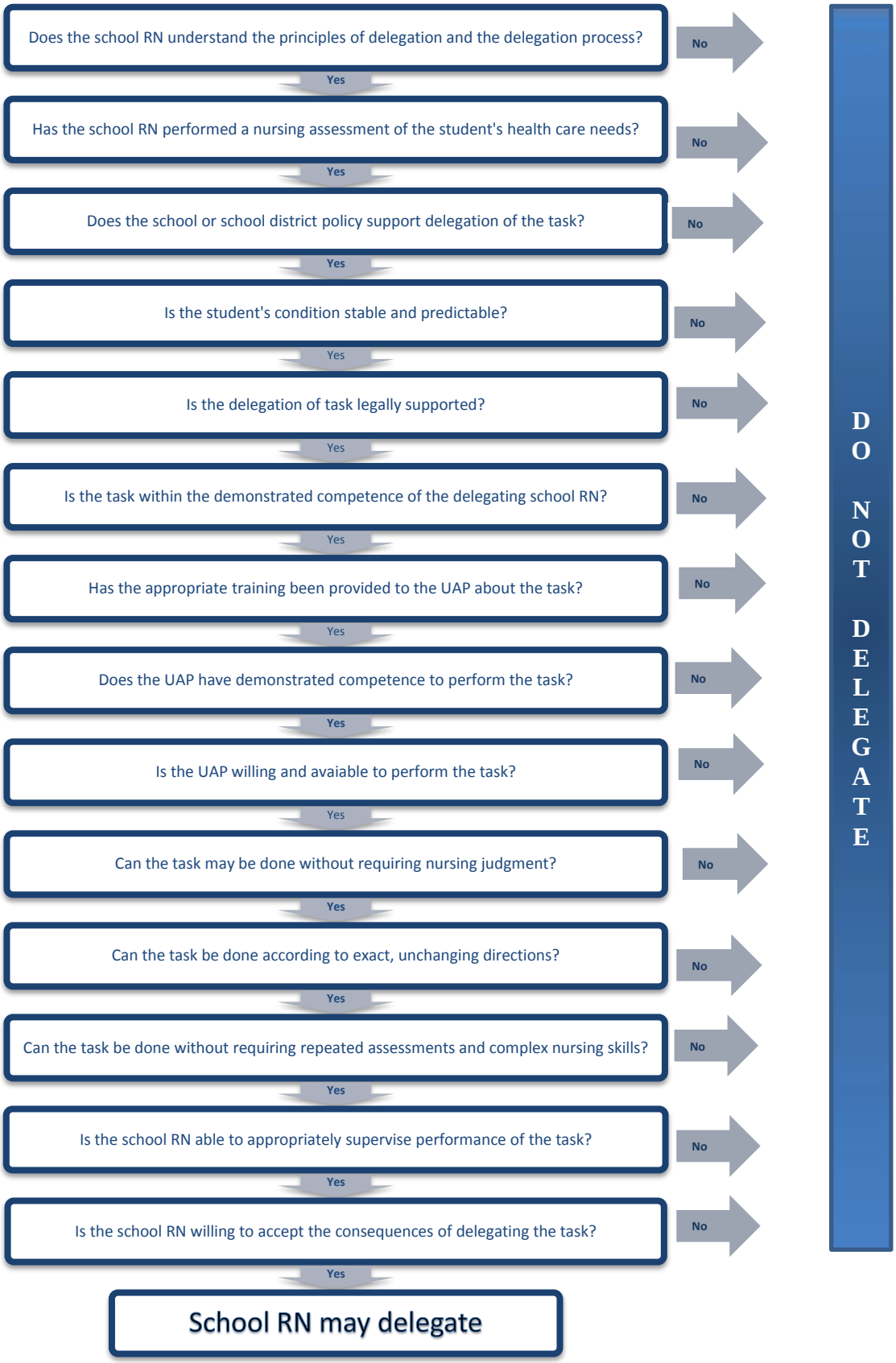
Consultation

School nurses should be knowledgeable about available support resources that provide assistance and consultation from other school nurse colleagues and professional organizations about delegation and related activities such as the Office of Superintendent of Public Instruction, School Health Services Program, Administrator, Regional School Nurse Corps Nurse Administrators, School Nurses Organization of Washington, and National Association of School Nurses.

Conclusion

Safe delegation is critical for the provision of safe, effective, and efficient student health services. Delegation is a process that, used appropriately, can result in safe and effective nursing care. Delegation can free school RNs to attend to more complex patient care needs and allow students with acute and chronic health care needs to participate in school. School nurses need to be able to work effectively with UAP and be competent to delegate, assign, and supervise delegable tasks. School nurses faced with pressure to delegate inappropriately must feel it is safe to follow nursing standards and regulatory practices. Following employer directives does not relieve the school nurse of accountability and responsibility for delegating according to nursing standards and regulation.

School Registered Nurse Delegation Decision Tree



References

American Nurses Association and National Council of State Boards of Nursing. Joint Statement on Delegation

National Association of School Nurses (2010). Delegation: Position Statement

National Council of State Boards of Nursing (2005). Working with Others: A Position Paper

National Association of School Nurses. Delegation in the School Setting. Is it Safe? Resha, C. (2010)

Washington State Nurses Association (2013). Registered Nurses and Delegation

How to Respond
Injury and Illness at School

October 2016

Emergency Telephone Numbers

Emergency: **911**

Washington Poison Center: **1-800-222-1222**

Local Health Jurisdiction:_____

Local Police Department: _____

Local Fire Department: _____

Local Hospital:_____

Local Mental Health Crisis Line:[1] _____

Mental Health Crisis WA Recovery Help Line: **1-866-789-1511**

National Suicide Prevention Hotline: **1-800-273-8255**

Personal and private information learned about students is considered privileged information and is protected by confidentiality laws. Please be aware of the laws and penalties for breaching confidentiality.

Washington State Department of Health

DOH 130-021 September 2016

For persons with disabilities, this document is available on request in other formats. To submit a request, please call 1-800-525-0127 (TDD/TTY 711).

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About the Guide

How to Respond: Injury and Illness at School is a reference guide from the Washington State Department of Health and the Washington State Office of Superintendent of Public Instruction through funding from the Centers for Disease Control and Prevention (CDC).

This booklet is designed to help school personnel and volunteers respond quickly, safely, and effectively when students are injured or become ill at school or during a school-sponsored activity. Knowing how to respond to a medical emergency may mean the difference between life and death.

This book is not a substitute for taking a first aid course.
We recommend that all adult staff complete basic first aid training and mental health first aid training and that they familiarize themselves with this booklet, how to use it, and where to find it. The booklet can hang on the wall of a classroom or health room, fit into a school first aid kit, and be carried on field trips or athletic events. Other recommended areas include being carried in emergency backpacks and on school buses. In addition, please stay current on health-related state laws and required staff training.

The information in this booklet is based in part on the American Academy of Pediatrics' course book *Pediatric First Aid for Caregivers and Teachers;*[2] Washington State Office of Superintendent of Public Instruction's *Infectious Disease Control Guide*[3] and *Health Services*;[4] National Association of School Nurses' *School Nursing: A Comprehensive Text* ;[5] American Heart Association 2015 *Highlights: Guidelines Update for CPR and ECC*;[6] and the CDC.

Topics are divided into "Medical Emergencies and Injuries" and "Common Illnesses and Health Problems". Each topic also describes when the situation requires immediate medical care. It is important to document conditions and the care given.

The health concerns listed in this guide were directed by the Washington State School Data Workgroup who identified "Reason for Visit," "Intervention" and "Disposition" medical conditions. Using these conditions helps us better understand how to address our students' health needs.

Reviewed and approved by:

- Washington State Department of Health
- Office of Superintendent of Public Instruction, Health Services
- Washington Chapter of the American Academy of Pediatrics
- Washington State School Nurse Corps

Contents

Contents

NOTE: Topics in red indicate medical emergency or may require urgent care.

Students with Special Health Care Needs:

Emergency Care Plan or Individual Health Care Plan

Students should have up-to-date Emergency Care Plans if they have life-threatening health conditions. Other students may have special needs that are less severe, but still require awareness of their conditions. These students may need Emergency Care Plans (ECPs) or Individual Health Care Plans (IHPs).

Teachers, administrators and unlicensed school staff that have responsibility for students with these conditions should have appropriate training to the contents of these plans, directed and delivered by the school nurse.

The school nurse may need to periodically reevaluate a student's condition and change health plans as needed. Share any changes you may see in a student's condition with the school nurse.

Never assume a student is independent in recognizing their need for assistance with their health concerns. Ask your school nurse for more information regarding these students if you feel you have a need to know more to safely care for them.

Examples of conditions you may encounter:

- Asthma.
- Diabetes.
- Seizures.
- Severe allergies.
- Less common conditions that may predispose a student to the possibility of dying at school (undiagnosed heart condition, heart-related illness and eating disorders like bulimia and anorexia nervosa).
- Students with health conditions that require accommodations to ensure safety and access to their education.

What to Do in a Medical Emergency

Do not move a student if he or she has a head, neck, or back injury, or is having trouble breathing. If there is a clear danger of further injury, then move the student carefully to safety. Do not deal with medical emergencies by yourself—get help!

While you give first aid, have someone else:

- **Call 911.**
- Notify the school nurse, if available.
- Notify the student's parent or legal guardian.

Do not delay emergency medical care because you can't reach a parent or legal guardian. Use your best judgment.

Before calling 911, survey the scene and make sure it is safe. Check the student's airway, breathing, and circulation (the ABCs of first aid). Someone trained in cardiopulmonary resuscitation (CPR), automated external defibrillator (AED), and first aid should start providing emergency care.

Call 911 for medical emergencies:

- Severe allergic reaction (Anaphylaxis).
- Choking or severe difficulty breathing.
- Shock (see page 51).
- Deep wound or part of the body that was crushed.
- Bleeding that is difficult to control.
- Back and neck injuries or broken bones.
- Severe head injury.
- Unconsciousness.
- Seizure—if the student has never had a seizure before or if directed by student's Emergency Care Plan.
- Serious burns.
- Spill or release of hazardous chemicals.

NOTE: In a medical emergency, if the parent's consent is not readily available, the consent requirement is satisfied and the minor can receive medical services [RCW 7.70.050(4)]. Follow your district policy and procedure for emergency treatment.

When calling 911:

- Stay on the phone and follow their instructions.
- Give the address and clear directions.
- If possible, have someone meet the emergency medical team when they arrive and direct them to the exact location.

Be ready to give this information to medical personnel:

- Name, age, and sex of the student.
- A copy of the Individual Health Plan.
- A description of the injury or symptoms.
- The student's condition.
- The name and contact information of the student's parent or legal guardian.
- The name of the student's healthcare provider.

Call the student's parent or legal guardian.

- Describe the medical emergency and what you are doing to care for the student.
- Find out the recommended hospital or medical facility and the student's healthcare provider.
- If the student is being transported to a medical facility, inform the student's parent or legal guardian and have them meet the student at the facility.

When calling 911 for transport:

- Do not use a personal car or school car for transporting a critically ill or injured student.
- Keep trying to reach the student's parent or legal guardian or the student's healthcare provider.
- Call an alternate emergency number for the student if you can't reach a parent or legal guardian.

Complete a written record of the incident immediately.

It is important for the administrative team to be aware as they may be contacted by the student's parent or legal guardian regarding the emergency/incident.

911: CPR, Breathing Stopped

Child (ages 13 to adult):[7]

1. **Verify that the person is unresponsive and is not breathing or is only gasping.**

2. **Ensure that the person is face-up on a firm, flat surface.**

3. **Give 30 chest compressions.**

   Push hard and fast in the center of the chest to a depth of at least 2 inches and at a rate of 100–120 compressions per minute.

4. **Give 2 rescue breaths.**

   - **Open the airway, pinch the nose shut, and make a complete seal over the person's mouth with your mouth.**
   - **Blow into the person's mouth for about 1 second, ensuring that the chest rises.**

     If the chest does not rise, retilt the head and ensure a proper seal before giving the second rescue breath.
   - **Take a breath, make a seal, and then give the second rescue breath.**

     If the second breath does not make the chest rise, begin compressions.

     After the next set of chest compressions, open the mouth, look for an object and, if seen, remove it.

     Continue to check the mouth for an object after each set of compressions until the rescue breaths go in.

5. **Continue giving sets of 30 chest compressions and 2 rescue breaths.**

911: CPR, Breathing Stopped

Child (ages 1 through 12):[7]

1. **Verify that the child is unresponsive and is not breathing or is only gasping.**

2. **Ensure that the child is face-up on a firm, flat surface.**

3. **Give 30 chest compressions.**

   Push hard and fast in the center of the chest to a depth of about 2 inches and at a rate of 100–120 compressions per minute.

4. **Give 2 rescue breaths.**

   - **Open the airway, pinch the nose shut, and make a complete seal over the child's mouth with your mouth.**
   - **Blow into the child's mouth for about 1 second, ensuring that the chest rises.**

     If the chest does not rise, retilt the head and ensure a proper seal before giving the second rescue breath.
   - **Take a breath, make a seal, and then give the second rescue breath.**

     If the second breath does not make the chest rise, begin compressions.

     After the next set of chest compressions, open the mouth, look for an object and, if seen, remove it.

     Continue to check the mouth for an object after each set of compressions until the rescue breaths go in.

5. **Continue giving sets of 30 chest compressions and 2 rescue breaths.**

911: CPR, Breathing Stopped

Infant (birth to 12 months):[7]

1. **Verify that the infant is unresponsive and is not breathing or is only gasping.**

2. **Ensure that the infant is face-up on a firm, flat surface.**

3. **Give 30 chest compressions.**

   Push hard and fast in the center of the chest to a depth of about 1½ inches and at a rate of 100–120 compressions per minute.

4. **Give 2 rescue breaths.**

   - **Open the airway and make a complete seal over the infant's nose and mouth with your mouth.**
   - **Blow into the infant's nose and mouth for about 1 second, ensuring that the chest rises.**

     If the chest does not rise, retilt the head and ensure a proper seal before giving the second rescue breath.
   - **Take a breath, make a seal, and then give the second rescue breath.**

     If the second breath does not make the chest rise, begin compressions.

     After the next set of chest compressions, open the mouth, look for an object and, if seen, remove it.

     Continue to check the mouth for an object after each set of compressions until the rescue breaths go in.

5. **Continue giving sets of 30 chest compressions and 2 rescue breaths.**

Using an Automated External Defibrillator (AED)

An AED is a medical device that can analyze heart rhythms and deliver an electric shock that may be able to restore a normal heart rhythm.

- For children age 12 and younger, give 5 cycles of CPR before using the AED.
- Attach pads to student. Use pediatric pads for children age 8 and younger, and adult pads over age 8. May use adult pads if pediatric ones are unavailable.
- Follow the AED prompts as given.
- Ensure no one is touching the student when shock is to be delivered.
- As soon as shock is delivered or the AED prompts "no shock," immediately start CPR again, beginning with chest compressions.
- Continue to follow AED prompts until student is responsive or EMS takes over.
- If the student is being transported to a medical facility, inform the student's parent or legal guardian and have them meet the student at the facility.

Allergies

Allergies can be caused by foods, dust, plants, pollen, animal dander, latex, mold, insects, mites, fragrances, medications, and chemicals.

Students with known allergies should have an Individual Health Care Plan for taking medications and dealing with symptoms and emergencies. Follow the plan.

Have someone notify the school nurse, if available.

Watch for:

- Symptoms and note what triggers the allergy.
- Difficulty breathing. **Call 911 if unsure about student's condition.**

Mild and Moderate Allergic Reactions

Try to determine how the student was exposed to the allergen. Stop exposure if possible.

Watch for:

- Runny nose.
- Itchy or watery eyes.
- Itchy throat.
- Coughing or wheezing.
- Rashes or hives.
- Tissue swelling.

First Aid:

- Monitor student for any signs that the reaction is becoming severe (see page 12).
- Notify the student's parent or legal guardian as soon as possible.

Severe Allergic Reaction (Anaphylaxis)

If a student has a known history of Anaphylaxis or severe allergic reaction and has known or suspected exposure to an allergen, give epinephrine immediately and call 911.

Students with severe allergies should have an Individual Health Care Plan for taking medications and dealing with symptoms and emergencies. Follow the plan. Notify school nurse, if available.

Watch for:

- Swelling of the face, lips, tongue, mouth, and airway.
- Wheezing and shortness of breath.
- Tightness in the chest.
- Dizziness.
- Blue or gray color around the lips.
- Nausea and vomiting.
- Itchy skin, hives or other rashes appearing quickly.

First Aid:

- Administer an epinephrine auto-injector if the student has one prescribed. **Call 911 and ask for help.**
- Have student sit in any position that is comfortable and allows them to breathe more easily.
- Calm and reassure the student.
- Watch the student's breathing carefully.
- If unresponsive, lay the student on his or her left side to reduce the risk of blocking the airway. Check for breathing, and if not breathing, start CPR until the student starts breathing or until the emergency medical team arrives.
- If the student is being transported to a medical facility, inform the student's parent or legal guardian and have them meet the student at the facility.

IMPORTANT: State law and school policy may allow administration of an epinephrine auto-injector from stock supply with standing order protocol for a diagnosed student without epinephrine auto-injector. (RCW 28A.210.380) Ask your school nurse.

Asthma Attack or Breathing Difficulty

Call 911 if the student has severe trouble breathing and does not have a quick-relief inhaler or if the inhaler is not helping. Notify the school nurse, if available. Students with asthma should have an Individual Health Care Plan for taking medications and dealing with symptoms and emergencies. Follow the plan.

Early signs of an asthma attack:

- Coughing.
- Shortness of breath when walking.
- Tickle in throat.

Moderate to severe symptoms:

- Tightness in chest.
- Wheezing or grunting.
- Unable to talk without stopping to breathe.
- Gasping, rapid breaths.
- Nostrils flaring.
- Feelings of fear or confusion.
- Bluish color of lips and skin.
- Changes in alertness.

First Aid:

- Have the student sit in an upright position and breathe slowly and deeply.
- If the student has medication and is able to take it, assist the student to inhale medication slowly and fully.
- Calm and reassure the student.
- If symptoms don't resolve in 20 minutes or if symptoms worsen, **call 911**.
- Inform the student's parent or legal guardian about the attack.
- If the student is being transported to a medical facility, inform the student's parent or legal guardian and have them meet the student at the facility.

IMPORTANT: Quick-relief inhalers should only be used with both a licensed health professional's instructions and with consent from the student's parent or legal guardian.

Choking

Clearing a blocked airway may be critical to saving a student before the emergency medical team arrives. If the student is choking and responsive, follow the steps to clear the blocked airway. Repeat until the object is dislodged.

Have someone call 911.

Have someone notify the school nurse, if available.

Steps to clear a blocked airway:

- **For infants**
  Hold the infant face down on your arm, chest in your hand and infant's head lowered, give five slaps between the shoulder blades, then turn the infant face up, and using your fingers to press up on the breastbone, give five quick chest thrusts.
- **For older students**
  Get behind the student, make a fist with one hand and grasp it with the other hand just above the student's navel, pull the student close to you, and thrust your fist upward against the student's abdomen.
- A good cough is more effective than anything you can do.
- If student becomes unresponsive, start CPR.
- If the student is being transported to a medical facility, inform the student's parent or legal guardian and have them meet the student at the facility.
- Even if the object was dislodged, inform the student's parent or legal guardian. Advise them that the student must be seen by their healthcare provider.

In Washington State, minors at age 13 can independently and confidentially access outpatient mental health and substance abuse treatment services.

For inpatient services, parent or legal guardian permission is required. Some schools provide school-based behavioral health services. Please refer to your school or district policies regarding internal referral protocols and key contact people.

Mental Health

Many common mental illnesses and disorders, also called brain disorders, are treatable conditions, and symptoms of them are not always an emergency. Many students with mental illness are able to thrive at school. Sometimes, these conditions are undetected and untreated.[8]

Some common mental illnesses/brain disorders that affect adolescents include:[9]

- Depression, Bipolar Disorder and other mood disorders.
- Anxiety disorders.
- Eating disorders.
- Attention Deficit Hyperactivity Disorder (ADHD) and other behavioral disorders.

What is a mental health emergency?[10]

- Life threatening or likely to become life threatening.
- Threat of imminent harm to self or others, or harmful actions already taken (like hurting someone, taking an overdose of medication, or pulling out a weapon).
- Intoxication or self-injury that requires medical attention.
- Erratic or strange behavior that endangers the student's safety or others' safety (like behavior that is unpredictable and the student isn't able to control).

What should I do?

- **Call 911** or get a colleague to do so.
- Ensure other students' safety, with help from school security or other colleagues if possible.
- **Do not leave the student alone**, even for a moment.

- Do what you safely can to stabilize the student's safety, such as:
  - Removing harmful objects from the environment.
  - Helping the student de-escalate their behavior by helping them orient to reality, speaking in a calm and firm tone and helping them remember and use coping skills.
  - Seeking help from colleagues who can provide crisis intervention or first aid.
- Follow your school's crisis plan for emergencies.

What is a mental health crisis?[11]

- Not life-threatening.
- Evidence of emotional or behavioral distress that the student can't manage on their own:
  - Agitated, angry or emotionally distraught.
  - Threats of harm to self or others without action.
  - Serious symptoms of depression like withdrawal from friends and activities or self-loathing or hopeless talk.
  - Intoxication.
  - Erratic or strange behavior.

What should I do?

When a student is having a mental health crisis, use Youth Mental Health First Aid.

Youth Mental Health First Aid - ALGEE:[12]

Assess for risk of suicide.

Listen nonjudgmentally.

Give reassurance and information.

Encourage professional help.

Encourage self-help and other support strategies.

Tips for Youth Mental Health First Aid:

- Help the student de-escalate their behavior. Talk softly and calmly, repeat calming statements, and don't engage with power struggles or attempts to pick a fight.
- Seek support from a colleague with expertise in mental health, like a school nurse, counselor, social worker, psychologist or administrator.

- As you wait for that person to come to you or bring the student to that person, get more information. Use open-ended questions and a calm, supportive approach.
  - Has something happened to cause this crisis?
  - How does the student usually handle feelings like this?
  - Has the student used a very high dose of caffeine, alcohol, or any recreational drugs today? Are they currently intoxicated?
  - Does the student get any care for mental health now?
  - Does the student usually take medication that they haven't taken today?
- When that person arrives, help the student connect with them and communicate the answers to these questions.

Depression

Research indicates that depressive illnesses are disorders of the brain. Depression is a medical problem that ranges in severity, and depression can be treated.

Feeling sad or depressed for several days can lead to thoughts of suicide. Encourage and support treatment for individuals who may be depressed.[13]

- Immediately place the student in responsible hands, such as the school principal or counselor.
- Be patient, reassuring, and firm. Never dismiss feelings, instead point out realities and offer hope.
- Offer emotional support, understanding, patience, and encouragement. Talk to the student, and listen carefully.
- Encourage treatment. Remind students that with time and treatment, depression can subside.
- Watch for warning signs of suicide, severe self-destructive behavior, extreme agitation, irrational behavior, or threats to others. Never ignore comments about suicide, and report them to the school counselor, nurse, and/or principal.
- Have a school administrator, counselor, or nurse inform the student's parent or legal guardian. Advise them to consult with their healthcare provider immediately.
- Complete a written report of what happened.

For 24-hour help for crisis counseling and referrals, call the Washington Recovery Help Line at 1-866-789-1511.

Suicide Ideation

Warning signs of suicide include talking about killing oneself, giving away favorite things, talking, reading, and writing about death, and feeling isolated.

What should I do if a student appears to be considering suicide?

Every school is required to have a crisis plan in case a student is at risk of suicide (RCW 28A.320). Be familiar with yours, your role in it and where to find a copy quickly before you find yourself in a crisis!

- **Do not leave the student alone,** even for a moment.
- Know which of your colleagues have more training in suicide intervention. School nurses, counselors, social workers and psychologists are required to get training on suicide, so they are the appropriate people to reach out to for support early in this process.
- Maintain a caring, calm and nonjudgmental approach:[14]
  - **Show you care.** Ask the student open-ended questions about what you observe: "You seem very angry about something. Tell me more about what happened." or "You said you just don't want to be here anymore. What do you mean by that?" Listen to what the student has to say.
  - **Ask the question.** Ask calmly and directly about suicide: "Does that mean you plan to end your life?" or "Sometimes when people feel this way they think about suicide. Are you thinking about that?"
  - **Get help.** If the answer is yes, the National Suicide Prevention Lifeline (1-800-273-8255) is an immediate resource to use while waiting for a colleague with training on suicide to be available.
- Follow your school's crisis plan for suicide.
- Have a school administrator, counselor or nurse inform the student's parent or legal guardian. Advise them to consult with their healthcare provider immediately.

Call the National Suicide Prevention Lifeline, 1-800-273-8255 for additional information or support.

Alcohol and Drug Use

Look for inappropriate behavior, staggering, slurred speech, and dilated or constricted pupils.

- Know your school's policy on drug and alcohol use.
- Ensure an adult is available to monitor the student and watch for possible signs of overdose. Keep student in the clinic or health center if one exists.
- **Call 911** if the student loses consciousness.
- Have a school administrator, counselor or nurse inform the student's parent or legal guardian.
- If the student is being transported to a medical facility, inform the student's parent or legal guardian and have them meet the student at the facility.
- If not transported, advise the student's parent or legal guardian to have the student seen by their healthcare provider.
- Follow your school's reporting and communication procedures to ensure student support teams or school-based intervention specialists are appropriately informed.

Animal Bites

Secure the scene. Remove the student and others from the area. Call 911 if uncontrolled bleeding of wounds or if it involves a wild animal. Notify school nurse, if available.

If bitten by a dog, cat or ferret, inform animal control so owners can be located. Reporting of bites to local health jurisdiction will be determined by healthcare provider.

First Aid:

- Put on non-latex disposable gloves and follow standard precautions for exposure to blood and body fluids.
- Uncontrolled bleeding should be treated with direct pressure to wound(s) until EMS arrives.
- Wash minor wounds with soap and water.
- Cover with a bandage or dry dressing.
- For a minor injury in which the skin is not broken, wash the area with soap and rinse with water.
- Apply ice or cold pack. Always protect the skin by wrapping ice or a cold pack in a thin cloth. Direct contact of extreme cold on the skin can cause tissue damage.
- Inform the student's parent or legal guardian. Advise them to consult with their healthcare provider immediately and check on the student's last tetanus shot.

Bees, Insects, Spiders, Ticks

Call 911 if you know the bite is from a black widow or brown recluse spider. Call 911 if the student struggles to breathe or if the student is known to have severe allergic reactions.

Students with severe allergies should have an emergency care plan for taking medications and dealing with severe symptoms. Follow the plan. Have someone notify the school nurse, if available.

First Aid:

- Move the student to a safe area.
- If insects are on or in the clothing, remove clothing to prevent additional stings or bites.
- Watch the student carefully for allergic reactions to insect stings.
- Keep the student calm and quiet and keep the student from moving around.
- Put on non-latex disposable gloves.
- Remove the body and stinger of an insect, but do not squeeze.
- Scrape it out with a credit card, driver's license or similar stiff card.
- Caterpillar spines can be removed using the sticky side of tape.
- If possible, capture the spider, tick or insect for identification.
- Use tweezers to pull out a tick. Grasp the tick's body as close to the student's skin as possible with the tweezers and lift it in the direction it entered making a "tent" in the skin's surface. Hold it there until the tick lets go. This may take several seconds. Do not twist or jerk it out.
- Wash the bitten area with soap and water.
- Apply a sterile dressing or band-aid as needed.
- To reduce pain and swelling, place a cold pack wrapped in a cloth over the bitten area.
- Keep area elevated above the heart.
- **If the student becomes unresponsive and stops breathing, begin CPR and call 911**.
- Inform the student's parent or legal guardian. Advise them to consult with their healthcare provider.

Human Bites

Make sure the scene is safe. Have someone call 911 if the bite is serious or if there is uncontrolled bleeding. Have someone notify the school nurse, if available.

First Aid:

- Put on non-latex disposable gloves and follow standard precautions for exposure to blood and body fluids.
- Uncontrolled bleeding should be treated with direct pressure to wound(s) until EMS arrives.
- Wash the wound with soap and rinse with water.
- Cover with a bandage or dry dressing.
- Apply ice or cold pack. Always protect the skin by wrapping ice or a cold pack in a thin cloth. Direct contact of extreme cold on the skin can cause tissue damage.
- Inform the student's parent or legal guardian. Advise them to consult with their healthcare provider.

Amputation of a Finger (or Other Body Part)

Have someone call 911. Notify school nurse, if available.

First Aid:

- Put on non-latex disposable gloves and follow standard precautions for exposure to blood and body fluids.
- Have the student lie down.
- Apply direct pressure to the wound for at least five minutes to help stop the bleeding.
- Watch for signs of shock (see page 51).
- If the finger or other body part is still attached, keep it in a normal position as you apply pressure.
- Use sterile dressings over the wound while you apply pressure. If blood seeps through, add more dressings—**do not remove them**.
- If bleeding is hard to control, keep pressure on the wound, and also use your fingers to squeeze the pressure point on the inside of the upper arm just above the elbow.
- If the injury is on the lower body, press the palm of your hand on the pressure point at the top of the leg near the groin.
- If the finger or body part is detached, wrap it in clean gauze, put it in a plastic bag and put the bag on ice. The part should not be frozen or submerged in ice or water. Give it to the emergency medical team when they arrive.
- If the student is being transported to a medical facility, inform the student's parent or legal guardian and have them meet the student at the facility.
- Clean and disinfect any surfaces that came in contact with blood.

Bleeding

Have someone call 911 if bleeding is heavy or if there are signs of a puncture, stab, or other injuries, such as from a bad fall. Do not remove embedded object.

Students with bleeding disorders should have an emergency care plan for taking medications and dealing with bleeding. Follow the plan.

Have someone notify the school nurse, if available, especially when the bleeding is serious.

First Aid for Bleeding:

- Put on non-latex disposable gloves and follow standard precautions for exposure to blood and body fluids.
- Have the student lie down. Watch for signs of shock (see page 51).
- When bleeding is hard to control, apply direct pressure to the open wound with a clean dressing until the emergency medical team arrives or for at least five minutes. **Do not remove the dressing, but add more if needed.**

First Aid for Minor Cuts:

- Have the student apply direct pressure with a clean dressing or cloth for at least one to two minutes or until the bleeding has stopped.
- Once bleeding has stopped on a minor cut, slowly remove the dressing and wash the wound with soap and water.
- Apply a sterile dressing or band-aid.
- Inform the student's parent or legal guardian. If the bleeding is the result of an injury, advise them to check on the student's last tetanus shot. Advise them to have the student seen by their healthcare provider if the wound will not stay closed or may need stitches.
- Clean and disinfect any surfaces that came in contact with blood.

IMPORTANT: If you have direct contact with blood or body fluids, follow your school's exposure plan as required by the Washington Administrative Code on blood-borne pathogens.

Blisters

Do not open or pop a blister. Protect the blister with a band-aid or sterile dressing. This will help keep it from opening for as long as possible so the area can heal.

First Aid:

- If the blister has opened, put on non-latex disposable gloves and follow standard precautions for exposure to blood and body fluids.
- Wash the area with soap and warm water. Let it air dry.
- Apply a band-aid or sterile dressing.
- Inform the student's parent or legal guardian and advise them to check with their healthcare provider if the blister is inflamed or larger than a quarter.

Nosebleeds

If bleeding is severe and cannot be controlled after 15 minutes, call 911 and the student's parent or legal guardian. Notify the school nurse, if available.

First Aid:

- Put on non-latex disposable gloves and follow standard precautions for exposure to blood and body fluids.
- Keep the student sitting up.
- Gently pinch the soft parts of the nose together and gently press the nose against the bones of the face. If possible, have student do this. Have the student lean forward **Do not tilt the head back.**
- Hold for a full five minutes—do not peek to see if the bleeding has stopped.
- If available, place a cold pack or ice bag wrapped in a cloth on the nose and cheeks.
- **After five minutes**, release the pinch slowly. Reapply pressure for longer than five minutes if bleeding starts again.
- Have the student sit quietly until the bleeding stops. Tell him or her to avoid blowing or touching the nose.
- Inform the student's parent or legal guardian about recurrent nosebleeds.
- Clean and disinfect any surfaces that came in contact with blood.

Punctures, Scrapes, Splinters

Call 911 if the wound is severe. For deep wounds or large splinters notify the school nurse, if available, especially when the wound is serious. Do not try to remove the object.

First Aid:

- Put on non-latex disposable gloves and follow standard precautions for exposure to blood and body fluids.
- Clean the injury thoroughly and apply a sterile dressing or band-aid as needed.
  - **For minor punctures:** Do not try to pick out debris. Soak or wash in water. Do not use soap.
  - **For scrapes:** Apply pressure with gauze or a sterile dressing to stop bleeding, then wash the wound with soap and warm water.
  - **For splinters:** Remove small slivers close to the surface and wash the area with soap and warm water.
- Inform the student's parent or legal guardian, and advise them to check with their healthcare provider if further treatment is needed and to check on the student's last tetanus shot.
- Clean and disinfect any surfaces that came in contact with blood.

Skin Infections and Open Sores

Do not touch sores. Notify the school nurse, if available, especially when the infection or sore is serious.

First Aid:

- Put on non-latex disposable gloves and follow standard precautions for exposure to blood and body fluids.
- Have the student wash hands frequently or use alcohol-based sanitizer if soap and warm water are not available.
- Avoid contact with any pus or fluid.
- Cover the sore with a bandage taped on all sides.
- If the sore is leaking fluid, put on extra bandages or dressings taped on all sides.

- The student does not need to be removed from school unless the infection cannot be covered by a bandage or fluid cannot be contained in a bandage. If unsure, please consult the OSPI *Infectious Disease Control Guide*.[15]
- Inform the student's parent or legal guardian. Advise them to consult with their healthcare provider.

Take precautions:

- Everyone who has come in contact with the skin infection should wash their hands, including the student with the infection.
- Clean and disinfect with approved disinfectant all surfaces that came in contact with the infection.
- Dispose of contaminated items in a plastic bag and label it.

Swelling and Bruises

To control swelling, place a cold pack or ice bag wrapped in a cloth over the injury.

Call 911 if there are signs of other injuries or if the cause of the swelling is a severe crush injury, where the body part was squeezed or caught between two hard surfaces.

Have someone notify the school nurse, if available, especially when the swelling or bruise is serious.

First Aid:

- Wrap the area of the injury in stretchy gauze or elastic bandages.
- Leave the tips of fingers and toes exposed so you can tell if the area is wrapped too tightly.
- Elevate the injury unless you suspect a broken bone or crush injury.
- Apply ice or cold pack. Always protect the skin by wrapping ice or a cold pack in a thin cloth. Direct contact of extreme cold on the skin can cause tissue damage.
- Inform the student's parent or legal guardian, and advise them to check with their healthcare provider if further treatment is needed.

Back and Neck Injuries

Have someone call 911 if the student is unresponsive or if the student is unwilling to move a large body part.

Make sure the student does not move and that nobody moves the student unless absolutely necessary. Any movement of the neck or spine can make the injury worse. Let student remain in position as they are, without repositioning. Gently immobilize the head.

Have someone notify the school nurse, if available, especially when the injury is serious.

What to watch for:

- Inability to move arms or legs.
- Pain in the back or neck.
- Tenderness, swelling or bruising to back or neck.
- Headache or pain radiating through the shoulders.
- Desire to keep neck still.
- Signs of shock (see page 51).

First Aid:

- Keep the student warm and safe from further injury.
- Encourage the student to remain still and calm until the emergency medical team arrives.
- If the student is wearing a helmet, do not try to remove it.
- If the student is being transported to a medical facility, inform the student's parent or legal guardian and have them meet the student at the facility.

Broken Bone, Dislocation, Sprain, Strain

Have someone call 911 if bleeding is severe, if the student is unresponsive, or if the student is unwilling to move a large body part.

Have someone notify the school nurse, if available, especially when the injury is serious.

First Aid if Bone Broke Through Skin:

- Put on non-latex disposable gloves and control the bleeding. Apply pressure with sterile dressing. Do not move the ends of the bone.
- If the student must be moved, a splint helps prevent further injury. Use a folded blanket, magazine, or cardboard to support the injured part.
- Watch for signs of shock (see page 51).

First Aid for Minor Injuries:

- **Rest:** Find a comfortable position for the student, sitting or lying down. Encourage the student to remain still.
- **Ice:** Place a cold pack or ice bag wrapped in a cloth over the injured area for periods of 20 to 30 minutes.
- **Elevation:** Use pillows to stabilize the injured part above the level of the heart.

Burn Severity

The severity of a burn involves three factors: size, location and depth. Burns on the face, hands, feet and genitals are more serious than burns on other parts of the body. Larger and deeper burns are also more serious.

- **Superficial first-degree burns** involve only the top layer of skin.
- **Partial thickness or second degree burns** go deeper and cause blisters.
- **Full-thickness or third degree burns** damage the full depth of the skin and even muscle and nerve tissue.

First Aid for All Burns:

- Cool the burn right away in cool water. Do this for all degrees of burns. Use a container of cool water or a gently running water tap.
- If large areas of the body are burned, cool smaller sections with water for one or two minutes to avoid chilling the whole body.
- Use a cold damp cloth for areas you cannot put in water—re-wet it every few minutes.
- If the student is being transported to a medical facility, inform the student's parent or legal guardian and have them meet the student at the facility.

Chemical or Electrical Burn

Make sure the scene is safe before you get the student away from the source of the burn. Don't become another victim. Have someone call 911 if the burn involves eyes, face, hands, feet or genitals, or is a bigger area than the size of the student's palm (one percent of the body surface). Have someone notify the school nurse, if available, especially when the burn is serious.

First Aid for Chemical Burns:

- Immediately rinse chemical from eyes. If possible, position the student's head over a sink with the injured eye down.
  - **Dry chemical:** Brush any dry chemicals off of the skin and then rinse under a tap continuously for 15 to 20 minutes. Take care not to get any in your eyes or the student's eyes.
  - **Wet chemical:** Flush affected areas with large amounts of cool running water for at least 20 minutes or until emergency personnel take over.

First Aid for Electrical Burns:

- Do not go near the person until the power is shut off. If a power line is down, wait for the fire department or power company.
- Electrical burns and burns of the face, hands and genitals need treatment by a medical professional.

Heat, Flames, or Sun Burn

Have someone call 911 if the burn involves eyes, face, hands, feet, or genitals, or is a bigger area than the size of the student's palm (one percent of the body surface).

Do NOT use cotton, salves, ointments or ice packs. Do not give the student anything to eat or drink. Have someone notify the school nurse, if available.

First Aid:

- Get the student safely away from the source of the burn—out of the sun or away from flames.
- Cool the burn right away in cool water. Do this for all degrees of burns. Use a container of cool water or a gently running water tap.
- If large areas of the body are burned, cool smaller sections with water for one or two minutes to avoid chilling the whole body.
- Use a cold damp cloth for areas you cannot put in water—re-wet it every few minutes.
- For extensive or severe burns, treat for shock (see page 51).
- If the student is being transported to a medical facility, inform the student's parent or legal guardian and have them meet the student at the facility.

Diabetes

Diabetes is a condition in which the body cannot regulate the sugars in the blood stream. A student with Type 1 diabetes requires manufactured insulin by injection (or other routes) because the pancreas stops making insulin. A student with Type 2 diabetes may still make insulin but it may not be enough or can't be utilized by the cells.

The school nurse will consult and coordinate with the student's parents and healthcare provider in the creation of an **Individual Health Care Plan/ Section 504 Plan** prior to the student attending school. The school nurse will train and supervise appropriate school staff in the proper care and procedures for the care of the student with diabetes.

A Parent Designated Adult (PDA) may also provide care. A PDA is a volunteer who may be a school employee, who receives additional training from a healthcare professional or expert in diabetes care. The PDA is selected by the parents and provides care consistent with the individual health plan. The care delivered by a PDA would otherwise be performed by a licensed health professional.

Diabetic Emergencies

Hypoglycemia (low blood sugar)[16] is a sudden, potentially life threatening event in a student who takes insulin. It is defined as a blood sugar below 70mg/dl. This condition can develop in minutes and requires immediate attention.

Symptoms :

- Irritability
- Anxiety
- Paleness
- Drowsiness
- Lethargy
- Trembling
- Shakiness
- Excessive sweating
- Weakness
- Dizziness
- Confusion
- Slurred speech
- Poor coordination
- Staggering
- Loss of responsiveness
- Seizures
- Fatigue
- Blurred vision

DO NOT LEAVE STUDENT ALONE

Treatment of low blood sugar should not be withheld if testing is unavailable and student is symptomatic.

First Aid:

- **Mild to moderate low blood sugar:**
  - Follow Student's Individual Health Plan for testing and treatment. Student can self-treat, or where needed by all school staff. Call school nurse or PDA as indicated in plan.
  - Student will ingest 15 grams of quick carbohydrates. *(Example: 4 oz. juice, 3 tsp glucose jell, 3–4 glucose tabs)*
  - Wait 15 minutes.
  - Student or appropriate staff will recheck blood sugar. If blood sugar is still below 70 mg/dl or symptoms persist, repeat with 15 grams quick sugar.
  - Recheck blood sugar in 15 minutes.
  - If blood sugar is above 70mg/dl, follow with a protein/complex carbohydrate snack (cheese and crackers) if next meal is more than one-half hour away.
  - If blood sugar continues to be below 70mg/dl, follow emergency instructions in Individual Health Care Plan. **Call 911 if unsure.**
- **Severe low blood sugar:**
  - Student may be unable to swallow, be unconscious or have a seizure.
  - Do not give anything by mouth.
  - Roll student on their side. **Call 911**.
  - School nurse or PDA may give Glucagon per healthcare provider order.
  - Be prepared to perform CPR.
- If the student is being transported to a medical facility, inform the student's parent or legal guardian and have them meet the student at the facility.

Hyperglycemia (high blood sugar)[17] is defined as blood sugar above 240mg/dl. It usually occurs over hours or days. It can be an emergency if it develops into diabetic ketoacidosis (DKA). If untreated it can lead to coma or death.

Symptoms:

- Extreme thirst
- Frequent urination
- Drowsiness
- Difficulty concentrating
- Fruity smell on student's breath
- Fast breathing
- Warm dry skin
- Nausea and vomiting
- Headache
- Loss of responsiveness

First Aid:

- Follow the Individual Health Plan for testing and treatment of hyperglycemia. Call school nurse, PDA or designated staff for assistance.
- Encourage water or sugar free fluid consumption.
- Check for ketones as indicated in plan.
- **Call 911 if student is unconscious.** Place on side. Be prepared to perform CPR.
- If the student is being transported to a medical facility, inform the student's parent or legal guardian and have them meet the student at the facility.

Type 2 Diabetes

Type 2 Diabetes is primarily a disease of insulin resistance. There are complex factors of heredity, ethnicity and environmental factors such as obesity and physical inactivity. Average age of onset is 12–14 years of age.

Symptoms you may see:

- Fatigue
- Thirst
- Weight loss
- Blurred vision
- Frequent infections and poor wound healing

First Aid:

- Follow the student's Individual Health Plan. Appropriate staff may give medications or treatments that may be prescribed by healthcare provider.
- Inform school nurse and student's parents or legal guardian of health concerns.

Chemical in the Eye

Hold the injured eye open and flush the eye with clean, lukewarm water. Have someone call the Washington Poison Center, 1-800-222-1222. Follow their instructions. Have someone notify the school nurse, if available.

First Aid:

- Put on non-latex disposable gloves.
- If possible, position the student's head over a sink with the injured eye down.
- Keep the student as still as possible.
- Rinse the eye by running water into the inside corner of the eye (by the nose) for 15 to 20 minutes or until the emergency medical team arrives.
- If the student is being transported to a medical facility, inform the student's parent or legal guardian and have them meet the student at the facility.
- If the student is not transported, advise the student's parent or legal guardian that the student must be seen by their healthcare provider.

Cuts to the Eye or Lid and Minor Bruising

Have someone notify the school nurse, if available.

First Aid for Cuts to the Eye or Eye Lid:

- Put on non-latex disposable gloves.
- Keep the student in a seated position.
- Cover the eye with a gauze pad and bandage loosely or an eye shield if the student can tolerate it.
- Do not try to flush the eye with water.
- Do not apply pressure to control bleeding.
- Do not apply any medicine, drops, or ointment to the eye.

First Aid for Minor Bruises:

- Gently place a cold pack or ice bag wrapped in a wet cloth over the injured eye for 10 to 15 minutes.
- Inform the student's parent or legal guardian. Advise them to consult with their healthcare provider.

Penetrating Object in the Eye

For penetrating eye injuries, have someone call 911. Have someone notify the school nurse, if available.

First Aid:

- Put on non-latex disposable gloves.
- Keep the student as quiet and still as possible. The best position is for the student to lie flat on his/her back. Don't force the student to lie in this position if they resist.
- Never attempt to remove the penetrating object. Never put pressure on the eye.
- If the student is being transported to a medical facility, inform the student's parent or legal guardian and have them meet the student at the facility.

Small Object in the Eye

Small objects, like dust or hair, can usually be removed.

First Aid:

- Put on non-latex disposable gloves.
- Gently pull down the lower eyelid while the student looks up, and try to find the object.
- Wipe the inner surface of the lower lid with clean, wet gauze.
- Gently lifting the upper lid out and down will produce tears that can help wash the object out of the eye.
- If the object remains, flush the eye with clean, lukewarm water.
- Inform the student's parent or legal guardian. Advise them to consult with their healthcare provider.

Head Injury (Concussion)

Call 911 if the head injury is severe and there are signs of shock (see page 51). Consider the possibility of a spinal injury when caring for a student with a head injury. Move student only if necessary. Watch for loss of consciousness or seizure. Notify the school nurse, if available.

Signs of Head Injury (concussion):

- Unresponsiveness for any length of time.
- Confusion or memory loss.
- Unusual sleepiness.
- Listless or tires easily.
- Agitation, irritability or combativeness.
- Pale and sweaty skin.
- Nausea or vomiting.
- Severe headache or dizziness.
- Blurred vision.
- Trouble with walking or balance.
- Slurred speech; slowness in responding to questions.
- Seizure.
- Blood or clear fluid persistently dripping from nostril or ear canal.
- Loss of bowel/bladder control (when unusual for that student).

First Aid:

- **If student is vomiting and has a head injury, call 911**.
- Try to determine the cause of the head injury. Even slight bumps can cause a concussion and have serious effects.
- Watch for signs of a concussion.
- Keep the student dry and warm.
- Place a cold pack or ice bag wrapped in a cloth on the injury for 10 to 15 minutes to reduce swelling.
- Do not allow the student to continue to participate in sports or physical activities if there is reason to suspect a concussion.

IMPORTANT: Inform the student's parent or legal guardian and advise them to consult with their healthcare provider immediately.

Loss of Consciousness and Fainting

Fainting is a temporary loss of consciousness that may have many possible causes. The episode is usually brief, typically lasting for less than a minute.

Call 911 if the student remains unresponsive for more than a minute. Notify the school nurse, if available.

Possible causes:

- Diabetic condition or low blood sugar.
- Choking.
- Not eating.
- Dehydration.
- Injury or blood loss.
- Allergic reaction or poisoning.
- Holding one's breath or hyperventilating.
- Fatigue or illness.
- Standing for a long time.
- Being too warm.
- Use of drugs or alcohol.
- Stress, fear, emotional upset.
- Heart problems.

First Aid:

- Lay the student on his/her back and check for breathing.
- If not breathing, go to page 11 and follow the steps for Breathing Stopped. **Have someone call 911.**
- Prop the legs up on a pillow or rolled towel to increase blood flow to the brain.
- Loosen tight clothing.
- Do not give anything by mouth.
- Write down details of what happened, including the amount of time the student was unconscious, possible cause, and other signs or symptoms.
- Inform the student's parent or legal guardian. Advise them to consult with their healthcare provider.

Heat Exhaustion and Heat Stroke

Heat related injuries can be life threatening if not recognized. These injuries can develop when students are exposed to hot temperatures, actively playing, sweating or overly clothed. Students do not regulate body temperature as effectively as adults.

If these conditions are suspected, call the school nurse for assistance, if available. Be prepared to call 911.

Signs and Symptoms of Heat Exhaustion

- Flushed (red) skin, especially in the face.
- Moist, sweaty skin.
- Nausea and vomiting.
- Headache.
- Thirsty, dry tongue and mouth.
- Dizziness.
- Fainting from standing up too fast.
- Fatigue.
- Fast breathing rate.
- Normal to slightly elevated body temperature.

First Aid Care for Heat Exhaustion:

- Move student to cool place.
- Remove outer clothing.
- Pour cool water on skin.
- Continue to rinse and reapply cool cloths once they become warmed by the body.
- Place cool cloths on skin and direct a fan towards student.
- Have student drink lots of water.
- Inform the student's parent or legal guardian. Advise them to consult with their healthcare provider.
- If student does not improve or cannot drink fluids, **call 911**.

Signs and Symptoms of Heat Stroke (Life-threatening)

- Flushed (red) face and skin.
- Dry hot skin (not sweating).
- Confusion or disorientation.
- Unresponsiveness.
- High body temperature (104°F or higher).
- Progression to seizures, stroke or cardiac arrest.

First Aid for Heat Stroke:

- **Call 911**.
- Call the student's parent or legal guardian.
- Cool the student immediately.
- Remove outer clothing.
- Pour cool water over student's skin.
- Direct fan towards student.
- Put ice packs, wrapped in cloths in armpit and groin areas.
- Do not try to give fluids by mouth because students with heatstroke are not alert to safely swallow.

IMPORTANT: Heat stroke is life threatening. Be prepared to perform CPR if student becomes unresponsive. Call 911 if suspected. If the student is being transported to a medical facility, inform the student's parent or legal guardian and have them meet the student at the facility.

Hypothermia and Frostbite

Call 911 if the student is severely chilled and sluggish. Bring the student to a warm place. Notify the school nurse, if available.

First Aid for Hypothermia

Call 911—this is a life threatening condition that occurs when the body loses heat faster than it can produce heat. A student with hypothermia has a dangerously low body temperature (lower than 95°F).

- Until you can get the student to a warm room, hug the student close to your body.
- Strip off cold, wet clothes, socks and shoes. Replace with dry clothes and wrap the student in blankets.

First Aid for Frostbite:

I**njury caused by freezing of body tissues.**

- Allow toes, fingers, and ears to return to normal body temperature slowly.
- Do not rub toes, fingers, ears, or skin.
- Do not break any blisters, but wrap any that have broken in gauze.
- If toes or fingers are damaged, put dry gauze between them to keep them from rubbing.

The difference between frostnip (mild injury that affects areas exposed to the cold) and frostbite:

- If affected area returns to normal appearance after rewarming, the student has **frostnip** and does not need immediate medical care. Inform the student's parent or legal guardian to consult with their healthcare provider.
- If the area is very red, very pale, swollen or has blisters, the student has **frostbite**. Notify the student's parent or legal guardian that the student needs immediate medical care.

Oral Injuries

For treating any oral injury, always put on non-latex disposable gloves and follow standard precautions for exposure to blood and body fluids.

Abscesses and Toothaches

First Aid:

- Have the student rinse the mouth with warm saline solution.
- Use dental floss to remove anything trapped between teeth.
- Apply cold compresses to the jaw for up to 20 minutes.
- Inform the student's parent or legal guardian. Advise them to see a dentist as soon as possible.

Bleeding After Losing a Baby Tooth

First Aid:

- Put a clean, folded gauze pad over the spot that is bleeding.
- Have the student bite on the gauze with pressure for 15 minutes.
- Change the gauze and repeat if necessary. Avoid rinsing.
- Inform the student's parent or legal guardian. Advise them to consult a dentist if bleeding doesn't stop.

Braces and Wires Broken

First Aid:

- Broken wires can be covered with gauze until the student can be seen by an orthodontist.
- Do not remove wire embedded in the cheek, tongue or gums.
- Inform the student's parent or legal guardian. Advise them to see an orthodontist immediately.

Broken Tooth

First Aid:

- Gently clean dirt from the injured area with warm water.
- Place a cold pack or ice bag wrapped in a cloth on the face over the injured area.
- Inform the student's parent or legal guardian. Advise them to see a dentist immediately.

Displaced Tooth

First Aid:

- Position the student so that bleeding does not cause choking.
- Have the student rinse mouth with cold water.
- Have student bite down on a wad of gauze to help control bleeding or to stabilize the tooth.
- Apply ice or cold pack wrapped in a thin cloth over the injured area (on the face) if there is any swelling.
- Inform the student's parent or legal guardian. Advise them to see a dentist as soon as possible.

Permanent Tooth Knocked Out

First Aid:

- Have someone notify the school nurse, if available, when the injury is severe.
- Find the tooth. The faster you act, the better the chances of saving the tooth.
- Handle the tooth by its crown, not the root.
- If the tooth is dirty, gently rinse it with water. Do NOT scrub antiseptic on the tooth.
- Gently put the tooth back into its socket, making sure that the front of the tooth is facing you.
- Have the student hold the tooth in place with clean gauze.
- If the tooth cannot be reinserted into the socket, put the tooth into a cup of fresh milk, or a zip lock bag with some of the student's saliva. Or wrap the tooth in a clean wet cloth.
- Apply gentle pressure on the socket if bleeding continues.
- Do not remove the blood clot from the socket—it is important for healing.
- Inform the student's parent or legal guardian. Advise them to see a dentist immediately.

Jaw Injury – Broken or Dislocated

A broken or dislocated jaw requires prompt medical attention because of the risk of breathing problems or bleeding.

Have someone call 911. Have someone notify the school nurse, if available.

Symptoms of a Broken Jaw:

- Bleeding from the mouth.
- Difficulty opening the mouth widely.
- Facial bruising.
- Facial swelling.
- Jaw stiffness.
- Jaw tenderness or pain, worse with biting or chewing.
- Loose or damaged teeth.
- Lump or abnormal appearance of the cheek or jaw.
- Numbness of the face (particularly the lower lip).
- Very limited movement of the jaw (with severe fracture).

First Aid:

- Temporarily bandaging the jaw (around the top of the head) to prevent it from moving may help reduce pain.
- If the student is being transported to a medical facility, inform the student's parent or legal guardian and have them meet the student at the facility.

Symptoms of a Dislocated Jaw:

- Bite that feels "off" or crooked.
- Difficulty speaking.
- Drooling because of inability to close the mouth.
- Inability to close the mouth.
- Jaw that may protrude forward.
- Pain in the face or jaw, located in front of the ear or on the affected side, and gets worse with movement.
- Teeth that do not line up properly.
- The student's jaw line may appear distorted.

First Aid:

- Keep the student still and calm and try to keep the student from moving.
- Make sure the student can breathe.
- If the student is being transported to a medical facility, inform the student's parent or legal guardian and have them meet the student at the facility.

Lip, Cheek, or Tongue Cut or Bitten

First Aid:

- Have student rinse their mouth with water so that the site of injury can be identified.
- Gently clean the area of the injury with a clean, wet cloth.
- Apply pressure with gauze to stop the bleeding.
- Place a cold pack or ice bag wrapped in a cloth over the injury to control swelling.
- Inform the student's parent or legal guardian. Advise them to see a healthcare provider or dentist, especially if the injury is deep or bleeding doesn't stop easily.

Poisoning

Ingested Poison

If the student is unresponsive, have someone call 911. Have someone notify the school nurse, if available.

Watch for one or more of the following:

- Open container of medicine, chemical, illegal drug or alcohol.
- Spilled liquid, medication, or drug on the floor or on the student.
- Unusual odor from the student's mouth or clothes.
- Burns in and around the mouth indicating contact with a corrosive chemical.
- Nausea or vomiting.
- Abdominal pain or diarrhea.
- Drowsiness.
- Unresponsiveness.

First Aid

- If the student is responsive, gather the following information and call the Washington Poison Center, 1-800-222-1222:
  - Age and weight of the student.
  - What was swallowed, the amount and when.
  - The student's condition.
- **If the student is unresponsive and breathing, call 911** and place them on their side. This position helps keep the airway open and allows vomit to drain from the mouth.
- If the student is being transported to a medical facility, inform the student's parent or legal guardian and have them meet the student at the facility.

Inhaled Poison

Make sure the scene is safe before you remove the student from the toxic area. Don't become another victim. If the student is unresponsive, have someone call 911. Have someone notify the school nurse, if available.

Watch for one or more of the following:

- Source of fumes that may or may not have an odor
- Change in student's behavior
- Change in student's appearance

First Aid:

- If the student is responsive, gather the following information and call the Washington Poison Center, 1-800-222-1222:
  - Age and weight of the student.
  - What was inhaled, the amount and when.
  - The student's condition.
- If the student is being transported to a medical facility, inform the student's parent or legal guardian and have them meet the student at the facility.

Poisonous Plants

If the student's skin is exposed to poisonous plants have them immediately wash the skin with soap and running water.

Watch for one or more of the following symptoms:

- Rash
- Itching
- Blisters
- Swelling
- Redness

First Aid:

- Put on non-latex disposable gloves to protect yourself.
- Gather the following information and call the Washington Poison Center, 1-800-222-1222:
  - Age and weight of the student.
  - What and where the poison touched the student's skin, and when.
  - The student's condition.
- Clean the area to remove plant oil. Wash the skin immediately with soap and running water.
- Save a sample of the plant.
- Have the student change out of clothing that was exposed. Put the clothing in a plastic bag.
- Watch for allergic reactions.
- Inform the student's parent or legal guardian.

Pregnancy Complications and Miscarriage

Symptoms are severe vaginal bleeding with abdominal pain and severe cramping or leaking of amniotic fluid. Symptoms may include fever, fainting, or dizziness. Complications may include ectopic pregnancy and placenta previa.

Call 911 if bleeding is heavy and pain is severe.

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

- A miscarriage may happen over several days and may not be just one event.
- Bleeding may be light to heavy.
- Bleeding and pain together may be a sign of miscarriage. Pain may start a few hours to several days after bleeding.
- Amniotic Fluid Leakage: This is NOT normal and may indicate the beginning of labor.

First Aid:

- Put on non-latex disposable gloves and follow standard precautions for exposure to blood and body fluids.
- Refer for immediate medical assistance for cramping and bleeding.
- The student should be seen immediately by a healthcare provider if miscarriage is suspected.

Convulsive

Lay the student on his/her left side on the floor. This helps keep the airway clear. Have someone notify the school nurse, if available, especially when the seizure is serious.

The student may have an early warning of a seizure (known as an aura) or may shout and fall down.

Call 911 if:

- The seizure lasts for more than three to five minutes.
- The student has trouble breathing.
- The student is seriously injured.
- The student has never had a seizure before.

First Aid:

- Follow the student's Individual Health Plan if there is a history of seizures.
- Move toys and furniture out of the way so the student won't get injured.
- Protect the student's head with a towel, blanket, or clothing. Or slide your palm under the head to protect it. Be careful not to put yourself in danger.
- Loosen tight clothing.
- Note about how long the seizure lasts. Note the body parts that are affected. Your detailed description can be important for the healthcare provider.
- Let the student rest while lying on their side after the seizure.
- Stay calm and try to offer privacy where possible.
- Do not try to restrain the student or stop the convulsions.
- NEVER put anything into the student's mouth.
- Inform the student's parent or legal guardian.

Nonconvulsive

Make sure the student is in a safe place to avoid injury. Have someone notify the school nurse, if available.

Watch if the student:

- Has a blank look on face.
- Is unable to speak or move.
- Acts in odd ways.
- Chews or smacks lips.
- Fiddles with clothing.

First Aid:

- Note about how long the seizure lasts.
- Stay with the student and be reassuring. Convulsions may follow.
- Let the student rest.
- Follow the student's individual health plan if there is a history of seizures.
- Inform the student's parent or legal guardian. Advise them to consult with their healthcare provider.

Treatment for Shock

Shock may develop when a person is suddenly injured, bleeding, or ill. Even mild injuries or witnessing a traumatic injury or illness can lead to shock.

Call 911 if you think someone is in shock. Notify the school nurse, if available.

Signs of shock include:

- Restless or irritable.
- Nauseated or vomiting.
- Is experiencing an altered level of consciousness (drowsy, confused or loses consciousness).
- Has pale, cool or moist skin.
- Has a blue tinge to lips and fingernails.
- Is breathing rapidly and has a rapid pulse.

First Aid:

- **Treat as a medical emergency—call 911.**
- Do not move them if they have a head, neck, or back injury.
- Otherwise, have them lie down.
- Keep them dry and warm.
- Give nothing by mouth.
- Stop any bleeding.
- Keep them calm.

Abdominal Pain, Stomachache, Cramps

Abdominal pain is pain or discomfort encompassing the area between the bottom of the rib cage to the groin creases. The causes are varied and range from mild to life-threatening. It is one of the most common reasons for health room visits in school.

Always verify whether a student has an Individual Health Plan that addresses a chronic health condition that may cause abdominal pain. Follow the student's plan of care.

Call 911 anytime a student is unable to stand or move when complaining of abdominal pain.

For a student with an unknown cause of abdominal pain:

- Have the student lie down and rest in a comfortable position. Give nothing by mouth.
- Offer access to restroom.
- Ask the student about the quality, duration, location and severity of pain.
- Check temperature.
- Report to school nurse and call student's parent or legal guardian with report of symptoms. Mild causes of abdominal pain usually resolve within 2 hours or less.

Parents should seek immediate medical attention if:

- Pain becomes more severe.
- Pain is constant for over 2 hours.
- Student looks and acts sick.
- There is a history of injury.
- There is blood in stool or vomit.

Cold and Flu

Have the student cover coughs and sneezes with a tissue or shirt sleeve. Instruct the student to wash hands frequently.

- Make sure the student is in a comfortable position.
- Take the student's temperature. Allow the student to rest, and retake temperature.
- Do not send student home on bus if temperature is above 100.4°F or student appears ill and listless.
- Inform the student's parent or legal guardian.

Diarrhea

Diarrhea is caused by a number of things including viruses, bacteria, or parasites. It may be infectious. Watch for other symptoms such as vomiting, fever, and abdominal pain.

- Have the student wash hands thoroughly and frequently.
- Take the student's temperature. Allow the student to rest, and retake temperature.
- Have the student take small sips of water.
- Inform the student's parent or legal guardian.
- In all cases of persistent diarrhea, especially with fever and cramps, the student must be seen by their healthcare provider.
- If several students suddenly have diarrhea, notify your local health jurisdiction.

Ear Pain

Ear pain is often caused by a cold or flu. Watch for other symptoms such as fever, difficulty hearing, severe pain, irritability, discharge, and swelling around the ear.

- Make sure the student is in a comfortable position.
- Take the student's temperature. Allow the student to rest, and retake temperature.
- Never try to probe or remove an item from the ear; this requires medical attention.
- Inform the student's parent or legal guardian. Advise them to consult with their healthcare provider.

Fever

Low fever without other symptoms is not harmful or a reason to send a student home. If the student's fever is over 100.4°F call a parent or legal guardian. Check for the cause of the fever and monitor for other symptoms.

- Make sure the student is in a comfortable position but do not provide blankets for chill—try to warm room instead.
- Check to see if the student is overheated. See the section on Heat Stroke and Heat Exhaustion (page 39).
- Inform the student's parent or legal guardian. Advise them to consult with their healthcare provider.

Headache

Most headaches are minor and will go away without treatment.

- Have the student lie down in a darkened room.
- Place a cool, wet cloth on the forehead to relieve pain.
- Only give medication prescribed by healthcare provider.
- Inform a parent or legal guardian. Advise them to consult with their healthcare provider.

Severe or sudden headaches with a stiff neck and vomiting may be a sign of meningitis, a life-threatening infection. **Call 911 if you suspect meningitis.**

Head Lice

Head lice are parasitic insects that feed on the blood of the scalp. They lay eggs on the hair shaft until they hatch. Outbreaks are common and are not a sign of poor hygiene. Infestations are not a health hazard and do not spread any disease. It is principally a nuisance.

Lice is spread mainly from head-to-head contact. It is less commonly spread from inanimate objects. Call your school nurse for school and family support.

Watch for:

- Itching of head and scalp.
- Detection of live lice.
- Presence of nits (e.g., eggs or the young forms of a head louse attached to human hair).
- Sores and scratch marks on the head from scratching.
- Irritability and trouble sleeping reported.

How to respond:

- Put on non-latex disposable gloves and follow standard precautions for exposure to blood and body fluids.
- Maintain student confidentiality and refer to your district infection control policy and procedure protocol for head lice. Student with head lice may remain in class and go home at the end of the day.
- Notify the student's parent or legal guardian of suspected case and recommend they contact their healthcare provider or the school nurse for more information about treatment options.

Nausea and Vomiting

Viral infections are the most common cause of nausea and vomiting and are often contagious. Notify the school nurse, if available.

- Put on non-latex disposable gloves and follow standard precautions for exposure to blood and body fluids.
- Keep the student away from other students.
- Have the student lie down.
- Watch for other symptoms.
- If symptoms continue, student needs to be picked up. Call the student's parent or legal guardian.

Scabies

Scabies is an itchy, contagious skin infestation caused by a mite. It affects persons from all socioeconomic levels without regard to age, sex or standards of personal hygiene. The infestation is usually spread by prolonged close personal contact or contact with infested objects such as towels, bedding or clothing.

What you should look for:

- Rash of itchy bumps or blisters.
- Severe itching that is worse at night.
- Older students and adults may tend to have the rash between fingers, wrist, toes, waist or groin with visible tiny red lines about ½ inch long.

How to respond:

- Consider referring to school nurse to determine need for evaluation by healthcare provider.
- A student with mild cases may stay in school until the end of the day.
- Refer to school district infection control protocols.

Emergency Response to School-wide Event

Know your school's plan for handling emergencies, including responsibilities of administrators and staff.

- **Bomb threat:** EVACUATE!
- **Chemical spill:** If the chemical spill is in your room or nearby, evacuate. If the chemical spill is outside of the building, shelter in place. Close and seal doors and windows.
- **Earthquake:** Drop, cover under a desk or table, and hold. Turn away from windows. Evacuate only if instructed to do so.
- **Fire:** EVACUATE! Turn off lights. Close door as you leave.
- **Intruder:** Lock-down.
- **Power outage:** Shelter in place. Turn off computers, lights and electrical devices.
- **Radiation leak:** Shelter in place.
- **Threat outside of the building:** Modified lock-down.
- **Tsunami warning:** Evacuate.

Evacuate:

- Take students out of the building to an emergency assembly area or evacuation route.
- Bring any students in hallways with you.
- Stay away from overhangs, windows, and power lines.
- Keep your class separate from other classes.
- Take attendance.
- Follow school procedures for students being picked up or released to parents or legal guardians.

Shelter in Place:

- Move students to your assigned shelter location.
- Bring any students in hallways with you to the shelter location.
- Lock exterior doors near your room.
- Keep students calm and busy.
- Take attendance.
- Use e-mail or text message. Do not use phone to call.
- Close windows and seal them if directed.
- Turn off classroom heating and air vents. Cover vents.

Lock-down:

- Move students indoors.
- Bring any students in hallways into your room.
- Lock all doors, including exterior doors near your room.
- Close windows and blinds. Cover exposed windows.
- Turn off lights.
- Have students remain quiet. Stay low and out of sight.
- Use e-mail or text message. Do not use phone to call.
- Let the office know about any threats.
- Take attendance.

Modified Lock-down:

- Lock exterior doors near your room.
- Close windows and blinds. Cover exposed windows.
- Stop the movement of students between buildings or in halls.
- Bring students in from outside if it is safe to do so.
- Allow only known persons into the school or room.
- Reassure students by keeping calm and keeping them busy.
- Use e-mail or text message. Do not use phone to call.

Standard Precautions to Prevent Infection

These precautions help prevent the spread of germs to both you and the student. Assume that everyone can be the source of infections and everyone needs to be protected.

Follow instructions in the OSPI's *Infectious Disease Control Guide* for cleaning and disposal of contaminated materials.

Avoid direct contact with blood and other body fluids:

- Use a barrier between you and the body fluids, such as gloves, sterile dressings, cloths or tissues.
- Use non-latex disposable gloves if possible. Do not reuse gloves.
- Wash your hands frequently with soap and warm water.
- To avoid contact with blood, have the student hold a bandage or cloth over the area that is bleeding, if able.

Clean and sanitize contaminated surfaces, including sports equipment:

- Use disposable gloves and disposable cleaning materials.
- Wipe up the body fluids.
- Use a detergent to wash the surface, and rinse with water.
- Clean again with a sanitizing solution, such as one tablespoon of bleach in one quart of water, or other appropriate disinfectant.
- Remove and launder contaminated clothing as soon as possible.

Dispose of contaminated items and cleaning materials:

- Seal all contaminated materials, including gloves, in a plastic bag.
- Dispose of the bag in a plastic-lined trash can.
- Label the trash bag: "Contains blood and body fluids."
- Wash your hands thoroughly with soap and warm water.

IMPORTANT: If you have direct contact with blood or body fluids, follow your school's exposure plan as required by the Washington Administrative Code on blood-borne pathogens.

504 Evaluation

All students with health impairments should be considered for a 504 referral and evaluation. This includes, but is not limited to, students with life threatening conditions. It also includes students with impairments that are episodic or in remission. Best practice is to notify the school nurse, school counselor, and 504 coordinator when a student has a health impairment so that the student can be assessed for a 504 evaluation.

A 504 plan describes the accommodations, aids and services a student needs due to disability (as is very broadly defined for purposes of Section 504) during school related activities to participate and benefit from their education. A student is protected under Section 504 if they have an impairment that substantially limits one or more major life activities.

Health related issues that warrant a 504 evaluation include those that impact a student:

- Bending
- Breathing
- Caring for oneself
- Communicating
- Concentrating
- Eating
- Hearing
- Learning
- Lifting
- Performing manual tasks
- Reading
- Seeing
- Sleeping
- Speaking
- Standing
- Thinking
- Walking

IMPORTANT: There is no exhaustive list of impairments or of major life activities that impairment might substantially limit. No one person makes these determinations. This is the responsibility of a 504 team.

First Aid Supplies Checklist

Always check to see if your supplies are complete and are not out-of-date:

- Adhesive tape
- Band-aids (various sizes), including nonstick dressings
- Blankets
- CPR breathing barrier
- Elastic bandages (2", 4", 6")
- Eye bandages
- Eye shield
- Gauze squares (3", 4")
- Ice bags or instant cold packs
- Non-latex disposable gloves
- Paper bags, cups, towels
- Pencil or pen and pad of paper
- Plastic bags
- Roller bandage (3", 4" wide)
- Rubbing alcohol (for cleaning instruments)
- Safety pins
- Saline solution (sterile)
- Scissors
- Sanitizing solutions, hand sanitizer
- Soap (mild liquid)
- Splints
- Thermometer, digital
- Tissues
- Towels, disposable
- Triangle bandages
- Tweezers

IMPORTANT: Emergency medications should be included based on a specific student's care plan. Medications should be given only when provided by parent and prescribed by a primary healthcare provider (RCW 28A.210.260 and 270 and district policy). A statement signed by parent and provider authorizing use of medications should be kept at school and updated annually.

Health and Safety Resources

- American Diabetes Association
  www.diabetes.org
- Asthma and Allergy Foundation of America
  www.aafa.org
- Epilepsy Foundation Northwest
  www.epilepsynw.org
- Infectious Disease Control Guide for School Staff
  www.k12.wa.us/HealthServices/pubdocs/InfectiousDiseaseControlGuide.pdf
- OSPI Health Services
  www.k12.wa.us/HealthServices/default.aspx
- Seattle Children's Safety Resources
  www.seattlechildrens.org/safety-wellness/safety/
- School Nurse Corps Contact List
  www.k12.wa.us/HealthServices/SchoolNurse.aspx
- School Staff Health Training Guide
  www.k12.wa.us/HealthServices/pubdocs/WAStateSchoolStaffHealthTrainingGuide.pdf
- Student Health Services Guidebook
  www.esd105.org/Page/494
- Youth Mental Health First Aid Training
  www.mentalhealthfirstaid.org/cs/take-a-course/course-types/youth/

Resources and References

References

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3 Infectious Disease Control Guide. (2014) Office of Superintendent of Public Instruction. http://www.k12.wa.us/HealthServices/pubdocs/InfectiousDiseaseControlGuide.pdf

4 OSPI Health Services. Office of Superintendent of Public Instruction. http://www.k12.wa.us/HealthServices/Resources.aspx

5 School Nursing: A Comprehensive Text, 2nd Edition. (2013) Janice Selekman, ed. https://portal.nasn.org/members_online/members/viewitem.asp?item=S004&catalog=MAN&pn=1&af=NASN

6 American Heart Association Highlights: Guidelines Update for CPR and ECC (2015). https://eccguidelines.heart.org/wp-content/uploads/2015/10/2015-AHA-Guidelines-Highlights-English.pdf

7 First Aid/CPR/AED Ready Reference (Pediatric). American National Red Cross https://www.redcrossstore.org/item/754002

8 Brain Basics. National Institute of Mental Health. www.nimh.nih.gov/health/educational-resources/brain-basics/brain-basics.shtml#Introduction

9 Treatment of Children with Mental Illness. National Institute of Mental Health. (2009) www.nimh.nih.gov/health/publications/treatment-of-children-with-mental-illness-fact-sheet/index.shtml

10 Mental Health Emergency or Crisis. San Luis Obispo County. http://www.slocounty.ca.gov/health/mentalhealthservices/Mental_Health_Emergency_or_Crisis.htm

11 Ibid

12 ALGEE protocol from Mental Health First Aid. http://www.mentalhealthfirstaid.org/cs/

13 What is Depression? National Institute of Mental Health. http://www.nimh.nih.gov/health/topics/depression/index.shtml

14 Show you Care, Ask the Question, Get Help. This three-step model was developed by the Washington Youth Suicide Prevention Program, an excellent resource on suicide prevention with youth and young adults. www.yspp.org

15 Infectious Disease Control Guide. (2014) Office of Superintendent of Public Instruction. www.k12.wa.us/HealthServices/pubdocs/InfectiousDiseaseControlGuide.pdf

16 Guidelines for Care of Students with Diabetes. (2005) Washington State Task Force for Students with Diabetes. http://www.k12.wa.us/HealthServices/pubdocs/diabetes/GuidelinesStudentswithDiabetes.pdf

17 Ibid

8 Steps in First Aid to Students

1. **Survey the Scene**
   Take a brief moment to look around and make sure the scene is safe. Find out who is involved and what happened.

2. **Hands-off Check**
   As you approach the student, look at appearance, breathing, and circulation to decide if someone should call 911—this should take less than 30 seconds.

3. **Supervise**
   Make sure other students near the scene are supervised and safe.

4. **Hands-on Check**
   Check the student's condition. Decide if someone should call 911 and what first aid is needed.

5. **First Aid Care**
   Provide first aid that is appropriate for the injury or illness.

6. **Notify**
   As soon as possible have someone notify the student's parent or legal guardian. Also have someone notify the school nurse, if available.

7. **Debrief**
   If possible, talk to the student about any concerns. Talk with other students who witnessed what happened and how you and others responded.

8. **Document**
   Complete a written report of what happened.

Adapted from the American Academy of Pediatrics' course book: Pediatric First Aid for Caregivers and Teachers, 2nd Edition

Staff Model for the Delivery of School Health Services

Washington State Nursing Care Quality Assurance Commission

Washington State Office of Superintendent of Public Instruction

Dr. Terry Bergeson
State Superintendent of
Public Instruction

April 2000

STAFF MODEL FOR THE DELIVERY OF SCHOOL HEALTH SERVICES

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STAFF MODEL FOR THE DELIVERY OF SCHOOL HEALTH SERVICES

Acknowledgements

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We would also like to thank the following for their contributions to this model and recognize their continuous contributions to the students of the state of Washington. Their professionalism and dedication make it possible for all children in kindergarten through Grade 12 to have their health care needs assessed and addressed while their educational needs are met.

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STAFF MODEL FOR THE DELIVERY OF SCHOOL HEALTH SERVICES

Introduction

This document is divided into three sections. The first is a general discussion of nursing care in schools and the different levels of staff who may provide health services in terms of their training, education, licensure, certification, and responsibility. The staff model is two parts as described in the summary below.

SUMMARY: The staff model consists of a nursing assessment to determine levels of care needed for individual students in a school and an overall school district model with staffing level recommendations. The staff model is two parts: (1) "Levels of Nursing Care for Student Diseases and Conditions: Severity Coding," a nursing assessment to determine levels of care needed for individual students in a school, and (2) "School District Model for the Delivery of Health Services," an overall school district model with staffing level recommendations. The staff model is to be used to predict the nursing care and staff needs of individual schools and school districts.

In the school setting, it is essential to aggressively manage any health problems that are likely to compromise daily learning readiness. For this reason, school health care providers may prioritize concerns and assign health services staff somewhat differently from the traditional medical community.

I. Nursing Care in Schools

The school nurse's primary responsibility is to the students. Each school nurse is responsible for each component of the nursing process with children in school: assessing, planning, implementing, and evaluating the nursing care. This is a continuous process. The registered nurse is responsible for the initiation of the care plan. In order to complete the initial care plans, the registered nurse(s) must be alerted to the needs of the child(ren) who will attend school. Optimally, these needs would be identified and communicated prior to attendance at the school to allow for adequate planning and training of school personnel. Administrators (including special education) in each school must establish a procedure that identifies and communicates the student's actual or potential need(s) for nursing care to the registered nurse. The identification of these needs, at the port of entry, can be communicated through health forms, parents' messages to school administrative personnel, or the health room personnel. Time to assess the needs of children and develop the plans must be considered as additional to the time needed to provide the actual care.

Components of a nursing assessment are:

- Patient interview.
- Review of physical systems.
- Family history.
- Physical examination.
- Psychosocial nursing assessment (review of support systems, mental health assessment, etc.).
- Patient's compliance history.
- Understanding of procedures and outcomes.
- Physical environmental assessment.
- Functional assessment.
- Review of current medical diagnoses.
- Developmental assessment.
- Review of medications, interpretation of side effects, identification of effects on patient outcome (pharmacological assessment).
- Identification and interpretation of deviations from physiological norms.
- Interpretation of the impact of patient's medical history and treatment modalities on the patient's current condition.
- Evaluation of effectiveness of current treatment modalities.

From the information obtained in this nursing assessment, the nurse develops nursing diagnoses, a plan of care specific to the student, and provides for the implementation of the plan of care and ongoing evaluation. The plan of nursing care, often referred to as an individual health care plan (IHP), is a component of the interdisciplinary plan of care for a patient. The registered nurse is responsible for the "plan of nursing care" component of the interdisciplinary plan. (Excerpt from Washington State Board of Nursing, *Unlicensed Practice Task Force Recommendation,* March 1991).

L.P.N./R.N. Preparation

Licensed practical nurses (L.P.N.) use specialized knowledge, skill, and judgment to carry out selected aspects of the designated nursing regimen under the direction and supervision of a licensed physician and surgeon, dentist, osteopathic physician and surgeon, physician assistant, osteopathic physician assistant, podiatric physician and surgeon, advanced registered nurse practitioner, or registered nurse (RCW 18.79.060). L.P.N.s are fully licensed health professionals and are accountable for their own actions at all times. L.P.N.s may give medications in school settings, including injections, with indirect registered nurse (R.N.) supervision. WAC 246-840-705 describes the functions of a licensed practical nurse. In summary, a licensed practical nurse recognizes and meets basic client needs in routine nursing situations, which are defined as situations that are relatively free of scientific complexity, involving stable and predictable client conditions. L.P.N.s also function in more complex nursing care situations, and in these cases an L.P.N. would function

as an assistant to the registered nurse or physician. Licensed practical nurses can revise the care plan and deliver the care according to the plan.

As stated above, indirect supervision by an R.N. who is not on school premises is within the standards of care, as long as the L.P.N. is providing care for students in routine, noncomplex situations and as long as the supervisory role of the R.N. has been established. Periodic review of the plan and R.N. availability for questions are recommended components of school health services.

A registered nurse has the knowledge, skills, and license to provide nursing care. The registered nurse may have either a bachelor's of science in nursing (BSN), an associate degree in nursing (ADN), or a diploma from a hospital school of nursing. Registered nurses with a BSN possess the knowledge and skills to function independently in a community or school setting and to coordinate family and community services in managing students with significant health problems.

The Certificated School Nurse Employed by a School District

The registered nurse with educational staff associate (ESA) certification as a school nurse has the preparation to develop and administer a comprehensive school health program, contribute to the development and teaching of the health education program, and is familiar with school law and the implications for school nursing practice. The certificated school nurse has the knowledge and skills to perform and supervise nursing care of students. The knowledge and skills acquired through the certification process (WAC 180-79A-223[1]) are over and above the knowledge and skills required for licensure as a R.N. and that generally obtained in a BSN program. Persons serving as school nurses in first class districts must hold an ESA certificate (WAC 180-86-011). WAC 180-87-050, Misrepresentation or Falsification in the Course of Professional Practice, addresses professional misconduct by a person (such as a school nurse) acting as a nurse without the valid, appropriate certification.

For an employer (such as a school administrator), WAC 180-87-070(1) defines an act of unprofessional practice as the intentional employment of a person to serve as an employee in a position for which certification is required by rules of the State Board of Education when such person does not possess a valid certificate to hold the position for which such person is employed.

WAC 180-87-070(2) further defines an act of unprofessional practice as "The assignment or delegation in a school setting of any responsibility within the scope of the authorized practice of nursing, physical therapy, or occupational therapy to a person not licensed to practice such profession unless such assignment or delegation is otherwise authorized by law, including the rules of the appropriate licensing board." Nursing care can only be delegated by the R.N. within the regulations and guidance of the Nursing Care Quality Assurance Commission.

Other certificates are available within certain restrictions if an R.N. has no BSN. See WAC 180-79A-231(1)(c)(iii).

Delegation of Nursing Care

Properly credentialed health care professionals, including R.N.s and L.P.N.s, are able to work in the school settings, but must act within the scope of their respective practice acts. Licensed health care professionals must also comply with any specific laws that apply to the provision of health care in the school setting, laws that may be more or less restrictive than in other settings. For instance, registered nurses may delegate certain limited health care tasks to uncredentialed school employees so long as the registered nurse and the employee comply with delegation, training, and supervision requirements addressed in RCW 28A.210.260 and 28A.210.280. Under these laws, uncredentialed school employees may administer oral medications and perform clean intermittent catheterizations as delegated tasks, tasks that in other settings could not be lawfully performed by uncredentialed individuals. Registered or certified nursing assistants (and health care assistants) are not authorized to practice in the school setting, but they may function in the role of uncredentialed school employees who may receive the delegated tasks of administering oral medications or performing clean intermittent catheterizations. Therefore, nursing assistants (and health care assistants) would be limited to the performance of only those tasks they could complete as uncredentialed school employees under RCW 28A.210.260 and 28A.210.280.

If the nursing assistant or licensed practical nurse completes other tasks, he or she would then need to comply with all of the regulations that govern their practice. Schools are not included in the list of health care facilities as determined by the Washington State Nursing Care Quality Assurance Commission. Therefore, a nursing assistant's practice would be limited to the tasks he or she could complete as a school employee.

In the process of determining the appropriateness of nurse delegation in schools, the registered nurse uses his/her judgment to determine the competency of the individual accepting the training to complete a delegated task. The person to whom the R.N. delegates care must be trained, willing, and competent to accept the delegation of a nursing task or care. In every instance, the nurse retains responsibility to the student for the quality of nursing care provided by the delegatee. If, in the judgment of the registered nurse, the caregiver is not able or willing to complete the task, the caregiver is not considered competent and must not provide the care. Delegation and supervision are both part of the assessment phase in nurse delegation. The registered nurse evaluates the competency of the caregiver on a regular basis and therefore assesses the safety and efficacy of the caregiver providing the care. References to this are in RCW 18.79.040(1)(c) and RCW 18.79.260(2).

IDEA/Section 504 Staffing Accommodations

For students who have qualified for special education, the requirements of the Individual with Disabilities Education Act (IDEA) and state law for development of the

individualized education program (IEP) and for the provision of health and education services in the least restrictive environment must be met.

For students who do not require special education, Section 504 of the Rehabilitation Act of 1973 requires students with a disability to have full access to all activities, services, or benefits provided by public schools. Any school receiving federal funds must accommodate the special health care needs of its students with disabilities in order to provide them with a "free appropriate public education." Such accommodations should be documented in an appropriately developed Section 504 plan or, if the child also needs special education or related services, in an IEP. These accommodations must be developed with parental input and cannot be implemented without parental consent. The school district has a legal obligation to ensure that these accommodations are provided as described in the Section 504 plan.

Confidentiality of Health Care Information

All unlicensed health care providers, such as health room aides or pupil transportation staff who assist the health care provider in the delivery of health care to students, must be informed of the confidentiality requirements of the federal Family Education Rights and Privacy Act (FERPA) and state requirements under chapter 70.02 RCW, Medical Records—Health Care Information Access and Disclosure. Health care information about a student cannot be disclosed without signed consent of parent, guardian, or student except in selected situations identified by the licensed health care provider (such as the school nurse). See *Guidelines for Handling Health Care Information in School Records*, State of Washington, Superintendent of Public Instruction, September 1995.

II. Levels of Nursing Care for Student Diseases and Conditions: Severity Coding

Students attend school with a broad range of health conditions, from potentially life-threatening acute and chronic conditions to correctable vision problems and everything in between which could impede the student's ability to fully participate in the educational process. Severity coding is a method for planning adequate staffing to meet the varying needs of students.

Severity of condition does not always translate directly into nursing time with the students. Many students with significant chronic conditions **predictably** require daily nursing time. For example, a student with spina bifida who is not yet independent with urinary bladder management requires 40 minutes every day of the nurse's time for catheterizations at the same time every school day. Other students such as those with severe asthma may experience an acute asthma attack and require nursing assessment and care **at any time** during a school day.

Examples of treatments/intervention that may be performed in schools at all levels of severity are (these are only a few examples and not meant to be an exclusive list):

Blood glucose test
Continuous oxygen administration
Dressing change
Gastric tube feeding
Intermittent oxygen administration
Laboratory tests
Medication management
Monitor blood pressure
Monitor disability
Monitor illness
Monitor weight
Nebulizer treatments
Peak flow monitoring
Sterile bladder catheterization
Suctioning
Toileting
Tracheostomy care
Unsterile bladder catheterization

In order to plan, care for, and monitor the students with special health care needs, the school nurse will assign each qualifying student to a level of care based on the following categories: nursing dependent, medically fragile, medically complex, and health concerns. In addition to children being considered for assignment to these levels of severity, there are many other students not requiring care on a daily basis. Therefore, the School District Model for the Delivery of Health Services (pages 12–14) has been recommended for this larger population of students. This model is to be used in conjunction with severity coding which establishes the nursing staff needs of students within a school building.

Level A: Nursing Dependent

Nursing dependent students require 24 hours/day, frequently one-to-one, skilled nursing care for survival. Many are dependent on technological devices for breathing, for example, a child on a respirator, and/or for continuous nursing assessment and intervention. Without effective use of medical technology and availability of nursing care, the student will experience irreversible damage or death. Before a student enters school, a registered nurse will complete a nursing assessment of the student and determine an appropriate plan of care/individual health care plan.

Staffing requirements: Immediate availability of the nurse (registered nurse or licensed practical nurse as determined by the R.N.) “on the premises and is within audible and visual range of the patient [student] and the patient [student] has been assessed by the registered nurse prior to the delegation of duties to any care giver” (WAC 246-840-010[11][d]).

Statutory Authority

- RCW 18.79.260 Registered nurse—Activities allowed.
- RCW 18.79.270 Licensed practical nurse—Activities allowed.
- RCW 18.79.280 Medication, tests, treatments allowed.
- RCW 18.79.290 Catheterization of students—Rules.
- WAC 246-840-010 Definitions.
- WAC 246-840-700 Standards of nursing conduct or practice.
- WAC 246-840-705 Functions of a licensed practical nurse.

- WAC 246-840-710 Violations of standards on nursing conduct or practice.
- WAC 246-840-715 Standards/competencies.

Level B: Medically Fragile

Students with complex health care needs in this category face daily the possibility of a life-threatening emergency requiring the skill and judgment of a professional nurse. An individual health care plan or plan of nursing care developed by a registered nurse must be complete, current, and available at all times to personnel in contact with these children. This includes bus drivers for daily transportation and special events, sports coaches, and school personnel assigned to extracurricular activities. Every child in this category requires a full-time nurse in the building. Children in this category may be transported to school. Someone must be trained and available on the bus to provide care during transport to the school. This training must include the primary bus driver, the child, and back-up personnel. The registered nurse makes the decision of who will be trained and what level of preparation is required, and uses the nurse delegation principles described on pages 4–5.

Examples may include, but are not limited to:

- Severe seizure disorder, requiring medications that can be administered only by a nurse.
- Severe asthma with potential for status asthmaticus.
- Sterile procedures.
- Tracheostomy with frequent and/or unpredictable suctioning.
- Unstable and/or newly diagnosed diabetic with unscheduled blood sugar monitoring and insulin injections.

Staffing requirements: Every child in the medically fragile category requires a full-time nurse in the building. The nurse "is on the premises, is quickly and easily available and the patient [student] has been assessed by the licensed registered nurse prior to the delegation of the duties to any caregiver" (WAC 246-840-010[11][c]).

The child may need to transfer to a school where full-time nursing staff is provided if not available at the local school. If the child needs a high level of nursing service, but is not willing to move or the parents object to the move to the school where the service is provided, the parents, school administrators, and school nurse should meet and discuss options. Options **may** include a waiver signed by the parent in compliance with school district policy for the student to remain in the local school. In these cases, a move toward students attending their neighborhood schools works against the provision of adequate care if there is not a full-time nurse in the neighborhood school. Parents need to be fully aware of the services that are offered by a school. Placement of their children in schools where services are not available to the degree required, could present undue stress on the child, the nursing staff, parents, and school staff. If a waiver has been signed, the professional registered nurse in the school the child is attending must be aware of the child's condition and needs and develop emergency care plans for these children. Reasonable accommodation and provision of

education and health services under Section 504 or under IDEA must be considered and addressed in each child's individual health care plan.

Statutory Authority

- RCW 18.79.260 Registered nurse—Activities allowed.
- RCW 18.79.270 Licensed practical nurse—Activities allowed.
- RCW 18.79.280 Medication, tests, treatments allowed.
- RCW 18.79.290 Catheterization of students—Rules.
- WAC 246-840-010 Definitions.
- WAC 246-840-700 Standards of nursing conduct or practice.
- WAC 246-840-705 Functions of a licensed practical nurse.
- WAC 246-840-710 Violations of standards on nursing conduct or practice.
- WAC 246-840-715 Standards/competencies.

Level C: Medically Complex

The medically complex student has a complex and/or unstable physical and/or social-emotional condition that requires daily treatments and close monitoring by a professional registered nurse. Life-threatening events are unpredictable. Treatments, medications, and reporting of current signs and symptoms can be delegated, but delegation requires a trained, willing, and competent staff person and close supervision of that staff person by a registered nurse. The level of supervision required is determined by the R.N. but must be adequate to maintain safety and ensure competence of the direct caregiver. Adaptations of the medically complex student to the educational system must be negotiated and maintained with the student, family, school staff (classroom and administrative), and community health care provider(s).

Examples include, but are not limited to:

ADHD and on medications
Anaphylactic event
Cancer
Complex mental or emotional disorders
Immune disorders
Moderate to severe asthma; inhaler at school and peak flow meter
Oxygen, continuous or intermittent
Preteen or teenage pregnancy
Taking carefully timed medications
Taking medications with major side effects
Unstable metabolic conditions

Emotional disorders and homicidal and/or suicidal behaviors may be assessed and categorized at this level. These conditions require collaboration with school counselors. The registered nurse's role must be identified and defined and mutually agreed to in these cases. Pregnancy may also be classified at this level. Pregnancy issues must be assessed and may require weekly evaluation.

Staffing requirements: Children placed in this category require a professional registered nurse in the building a full day a week who is available on a daily basis when not in the school building. The registered nurse prioritizes issues weekly and provides a face-to-face assessment of these children at least one day a week. If children in this category become more fragile and meet the definition of Level A or Level B care, they may need to transfer to a school that meets the staffing requirements of the higher categories. This is dependent on the registered nurse's judgment and district policy. At Level C, the registered nurse "is not on the premises but has given either written or oral instructions for the care and treatment of the patient [student] and the patient [student] has been assessed by the registered nurse prior to the delegation of duties to any caregiver" (WAC 246-840-010[11][e]). If any alteration of the written care plan is required, it must be done by the registered nurse and must be documented. Licensed practical nurses can revise the care plans and consult with the registered nurse.

Statutory Authority

- RCW 18.79.260 Registered nurse—Activities allowed.
- RCW 18.79.270 Licensed practical nurse—Activities allowed.
- RCW 18.79.280 Medication, tests, treatments allowed.
- RCW 18.79.290 Catheterization of students—Rules.
- WAC 246-840-010 Definitions.
- WAC 246-840-700 Standards of nursing conduct or practice.
- WAC 246-840-705 Functions of a licensed practical nurse.
- WAC 246-840-710 Violations of standards on nursing conduct or practice.
- WAC 246-840-715 Standards/competencies.

Level D: Health Concerns

The student's physical and/or social-emotional condition is currently uncomplicated and predictable. Occasional monitoring is required. Required monitoring varies from biweekly to annually. Examples include, but are not limited to:

Dental disease
Diabetes self-managed by the student
Dietary restrictions
Eating disorders
Encopresis
Headaches, migraines
Sensory impairments
Orthopaedic conditions requiring accommodations
Uncomplicated Pregnancy

Staffing Requirements: Children placed in this category should have their health needs assessed at least once a school year by the registered nurse at the beginning of the school year or at the time of diagnosis. Reassessment occurs as the condition requires and the nurse's judgment determines.

Statutory Authority

- RCW 18.79.260 Registered nurse—Activities allowed.

- RCW 18.79.270 Licensed practical nurse—Activities allowed.
- RCW 18.79.280 Medication, tests, treatments allowed.
- RCW 18.79.290 Catheterization of students—Rules.
- WAC 246-840-010 Definitions.
- WAC 246-840-700 Standards of nursing conduct or practice.
- WAC 246-840-705 Functions of a licensed practical nurse.
- WAC 246-840-710 Violations of standards on nursing conduct or practice.
- WAC 246-840-715 Standards/competencies.

Social/Emotional Factors, Comorbidity

Classification of students by the severity of their condition(s) remains the responsibility of the registered nurse. The registered nurse may factor into his/her decision any of the following or other significant factors that increase health care need:

Chronic illness stressors	Homeless
Drug/alcohol stressors	Poverty/low income
English-as-second language	Reentry
High mobility/turnover	Special education, enrolled

The student's diagnosis may place him or her at Level D, but if the student has more than one diagnosis (comorbidity) or any of the above risk factors, the nurse may place the student in a higher level of severity and increase monitoring, at least initially.

Transportation

A student may need transportation as a related service, as determined under procedures provided under IDEA and chapter 392-172 WAC, because of student characteristics which could require nursing care, or intervention, or require the use of adaptive or assistive equipment. In these situations, the pupil transportation staff should be invited to participate in the nursing assessment and care planning process as a resource person and potential provider of care.

Time allotted for training by the registered nurse and for the pupil transportation personnel needs to be considered in the staffing model. Informing and training transportation staff prior to the first transport is essential to ensure safe transport. The degree of ongoing nursing supervision must also be addressed and provided. Appropriate substitutes for the transportation personnel must be trained as well. Liability questions associated with the provision of nursing care and supervision need to be addressed. The registered nurse will assess the student and secure answers to the following questions prior to transportation arrangements being made:

1. Can the student be safely transported?

2. Can the student's medical equipment be transported?

3. What inservice training is necessary to safely transport this student, e.g., use of medical equipment, signs and symptoms of illness or disease progression, universal precautions, etc.?

4. Is an additional staff person necessary in the vehicle to observe and care for the student during transport?

5. What level and degree of nursing supervision is required by the transportation staff for the student?

Level C or D students may require some adaptations but not require nursing staff to be on the bus. If a student in Level C or D experiences deterioration in condition or an acute episode requiring increased nursing care, the nurse will reassess the student. If the student is then categorized as Level A or B, the student may be transported to a school with full-time nursing services depending on district policy and/or additional or licensed personnel resources may be added to the bus.

III. School District Model for the Delivery of Health Services

In this section we will discuss the second part of the staff model which describes a districtwide staffing model. "Levels of Nursing Care for Student Diseases and Conditions: Severity Coding" determines health services staffing for students within a school building based on the student's condition and the nursing services the student requires during the school day (pages 6–12). The following "School District Model for the Delivery of Health Services" provides recommendations for districtwide staffing for health services.

The recommended model for districtwide staffing for health services consists of:

- One professional school nurse for every 1,500 regular education students, including those on the health concerns level (Level D).
- A health room paraeducator to student ratio based on the grade level within a building.
- Additional assigned professional registered nurses, L.P.N.s, and unlicensed school staff to whom the care of students on Levels A, B, and C have been delegated based on individual student need as determined by the registered nurse's assessment.

Certificated School Nurses

The certificated school nurse could be expected to have the abilities because of her/his educational preparation (see page 4) for the activities described here. The school nurse with educational staff associate (ESA) certification has responsibility for assessing the health care needs of all 1,500 students in his/her caseload; assigning students to an appropriate level (A–D); delegating the care to R.N.s, L.P.N.s, and unlicensed school staff; and providing appropriate training and supervision of the

caregiving staff. The school nurse participates as a member of each student's evaluation group, which includes parent(s), participates in the development of the student's IEP, and ensures the implementation of the health care aspects of the IEP. For students not receiving special education, the nurse develops an IHP. The nurse participates in the development of health education curricula and teaches classes when appropriate. The nurse evaluates and monitors the school environment for health and safety hazards and works with the local health department in the control of communicable disease and the monitoring of student immunization against vaccine-preventable disease.

The school nurse recommends or designs accommodations (Section 504 Plan) that permit the student to participate fully in learning and communicates to school staff to ensure understanding and compliance with the student's educational program goals. The school nurse ensures that each student in his/her caseload is well enough to learn each school day and that any student and family health issues that may increase absences or negatively affect the student's ability to learn are identified and addressed.

The school nurse provides case management for students in his/her caseload and interacts with parents, primary health care providers, community and school resources to provide a school environment that is safe, healthy, and conducive to learning.

The school nurse in this role should have current ESA certification in order to meet the basic requirements for managing the health care of 1,500 students within the educational system and culture.

Non-ESA Certificated Nurses/L.P.N.s

As previously discussed on pages 3–5, other registered nurses and licensed practical nurses can work in the school settings without the ESA certificates. Licensed practical nurses work under the supervision of R.N.s, physicians, and other authorized health care providers.

Health Room Assistants

The health room assistant (HRA) is specially trained to staff the health room and provide care to students based on protocols developed and supervised by the registered nurse. The HRA has completed the Office of Superintendent of Public Instruction (OSPI) "Orientation-Level Training for Paraeducators Working with Students with Special Health Care Needs" course. The HRA may be a registered or certified health care provider which would require the HRA to act within her/his scope of practice with the exception of clean intermittent catheterization and oral medication administration (see page 5) and comply with the Uniform Disciplinary Act.

The health room assistant is in the building daily at least during the high use times such as 11 a.m.–1 p.m. when most medications are given. The recommended ratio is:

1. Elementary schools—at least 0.1 FTE/100 students.

2. Middle and high schools—at least 0.1 FTE/200 students.

Up to a limit of one HRA per building is recommended. The HRA may be in the school at times the school nurse is not, but there must be provision for at least weekly face-to-face communication with the school nurse on a routine, scheduled basis. The R.N. has responsibility for selection, training, and supervision of the HRA and for the development of health room protocols. The hiring and performance evaluation of the HRA remains with the school administration with weighted comments from the supervising R.N. in health care provision by the HRA. As indicated in the introduction, however, registered/certified nursing assistants and certified health care assistants are not authorized to practice in the school setting; they may function in the role of uncredentialed school employees who may receive the delegated tasks of administering oral medications or performing clean intermittent catheterizations under RCW 28A.210.260 and 28A.210.280.

Clerical Staff

For the nursing staff to complete nursing responsibilities, clerical staff are needed as support for filing the individual health plans, data entry, and ensuring that the health forms and immunization records are completed.

Summary

This paper provides a discussion of an approach to the hiring and assignment of staff for the provision of school health services that considers the individual student nursing care needs during the school day, plus the need for school nurse services by all students within a district.

Chapter 246-760 WAC

AUDITORY AND VISUAL STANDARDS—SCHOOL DISTRICTS

Chapter Listing

WAC Sections

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

246-760-090 What are the visual acuity screening referral procedures?
[Statutory Authority: RCW 28A.210.200. WSR 02-20-079, § 246-760-090, filed 9/30/02, effective 10/31/02. Statutory Authority: RCW 43.20.050. WSR 91-02-051 (Order 124B), recodified as § 246-760-090, filed 12/27/90, effective 1/31/91. Statutory Authority: RCW 28A.31.030. WSR 87-22-010 (Order 306), § 248-148-131, filed 10/26/87.] Repealed by WSR 17-03-009, filed 1/4/17, effective 7/1/17. Statutory Authority: RCW 28A.210.020.

246-760-001
Purpose and application of auditory and visual screening standards for school districts.

Each board of school directors in the state shall provide for and require screening of the auditory and visual acuity of children attending schools in their districts to determine if any child demonstrates auditory or visual problems that may negatively impact their learning. Each board of school directors shall establish procedures to implement these rules.

[Statutory Authority: RCW 28A.210.020. WSR 17-03-009, § 246-760-001, filed 1/4/17, effective 7/1/17. Statutory Authority: RCW 28A.210.200. WSR 02-20-079, § 246-760-001, filed 9/30/02, effective 10/31/02. Statutory Authority: RCW 43.20.050 and 28A.210.020. WSR 92-02-019 (Order 225B), § 246-760-001, filed 12/23/91, effective 1/23/92. Statutory Authority: RCW 43.20.050. WSR 91-02-051 (Order 124B), recodified as § 246-760-001, filed 12/27/90, effective 1/31/91; Order 63, § 248-144-010 (codified as WAC 248-148-010), filed 11/1/71.]

246-760-010
Definitions, abbreviations, and acronyms.

The definitions, abbreviations, and acronyms in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "AAPOS" or "American Association for Pediatric Ophthalmology and Strabismus" means the national organization that advances the quality of children's eye care, supports the training of pediatric ophthalmologists, supports research activities in pediatric ophthalmology, and advances the care of adults with strabismus.

(2) "Crowding bars" means four individual lines surrounding a single optotype.

(3) "Crowding box" or "surround box" means crowding bars on all four sides extended to form a crowding rectangle surrounding a single line of optotypes.

(4) "Distance vision" means the ability of the eye to see images clearly at a calibrated distance.

(5) "HOTV letters" means a test using the letters H, O, T, and V calibrated of a certain size used to assess visual acuity.

(6) "Instrument-based vision screening device" means a U.S. Food and Drug Administration approved instrument for vision screening that uses automated technology to provide information about amblyopia and reduced-vision risk factors such as estimates of refractive error and eye misalignment.

(7) "Lay person" means any individual who is conducting school-based vision screening other than a school nurse, a school principal or his or her designee, a licensed vision care professional, or an individual trained by and conducting vision screening on behalf of a nationally recognized service organization that utilizes a test-retest protocol for vision screening. This includes, but is not limited to, retired nurses, nursing students, parents, and school staff.

(8) "LEA vision test(s)" means a test used to measure visual acuity using specific symbols or numbers, designed for those who do not know how to read the letters of the alphabet.

(9) "Licensed vision care professional" means a licensed ophthalmologist or licensed optometrist.

(10) "Near vision acuity" means the ability of the human eye to see objects with clarity at close range, also termed near point acuity or near acuity.

(11) "Optotype" means figures, numbers or letters of different sizes used in testing visual acuity.

(12) "Principal's designee" means a public health nurse, special educator, teacher or administrator designated by the school principal and responsible for supervision, training, reporting and referral of vision screening in instances where the school nurse or school principal is not filling this role.

(13) "School nurse" means a registered nurse acting as the health professional in a school whose specialized practice and attendant tasks and activities advance student health, well-being and achievement; and conforms to Washington state educational and nursing laws according to chapters 18.79 RCW and 246-840 WAC, and WAC 181-79A-223.

(14) "Sloan letters" means a test using ten specially formed letters which include C, D, H, K, N, O, R, S, V and Z to assess visual acuity.

(15) "Test-retest protocol" means a method of screening where a screener conducts two or more screenings for any student who meets the referral criteria in order to ensure the reliability of the initial screening.

(16) "Visual acuity" refers to the ability of the visual system to discern fine distinctions in the environment as measured with printed or projected visual stimuli.

[Statutory Authority: RCW 28A.210.020. WSR 17-03-009, § 246-760-010, filed 1/4/17, effective 7/1/17.]

246-760-020
Frequency for schools to screen children.

(1) A school shall conduct auditory and distance vision and near vision acuity screening of children:

(a) In kindergarten and grades one, two, three, five, and seven; and

(b) Showing symptoms of possible loss in auditory or visual acuity and who are referred to the district by parents, guardians, school staff, or student self-report.

(2) If resources are available, a school may:

(a) Expand vision screening to any other grade;

(b) Conduct other optional vision screenings at any grade using evidence-based screening tools and techniques; or

(c) Expand vision screening to other grades and conduct optional vision screenings as outlined in (a) and (b) of this subsection.

(3) If resources permit, schools shall annually conduct auditory screening for children at other grade levels.

[Statutory Authority: RCW 28A.210.020. WSR 17-03-009, § 246-760-020, filed 1/4/17, effective 7/1/17. Statutory Authority: RCW 28A.210.200. WSR 02-20-079, § 246-760-020, filed 9/30/02, effective 10/31/02. Statutory Authority: RCW 43.20.050. WSR 91-02-051 (Order 124B), recodified as § 246-760-020, filed 12/27/90, effective 1/31/91. Statutory Authority: RCW 28A.31.030. WSR 87-22-010 (Order 306), § 248-148-021, filed 10/26/87.]

246-760-030
What are the auditory acuity screening standards for screening equipment and procedures?

(1) Schools shall use auditory screening equipment providing tonal stimuli at frequencies at one thousand, two thousand, and four thousand herz (Hz) at hearing levels of twenty decibels (dB), as measured at the earphones, in reference to American National Standards Institute (ANSI) 1996 standards.

(2) Qualified persons will check the calibration of frequencies and intensity at least every twelve months, at the earphones, using equipment designed for audiometer calibration.

[Statutory Authority: RCW 28A.210.200. WSR 02-20-079, § 246-760-030, filed 9/30/02, effective 10/31/02. Statutory Authority: RCW 43.20.050. WSR 91-02-051 (Order 124B), recodified as § 246-760-030, filed 12/27/90, effective 1/31/91. Statutory Authority: RCW 28A.31.030. WSR 87-22-010 (Order 306), § 248-148-031, filed 10/26/87.]

246-760-040
What are the procedures for auditory acuity screening?

(1) Schools shall screen all children referenced in WAC 246-760-020 on an individual basis at one thousand, two thousand, and four thousand Hz.

(2) The screener shall:

(a) Present each of the tonal stimuli at a hearing level of twenty dB based on the ANSI 1996 standards;

(b) Conduct screenings in an environment free of extraneous noise;

(c) If at all possible, complete screening within the first semester of each school year;

(d) Place the results of screenings, any referrals, and referral results in each student's health and/or school record; and

(e) Forward the results to the student's new school if the student transfers.

[Statutory Authority: RCW 28A.210.200. WSR 02-20-079, § 246-760-040, filed 9/30/02, effective 10/31/02. Statutory Authority: RCW 43.20.050 and 28A.210.020. WSR 92-02-019 (Order 225B), § 246-760-040, filed 12/23/91, effective 1/23/92. Statutory Authority: RCW 43.20.050. WSR 91-02-051 (Order 124B), recodified as § 246-760-040, filed 12/27/90, effective 1/31/91. Statutory Authority: RCW 28A.31.030. WSR 87-22-010 (Order 306), § 248-148-035, filed 10/26/87.]

246-760-050
What are the auditory acuity screening referral procedures?

(1) If a child does not respond to one or more frequencies in either ear:

(a) The school must rescreen the child within six weeks; and

(b) Notify their teachers of the need for preferential positioning in class because of the possibility of decreased hearing; and

(c) Notify the parents or legal guardian of the need for audiological evaluation if the student fails the second screening.

(2) Schools shall notify parents or legal guardian of the need for medical evaluation if:

(a) Indicated by audiological evaluation; or

(b) Audiological evaluation is not available.

[Statutory Authority: RCW 28A.210.200. WSR 02-20-079, § 246-760-050, filed 9/30/02, effective 10/31/02. Statutory Authority: RCW 43.20.050. WSR 91-02-051 (Order 124B), recodified as § 246-760-050, filed 12/27/90, effective 1/31/91. Statutory Authority: RCW 28A.31.030. WSR 87-22-010 (Order 306), § 248-148-091, filed 10/26/87.]

246-760-060
What are the auditory acuity screening qualifications for personnel?

Each school district shall designate a district audiologist or district staff member having:

(1) Responsibility for administering the auditory screening program; and

(2) Training and experience to:

(a) Develop an administrative plan for conducting auditory screening in cooperation with the appropriate school personnel to ensure the program is carried out efficiently and effectively;

(b) Obtain the necessary instrumentation for carrying out the screening program, and ensuring the equipment is in proper working order and calibration; and

(c) Secure appropriate personnel for carrying out the screening program, if assistance is necessary, and for assuring these personnel are sufficiently trained to:

(i) Understand the purposes and regulations involved in the auditory screening programs; and

(ii) Utilize the screening equipment to ensure maximum accuracy;

(d) Ensure records are made and distributed as appropriate; and

(e) Disseminate information to other school personnel familiarizing them with aspects of a child's behavior indicating the need for referral for auditory screening.

[Statutory Authority: RCW 28A.210.200. WSR 02-20-079, § 246-760-060, filed 9/30/02, effective 10/31/02. Statutory Authority: RCW 43.20.050. WSR 91-02-051 (Order 124B), recodified as § 246-760-060, filed 12/27/90, effective 1/31/91. Statutory Authority: RCW 28A.31.030. WSR 87-22-010 (Order 306), § 248-148-101, filed 10/26/87.]

246-760-070
Vision screening.

(1) A school shall conduct all vision screening using tools and procedures that are linguistically, developmentally and age-appropriate. For distance vision and near vision acuity screening schools shall use screening tools identified in WAC 246-760-071.

(2) A school shall conduct vision screening according to the tool's instructions and screening protocol and consistent with AAPOS and National Association of School Nurses guidance.

(3) A school is not required to screen a student who has already had a comprehensive vision examination by a licensed vision care professional within the previous twelve months. In order to waive the screening, schools need to have a report or form signed by a licensed vision care professional indicating that an examination has been administered. A school must place this report or form in the student's health record.

(4) A school is not required to screen a student who the school district has reported as having a visual impairment as required under RCW 72.40.060.

[Statutory Authority: RCW 28A.210.020. WSR 17-03-009, § 246-760-070, filed 1/4/17, effective 7/1/17. Statutory Authority: RCW 28A.210.200. WSR 02-20-079, § 246-760-070, filed 9/30/02, effective 10/31/02. Statutory Authority: RCW 43.20.050. WSR 91-02-051 (Order 124B), recodified as § 246-760-070, filed 12/27/90, effective 1/31/91. Statutory Authority: RCW 28A.31.030. WSR 87-22-010 (Order 306), § 248-148-121, filed 10/26/87.]

246-760-071
Required and alternative vision screening tools and referral criteria.

(1) A school must use the standardized optotype-based distance vision and near vision acuity screening tools approved for each grade as well as the rescreening and referral criteria by grade outlined in Table 1 of this section. When using a screening tool with a single isolated optotype or a single line of optotypes, the tool must include the use of crowding bars or crowding boxes.

(2) A school may use an instrument-based vision screening device in lieu of the optotype-based tools outlined in this section. Referral using instrument-based vision screening devices is determined through the manufacturer's criteria. If the instrument-based screening device does not generate a result for a student, a school must screen that student using the optotype-based tools outlined in this section.

Table 1

Purpose of Screening	Grade	Screening Tools	Rescreening and Referral Criteria
Distance Vision	Kindergarten	LEA vision test: Single LEA symbol (at 5 feet), or HOTV letter	Visual acuity worse than 20/40 in either eye
Distance Vision	Grade one	LEA vision test: Single LEA symbol (at 5 feet), or HOTV letter	Visual acuity worse than 20/32 in either eye
Distance Vision	Grades two and above	LEA vision tests: LEA symbols or numbers, or HOTV letters, or Sloan letters	Visual acuity worse than 20/32 in either eye
Near Vision Acuity	Kindergarten	LEA vision tests: LEA symbols near vision, HOTV, or Sloan letters	Visual acuity worse than 20/40 in either eye
Near Vision Acuity	Grade one and above	LEA vision tests: LEA symbols near vision, HOTV, or Sloan letters	Visual acuity worse than 20/32 in either eye

[Statutory Authority: RCW 28A.210.020. WSR 17-03-009, § 246-760-071, filed 1/4/17, effective 7/1/17.]

246-760-080
Vision screening procedures.

(1) A school shall:

(a) Screen children with their corrective lenses on;

(b) Place the results of screening, any referrals, and referral results in each student's health record; and

(c) Forward the results to the student's new school if the student transfers.

(2) If a student meets the referral criteria set forth in WAC 246-760-071 during the first vision screening and the screening was conducted by a lay person, then the school nurse, or the school principal or his or her designee as qualified under WAC 246-760-100(4) shall rescreen the student within two weeks or as soon as possible after the original screening before referring the child to a licensed vision care professional for an assessment.

(3) If the student meets the referral criteria set forth in WAC 246-760-071 during the first vision screening, and the screening was conducted by the school nurse; the school principal or his or her designee; a volunteer who is a licensed vision care professional; or an individual trained by and conducting vision screening on behalf of a nationally recognized service organization that utilizes a test-retest protocol for vision screening, a school may either refer the student after the first screening or rescreen the student at the discretion of the school nurse, or the school principal or his or her designee.

(4) A school shall notify a child's parent or guardian with a written referral if a child meets the referral criteria set forth in WAC 246-760-071 during:

(a) The first screening if a rescreening is not required; or

(b) The second screening if a rescreening is required or is conducted at the discretion of the school nurse, or the school principal or his or designee.

(5) This written referral shall indicate that school-based vision screening is not a substitute for a comprehensive eye examination, include the screening results, and include language recommending that:

(a) The parent or guardian take the child to a licensed vision care professional to receive a comprehensive eye examination; and

(b) An appropriate remedy, such as corrective lenses, be obtained if indicated.

(6) Only the school nurse, or the school principal or his or her designee may notify a child's parent or guardian in order to refer the student for professional care. A school nurse, or school principal or his or her designee shall notify parents or guardians in writing that their child should be evaluated by a licensed vision care professional when:

(a) The student meets the referral criteria for vision screening tests conducted under WAC 246-760-071; or

(b) The school nurse, or school principal or his or her designee observes other signs or symptoms related to eye problems that negatively impact the student's learning; or

(c) The student is unable to complete vision screening for any reason.

[Statutory Authority: RCW 28A.210.020. WSR 17-03-009, § 246-760-080, filed 1/4/17, effective 7/1/17. Statutory Authority: RCW 28A.210.200. WSR 02-20-079, § 246-760-080, filed 9/30/02, effective 10/31/02. Statutory Authority: RCW 43.20.050. WSR 91-02-051 (Order 124B), recodified as § 246-760-080, filed 12/27/90, effective 1/31/91. Statutory Authority: RCW 28A.31.030. WSR 87-22-010 (Order 306), § 248-148-123, filed 10/26/87.]

246-760-100
Qualifications for the visual acuity screening personnel.

(1) Persons performing visual screening may include, but are not limited to, school nurses, school principals, other school personnel, or lay persons who have completed training in vision screening; and ophthalmologists, optometrists, or opticians who donate their professional services to schools or school districts. If an ophthalmologist, optometrist, or optician who donates his or her services identifies a visual problem that may impact a student's learning, the vision professional shall notify the school nurse, or the school principal or his or her designee of the results of the screening in writing but may not contact the student's parents or guardians directly per RCW 28A.210.020.

(2) Screening must be performed in a manner consistent with this chapter and RCW 28A.210.020. Any person conducting vision screening must be competent to administer screening procedures as a function of their professional training and background or special training and demonstrated competence under supervision by the school nurse, or the school principal or his or her designee.

(3) A lay person shall demonstrate his or her competence at administering the screening tools including controlling for lighting or distractions that could affect the screening results.

(4) Supervision, training, reporting and referral of vision screening shall be the responsibility of the school nurse, or the school principal or his or her designee. The principal or his or her designee must demonstrate his or her competence in vision screening through supervised training by a competent school or public health nurse or licensed vision care professional, have supervisory ability and experience, and have the ability to work well with school staff and lay persons. Ideally, the person should demonstrate the ability to teach vision screening techniques and operations to others.

(5) Students in grades kindergarten through twelve may not assist with or conduct vision screening of other students in their school district, unless students are supervised and conducting screening within the scope of an advanced vocational health-related curriculum such as nursing.

[Statutory Authority: RCW 28A.210.020. WSR 17-03-009, § 246-760-100, filed 1/4/17, effective 7/1/17; WSR 10-15-100, § 246-760-100, filed 7/20/10, effective 8/20/10. Statutory Authority: RCW 28A.210.200. WSR 02-20-079, § 246-760-100, filed 9/30/02, effective 10/31/02. Statutory Authority: RCW 43.20.050. WSR 91-02-051 (Order 124B), recodified as § 246-760-100, filed 12/27/90, effective 1/31/91; Order 63, § 248-144-150 (codified as WAC 248-148-150), filed 11/1/71.]

Washington State Department of Health

Washington State Immunization Information System
Training Guide

School Module

WASHINGTON STATE IMMUNIZATION INFORMATION SYSTEM

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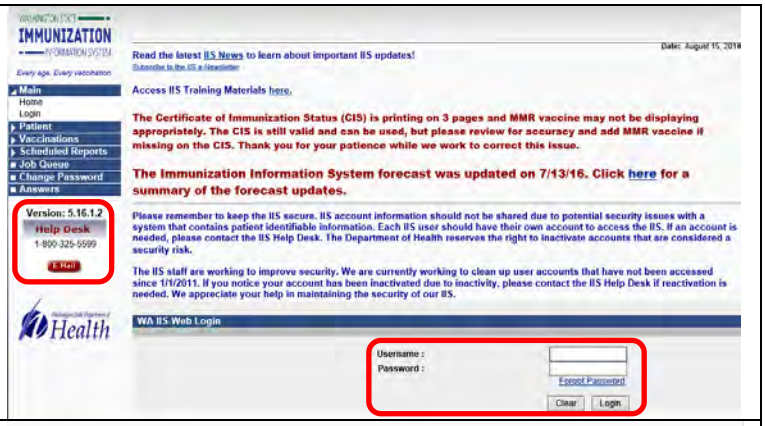
DOH 348-578 November 2016

School Module

Log In

Go to: www.waiis.wa.gov

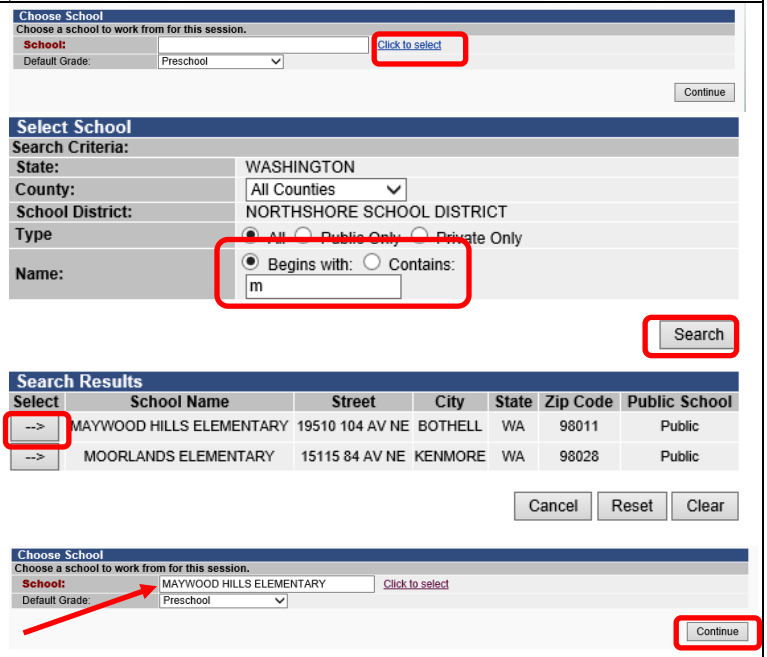
- Click ***Login*** under the main menu
- Enter your ***Username*** and ***Password.*** If you forget your password you can select *Forgot Password* and reset via email. You can also contact the Helpdesk via phone or email.
- Click ***Login*** or press ***Enter*** on your keyboard.
- The system will take you to the *Choose School* screen.



Choose a School

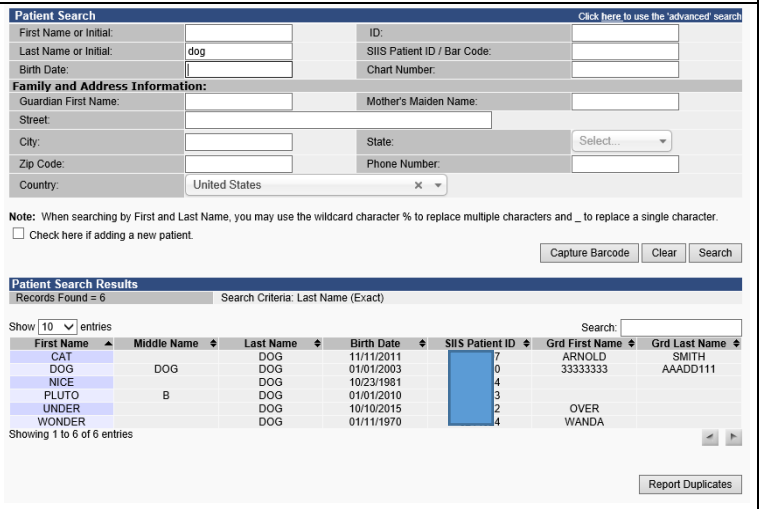
If you have access to more than one school you will need to select a school to continue.

- Click on ***Click to Select*** to open the *Select School* window.
- Type the name of the school or first few letters of the name. If you do not enter a school name clicking *Search* will display a list of all schools in the district.
- Click ***Search*** or press ***Enter*** on your keyboard.
- From the list, click on the arrow button to the left of the School Name to select that school.
- The *Select School* window closes and the selected school shows in the *School* field.
- Ignore the *Default Grade* selection/dropdown box.
- Click the ***Continue*** button.



Search for a Student

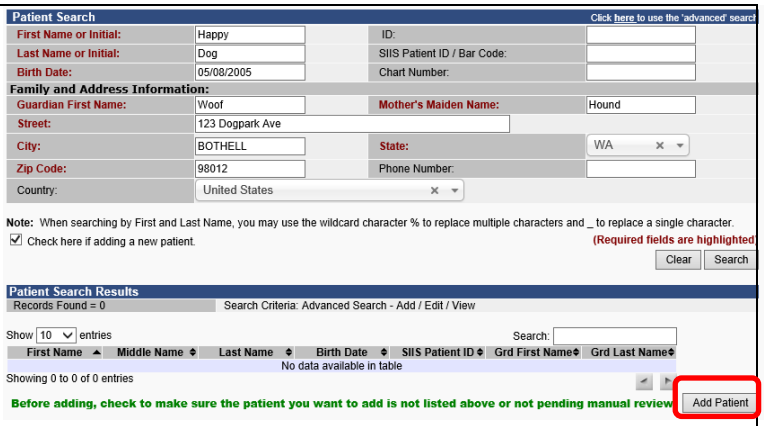
- Using the Navigation Menu, Click ***Search/Add*** under the Patient menu heading.
- Enter information in the Patient Search fields e.g., student name, birth date, OSPI Student ID. The more information provided the shorter the search results.
- Enter the birth date as a string of numbers; for example, May 8, 2005 = 050805.
- Click ***Search*** or press ***Enter*** on your keyboard.
- Select the correct student name by clicking once on the name. This opens ***the Patient Demographic*** screen.
- If you believe a patient is in the system more than once click the ***Report Duplicates*** button.



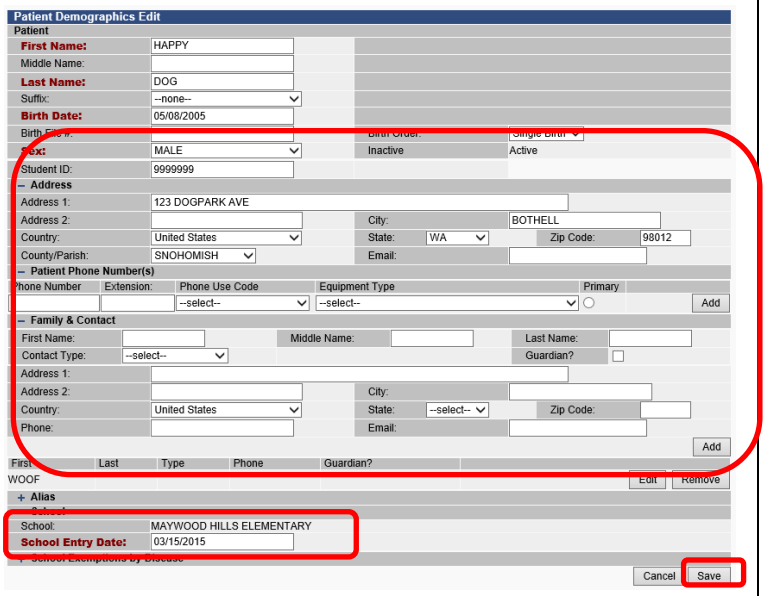
Add a Student and Attach Them to a School

A student not in the School Module can be added on the *Search/Add* screen under the *Patient* menu heading.

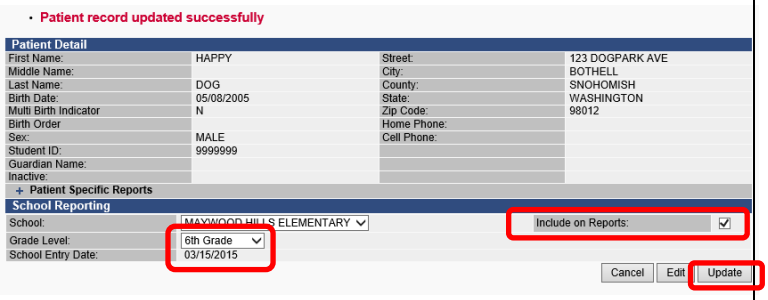
- Enter the student's first, last name and birth date.
- Check the box ***Check here if adding a new patient***.
- Enter all required fields marked red.
- Click ***Search*** or press ***Enter*** on your keyboard.
- If the student is not found, click ***Add Patient*** under *Patient Search Results.*



- The system will open the *Patient Demographics Edit* screen.
- Enter the ***Sex*** of the patient using the drop-down list.
- Enter the OSPI SSID in the ***Student ID*** Field.
- Enter the mailing ***Address*** Note: enter the zip code first to auto populate fields
- Enter the ***Phone Number*** and appropriate ***Phone Use Code.*** Click the ***Add*** button in the Phone section
- Enter the name of the ***Family Contact***. Click the ***Add*** button in the Family Contact section
- Click the + to expand ***School*** and enter the ***School Entry Date.*** It cannot be a future date.
- Enter additional information if available.
- Click ***Save.***

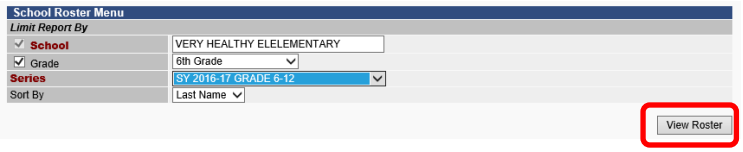


- The system will take you to the *Patient Detail* Screen.
- Select the correct ***Grade Level*** from the drop-down list.
- Click the checkbox to ***Include on Reports.***
- Click the ***Update*** button.
- You can return to the *Patient Detail* screen by clicking *Demographics* under the Patient menu heading.



View the Student Roster

- Click on ***Roster*** under the Schools menu heading.
- You can select the ***Grade*** using the dropdown list. Not selecting a grade will show all students in the roster.
- Select the desired ***Series*** using the dropdown list to apply compliance rules to the Roster. You are required to select a Series to view the Roster.
- Select the desired sort using the ***Sort By*** dropdown list.
- Click the ***View Roster*** button.



Edit the Roster

****To keep the Roster up to date students must be added and removed as students enroll and withdraw****

Add A Student

- Click the ***Add New Students*** button to go to the Patient Search/Add Screen

Remove a Student

- Check the box in the ***Remove*** column next to the student you wish to remove.
- Click the ***Save Roster Updates*** button.
- Click ***OK*** on the popup window asking if you are sure you want to delete.

Change a Student's Grade Level

- Select the desired grade from the dropdown list next to the student's name in the ***Move To*** column.
- Click the ***Save Roster Updates*** button.

Change the Grade of All Students on the Roster

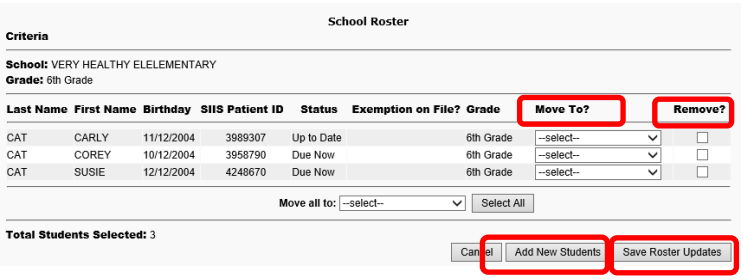
****Do at the End of Each School Year****

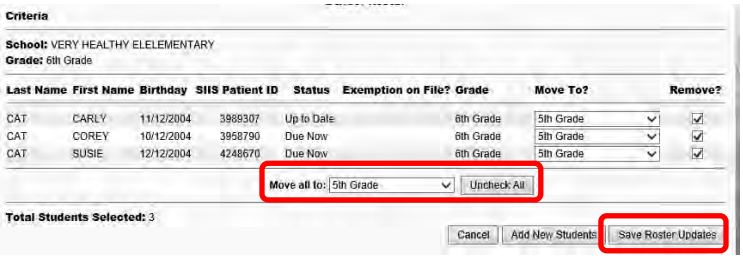
Remove all Students in the highest grade: graduating or moving to the next school, ex. 12th grade

- Click the ***Select All*** button. All of the student's Remove boxes will be checked.
- Click the ***Save Roster Updates*** button.

Change the Grade of All Remaining Students on the Roster

- Select the desired grade from the dropdown list box next to ***Move All To***. Start with the highest grade level, ex. Move 11th grade to 12th grade
- Click the ***Save Roster Updates*** button.





Vaccination Summary Page

After selecting a student, click on ***Summary*** under the *Vaccinations* menu heading. This view-only page will display the following sections:

Vaccination Summary
Lists a student's vaccines grouped by vaccine type. Immunizations marked with a red X are considered invalid. Click on the vaccine date for more detail, including the provider who gave the vaccine.

Invalid Vaccinations
Lists the reason a vaccine dose marked with a red X is invalid.

Vaccine Deferrals
Notes the deferrals entered by the healthcare provider about deferred.

Vaccine Contraindications/Exemptions/Precautions
Notes the information entered by the healthcare provider. Some detail information may not display due to patient confidentiality. Exemptions entered in the School Module do not display here.

Vaccination Forecast
Lists vaccinations still needed and when they are due. Definitions of the Forecast Status can be found on the *Forecast* page under Vaccinations on the main menu.

Search for Immunization Records from a different State

- After selecting a patient from the *Patient Search/Add* screen, click ***Remote Registry*** under the *Patient* menu heading.
- Select the desired ***State Name*** from the *Remote Connection* dropdown list.
- Click the ***Query*** button.
- Currently WAIIS connects to the Arizona and Louisiana IIS

School Module

Vaccination View/Add Page

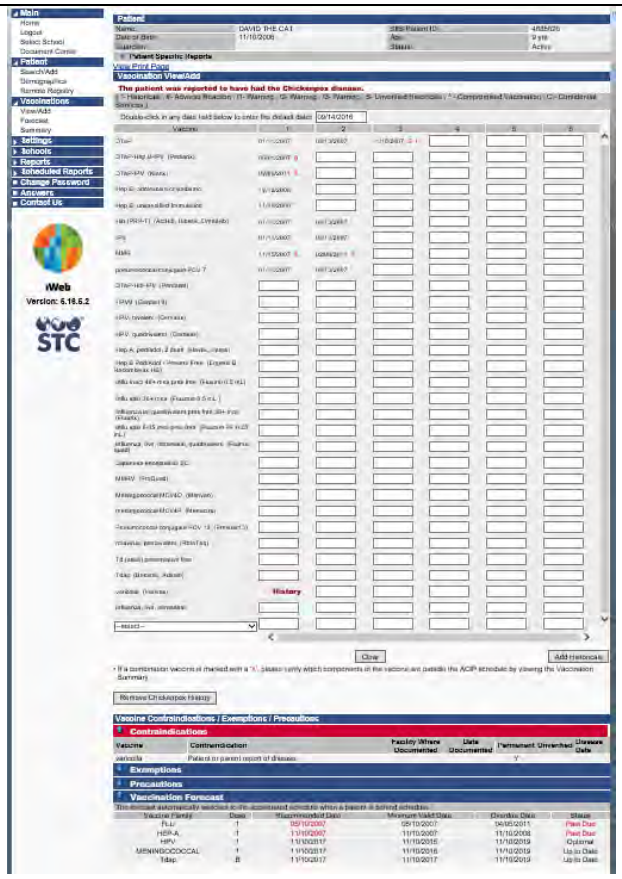
After selecting a student, click on ***View/Add*** under the *Vaccinations* menu heading. This page will display the following areas:

Vaccination View/Add

Lists all vaccinations administered and fields to enter additional doses. Immunizations entered in the School Module will have a red S after the immunization date. Only medically verified immunization records may be entered on this page. For more information about entering immunization dates see the *Add Missing Immunization* section below.

Vaccine Contraindications/Exemptions/Precautions and Forecast

Notes detail entered by the healthcare provider as well as the Vaccination Forecast. Exemptions entered in the School Module do not display here.



Add a Missing Immunization

Important:

- ✓ Only medically verified immunization records may be entered into the School Module. Follow the guidelines in the next column to determine if an immunization record is a valid medically verified record (see Appendix A for samples). The ultimate decision to enter an immunization record is based on the School Nurse's best clinical judgment.
- ✓ Due to FERPA rules, parent consent must be obtained prior to entering the dates into the School Module. Use the Certificate of Immunization Status (CIS) to document parent consent.

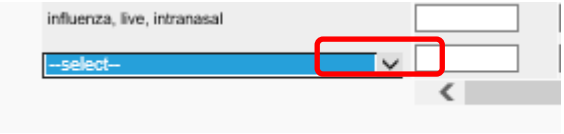
The following are examples of medically verified immunization records that may be entered into the IIS (see Appendix A for samples):

- Immunization records printed from a clinic or hospital Electronic Health Record.
- Immunization record or official CIS printed from another state's immunization registry.
- Official lifetime immunization record from WA or another state with a unique healthcare provider or clinic stamp, or another form of written healthcare provider documentation, such as a provider signature.
- For foreign students: translated official immunization record such as an immigration form or lifetime immunization record from another country with a clinic or healthcare provider stamp.
- CIS: handwritten immunizations can be accepted only if verified with a unique healthcare provider or clinic stamp, or another form of written healthcare provider documentation, such as a provider signature.

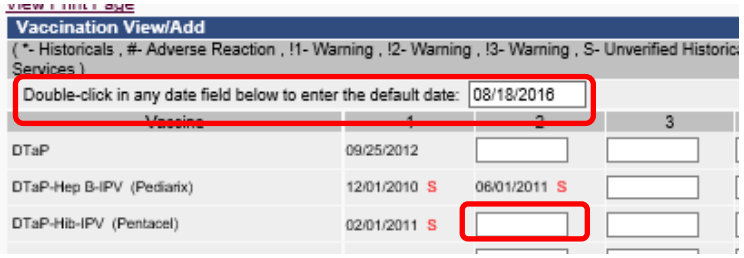
To Enter a Date

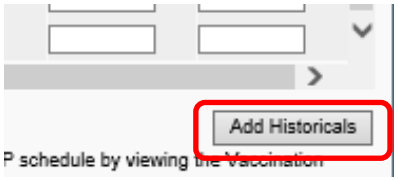
- After selecting a student, click on ***View/Add*** under the *Vaccination* menu heading.
- Click into the ***Box*** next to the appropriate vaccine brand. If the specific vaccine name is not specified on the student's immunization record use the *Default Vaccine to enter* specified in the next column. Additional vaccines can be found in the dropdown list at the bottom of the *Vaccine View/Add* section.

Vaccine	Default vaccine to enter
DTaP	DTaP unspecified
DT	DT (pediatric)
Hep A	Hep A 2 dose – Ped/Adol (Havrix, Vaqta)
Hep B	Hep B Ped/Adol – Preserv Free (Engerix, Recombivax)
Hib	Hib--PRP-OMP (PedvaxHib) PRP-T (ActHib, Hiberix, OmniHib)
Flu	Influ split 6-35 mos pres free (Fluzone PF.25mL syringe) Influ split 36+ mos (Fluzone)
MMR	MMR (MMRII) MMR/Varicella (ProQuad)
Pneumococcal	Pneumococcal(PCV) Pneumococcal, PCV-13 (Prevnar13)
Td	Td Adult, Preserv Free (Tenivac, Td-Merck, Td-MassBio)
Tdap	Tdap (Boostrix,Adacel)
Varicella	Varicella (Varivax) MMR/Varicella (ProQuad)



- Type the date as a string of numbers; for example, May 8, 2005 = 050805, or double click to use the ***Default Date*** at the top of the *Vaccination View/Add* section. The Default Date can be changed to any desired date.
- Click the ***Add Historicals*** button list at the bottom of the *Vaccine View/Add* section. You can add multiple dates in the vaccine fields before clicking the button. Remember to do this to save your work.
- Immunizations entered in the School Module will have a red S after the immunization date. Immunizations marked with a red X are considered invalid. Click on the vaccine date for more detail.

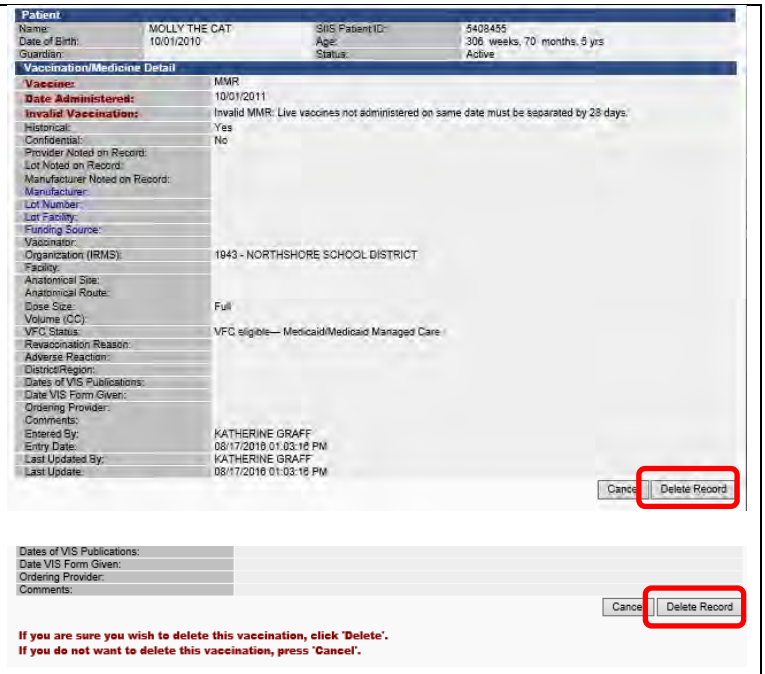




Delete an Immunization

Immunization dates can only be deleted if you entered the date.

- After selecting a student, click on ***View/Add*** under the *Vaccinations* menu heading.
- Click on the ***Immunization Date*** entered in error. The system will open *the Vaccination/Medicine Detail* page.
- Click the ***Delete Record*** button. The system opens a second *Vaccination Detail* screen.
- Click the ***Delete Record*** button to delete the record.
- Click ***Cancel*** to return to the previous screen without deleting the record.



Chickenpox History

Only healthcare provider verified history of disease may be entered.

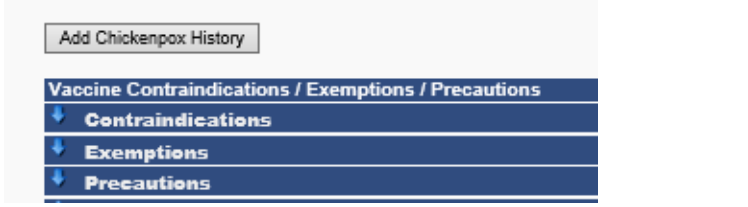
An exception is noted in the Individual Vaccine Requirements Summary document.

Add Chickenpox History

- After selecting a student, click on ***View/Add*** under the *Vaccinations* menu heading.
- Click the ***Add Chickenpox History*** button.

Delete Chickenpox History

- After selecting a student, click on ***View/Add*** under the *Vaccinations* menu heading.
- Click the ***Delete Chickenpox History*** button.



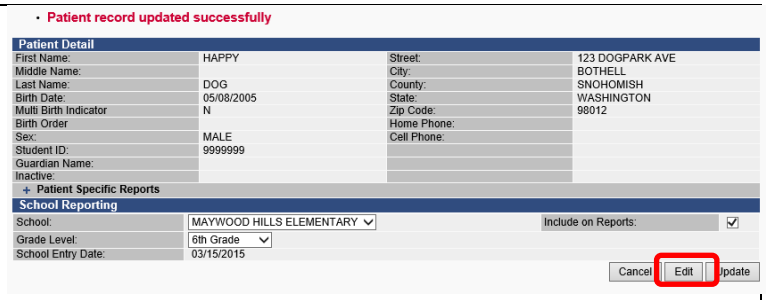
School Module

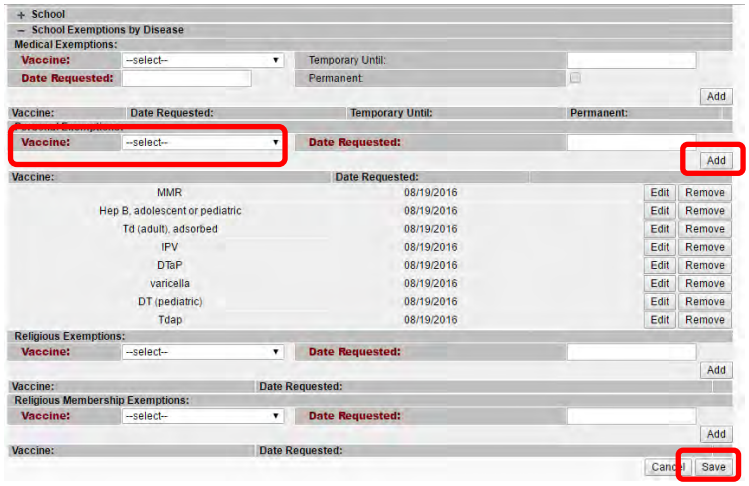
Add an Immunization Exemption

- ✓ Medical, Personal and Religious Exemptions require both parent/guardian and healthcare provider signatures on the Certificate of Exemption Form.
- ✓ Religious Membership Exemptions require only a parent/guardian signature on the second page of the Certificate of Exemption Form.

Add an Exemption

- After selecting a student, select ***Demographics*** under the *Patient* main heading.
- Click the **Edit** button.
- The system will open the *Patient Demographics Edit* page.
- Click the + to expand ***School Exemptions by Disease.***
- Click the desired ***Vaccine*** from the *Vaccine dropdown list.*
- Type the date of the parent/guardian signature on the Certificate of Exemption in the ***Date Requested*** field.
- If it is a Medical Exemption check the ***Permanent*** box OR type the exemption expiration date in the ***Temporary Until*** field.
- Click the ***Add*** button.
- Click the ***Save*** button.





Delete an Immunization Exemption

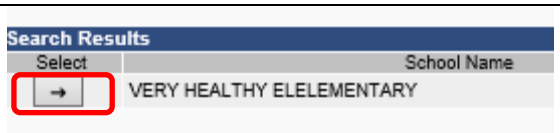
From the *Patient Demographics Edit* page:

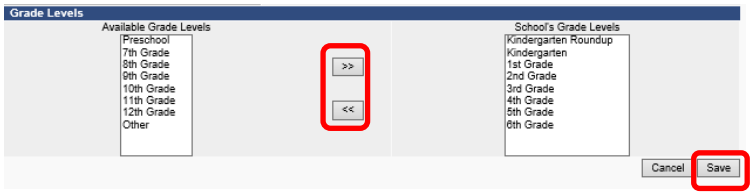
- Click the + to expand ***School Exemptions by Disease.***
- Click the ***Remove*** button of the desired exemption series.
- Click the ***Save*** button.

Edit School Grade Levels

To add or remove a grade level from a school:

- Click ***Edit School*** under *Schools* on the Main Menu.
- Click the ***Arrow*** button next to the desired school.
- Use the ***Right*** and ***Left Arrow*** buttons to move grades between the *Available Grade Level* and *School's Grade Levels* lists.
- Click the ***Save*** button.



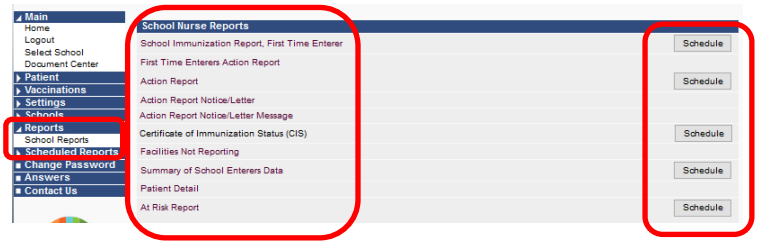


School Reports

The following reports are available in the School Module. To be accurate all reports that calculate compliance need to be run with the appropriate grade or age series selected.

To access School Reports

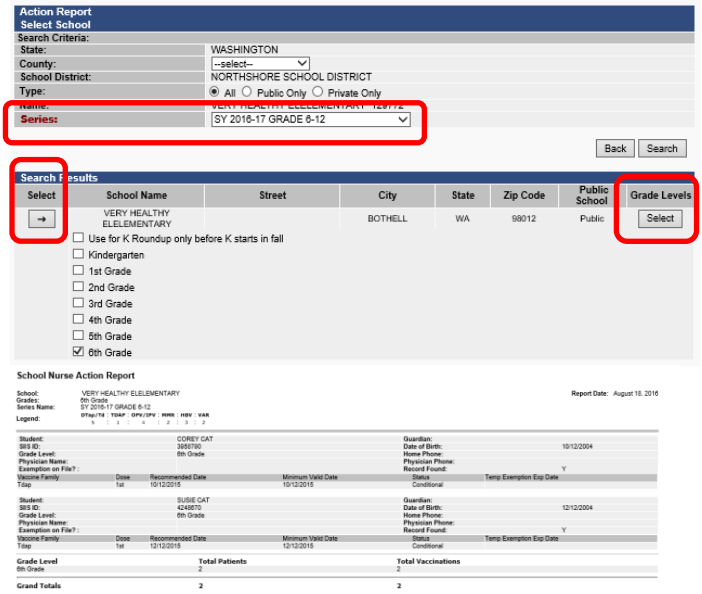
- Select ***School Reports*** under *Reports* on the Main Menu.
- Click on the desired ***Report Name*** to open the report parameters.
- Some reports can be scheduled to run at a specific time, ex. after hours



Action Report

This report lists students in *Out of Compliance* or *Conditional Status*

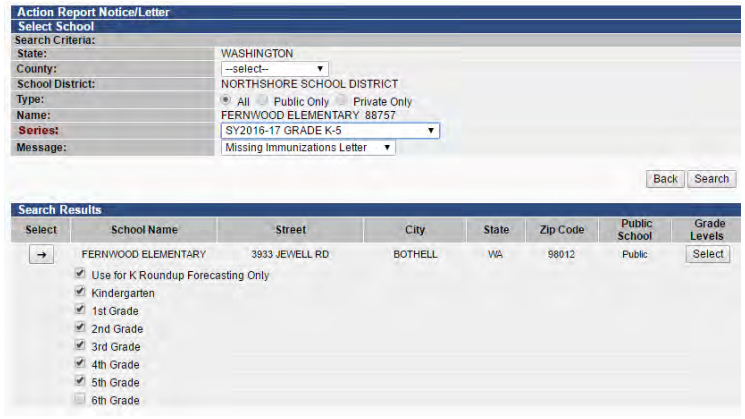
- Select the **Series** rules to apply with the *dropdown list*.
- Click the **Select** button under the *Grade Levels* column to open the grade list then click the **Boxes** next to the *Grade Level* to check or uncheck the desired grade levels.
- Click the **Arrow** button under *Select* to run the report.



Action Report Notice/Letter

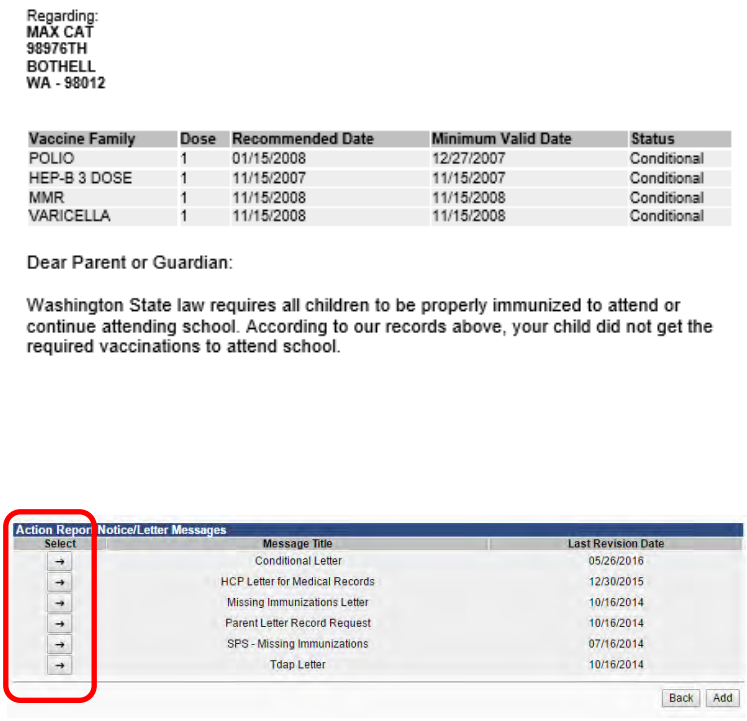
This report produces a letter, one per student based upon the parameters selected. The following letters are available:

- **Conditional Letter**: Letter to parent/guardian stating that student is in 30 day conditional status.
- **Healthcare Provider Letter**: Letter to healthcare provider asking they enter immunizations into the IIS or send of list of immunizations to the School Nurse.
- **Missing Immunizations Letter**: Letter to parent/guardian of student out of compliance listing the missing immunizations.
- **Parent Letter Record Request**: Letter to parent/guardian requesting immunizations record or healthcare provider information.
- **Tdap Letter**: Letter to parent/guardian of students missing a Tdap immunization.



To Run the Letters

- Select the ***Series*** with the *dropdown* list.
- Select the desired ***Letter*** from the Message *dropdown* list.
- Click the ***Select*** button under the *Grade Levels* column to open the grade list then click the ***Boxes*** next to the *Grade Level* to check or uncheck the desired grade levels.
- Click the ***Arrow*** button under *Select* to run the report.



Regarding:
MAX CAT
98976TH
BOTHELL
WA - 98012

Vaccine Family	Dose	Recommended Date	Minimum Valid Date	Status
POLIO	1	01/15/2008	12/27/2007	Conditional
HEP-B 3 DOSE	1	11/15/2007	11/15/2007	Conditional
MMR	1	11/15/2008	11/15/2008	Conditional
VARICELLA	1	11/15/2008	11/15/2008	Conditional

Dear Parent or Guardian:

Washington State law requires all children to be properly immunized to attend or continue attending school. According to our records above, your child did not get the required vaccinations to attend school.

Action Report Notice/Letter Messages

Action Report Notice/Letter Messages

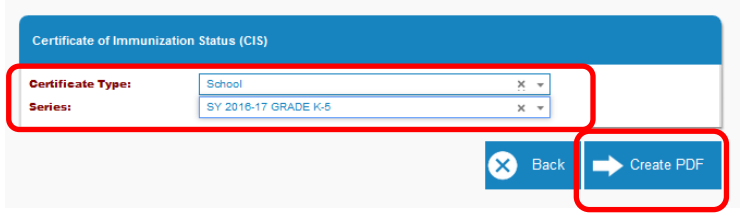
This screen allows the user to edit the text of the letters above. *Note: as of 09/15/2016 this screen is not working. IIS staff are working to resolve the problem*.

- Click the ***Arrow*** button under *Select* for the desired report.
- Type text in the edit boxes.
- Click the ***Save*** button.

Certificate of Immunization Status (CIS)

This report will produce a Certificate of Immunization Status Report (CIS) for the student selected from the Search/Add screen.

- Select the ***Certificate Type***
  - *Childcare* for preschool aged children
  - *School* for K-12 and
- Select the ***Series***
  - For *Childcare* select the age that is the closest to the child without exceeding the current age, ex. For a 4 month old child select CHILD CARE BY 3 MONTHS
  - For *School* select the grade range and school year
- Click ***Create PDF***



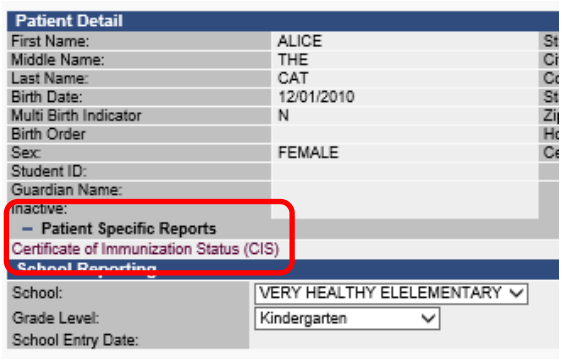
A CIS can also be printed from the:

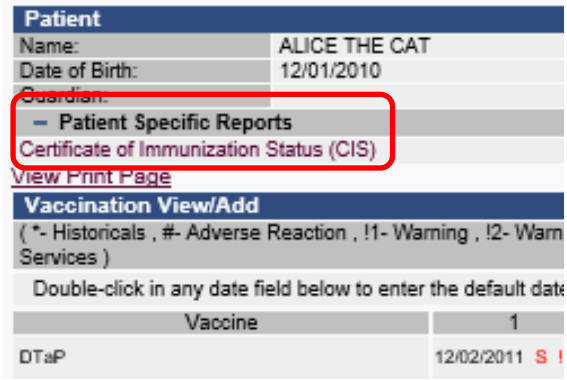
Demographics page

- Click ***Demographics*** under *Patient* on the Main Menu.
- Click the + sign to the left of *Patient Specific Reports* at the bottom of the *Patient Detail* section.
- Select ***Certificate of Immunization Status (CIS)*** from the list.

Vaccination View/Add page

- Click ***View/Add*** under *Vaccinations* on the Main Menu.
- Click the + sign to the left of *Patient Specific Reports* at the bottom of the *Patient* section.
- Select ***Certificate of Immunization Status (CIS)*** from the list.





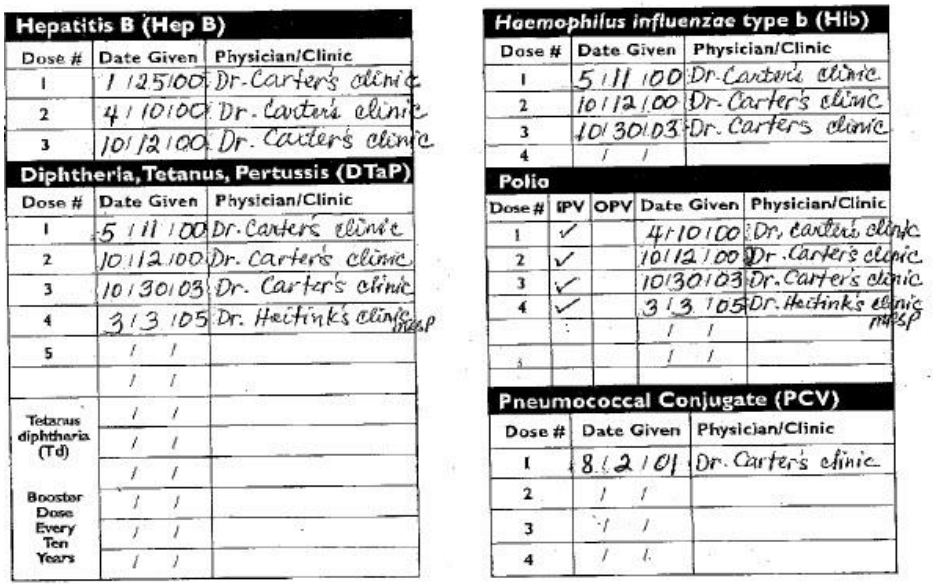
Additional Resources

Additional resources for the School Module and CIS are available at: www.doh.wa.gov/schoolmodule

Contact us at: SchoolModule@doh.wa.gov

Appendix A: Examples of Medically Verified Immunization Records

Official lifetime immunization record from WA or another state with a unique healthcare provider or clinic stamp, or another form of written healthcare provider documentation, such as a provider signature



Hepatitis B (Hep B)

Dose #	Date Given	Physician/Clinic
1	1/25/00	Dr. Carter's clinic
2	4/10/00	Dr. Carter's clinic
3	10/12/00	Dr. Carter's clinic

Diphtheria, Tetanus, Pertussis (DTaP)

Dose #	Date Given	Physician/Clinic
1	5/11/00	Dr. Carter's clinic
2	10/12/00	Dr. Carter's clinic
3	10/30/03	Dr. Carter's clinic
4	3/3/05	Dr. Heitink's clinic MMSP
5	/ /	
	/ /	
Tetanus diphtheria (Td)	/ /	
	/ /	
	/ /	
Booster Dose Every Ten Years	/ /	
	/ /	
	/ /	

Haemophilus influenzae type b (Hib)

Dose #	Date Given	Physician/Clinic
1	5/11/00	Dr. Carter's clinic
2	10/12/00	Dr. Carter's clinic
3	10/30/03	Dr. Carters clinic
4	/ /	

Polio

Dose #	IPV	OPV	Date Given	Physician/Clinic
1	✓		4/10/00	Dr. Carter's clinic
2	✓		10/12/00	Dr. Carter's clinic
3	✓		10/30/03	Dr. Carter's clinic
4	✓		3/3/05	Dr. Heitinks clinic MMSP
			/ /	
			/ /	

Pneumococcal Conjugate (PCV)

Dose #	Date Given	Physician/Clinic
1	8/2/01	Dr. Carter's clinic
2	/ /	
3	/ /	
4	/ /	

Measles, Mumps, Rubella (MMR)

Type of Vaccine	Dose #	Date Given	Physician/Clin
MMR	1	8/2/01	Dr. Carter's cl
MMR	2	3/3/05	MARK A-Hortink
MMR		/ /	
Measles		/ /	
Mumps		/ /	
Rubella		/ /	

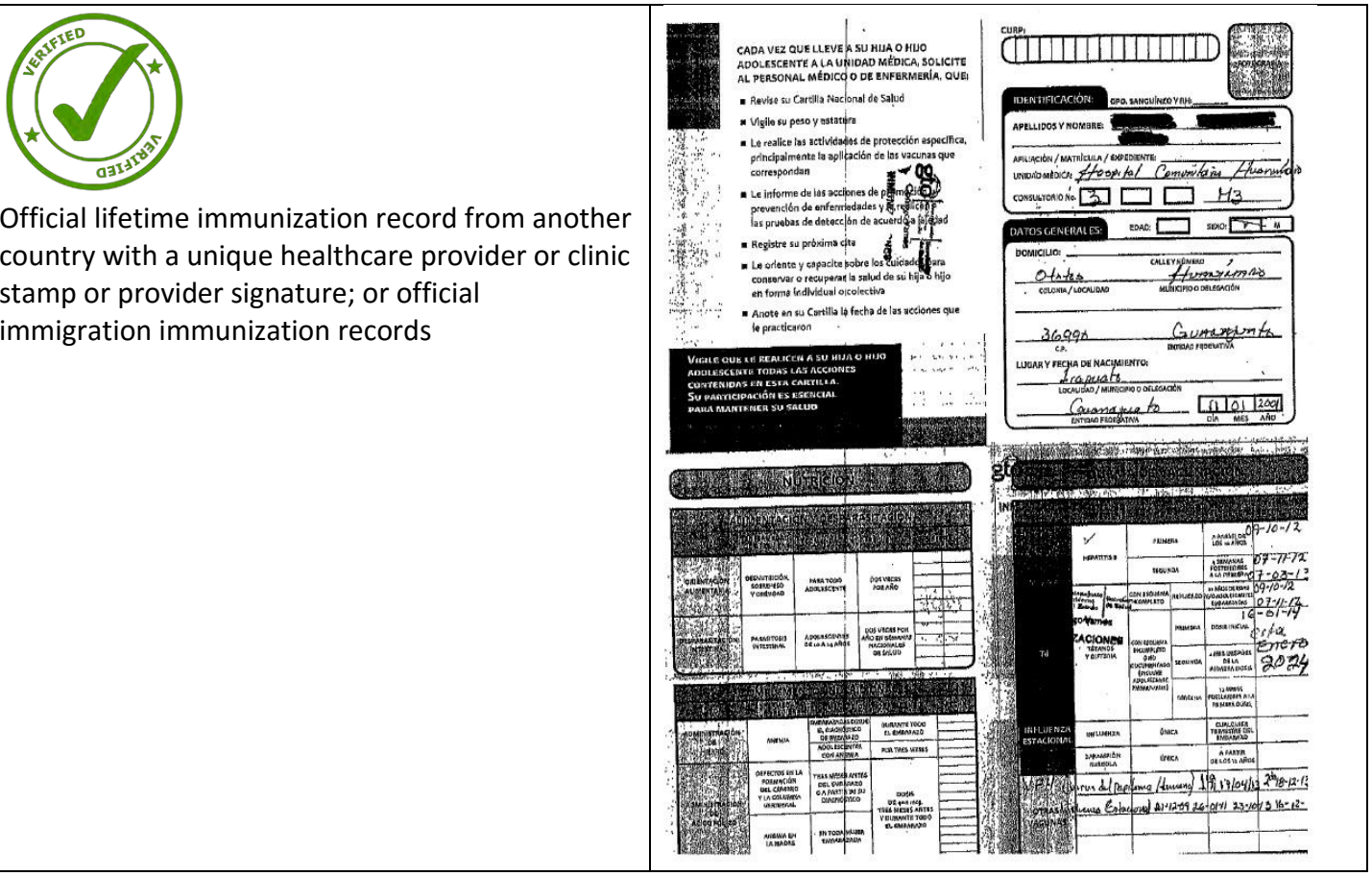
Varicella (Var)

Dose #	Date Given	Physician/Clinic
1	8/2/01	Dr. Carter's Clini
	/ /	

Hepatitis A (Hep A)

Dose #	Date Given	Physician/Clinic
1	/ /	
2	/ /	

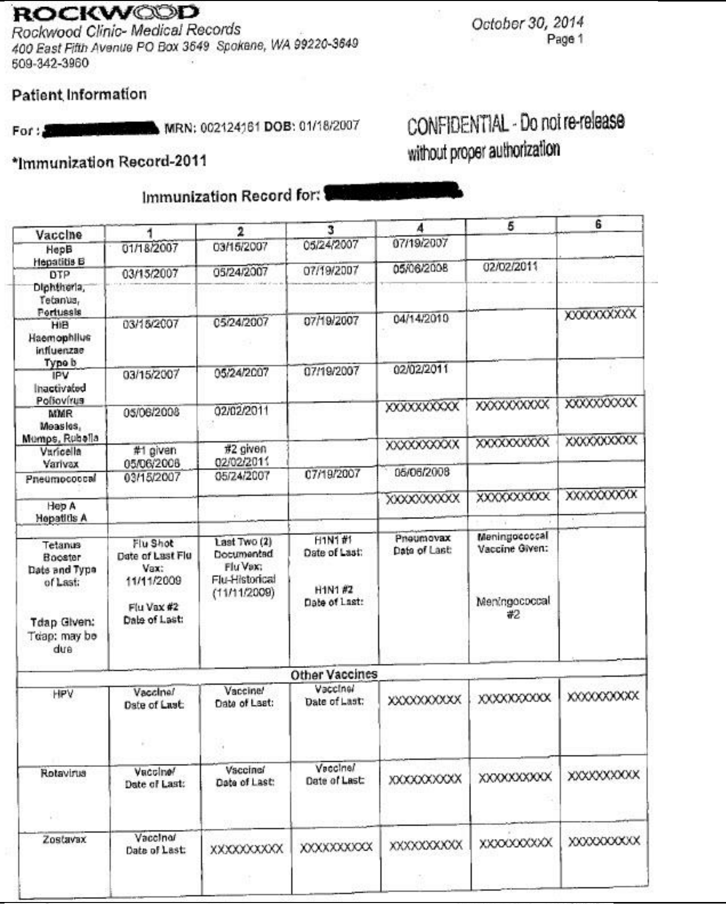
Allergies/Vaccine Reactions: _____



Official lifetime immunization record from another country with a unique healthcare provider or clinic stamp or provider signature; or official immigration immunization records

School Module

Immunization Record printed from a healthcare provider, clinic or hospital's Electronic Health Record



ROCKWOOD
Rockwood Clinic- Medical Records
400 East Fifth Avenue PO Box 3649 Spokane, WA 99220-3649
509-342-3960

October 30, 2014
Page 1

Patient Information

For : [redacted] MRN: 002124161 DOB: 01/18/2007

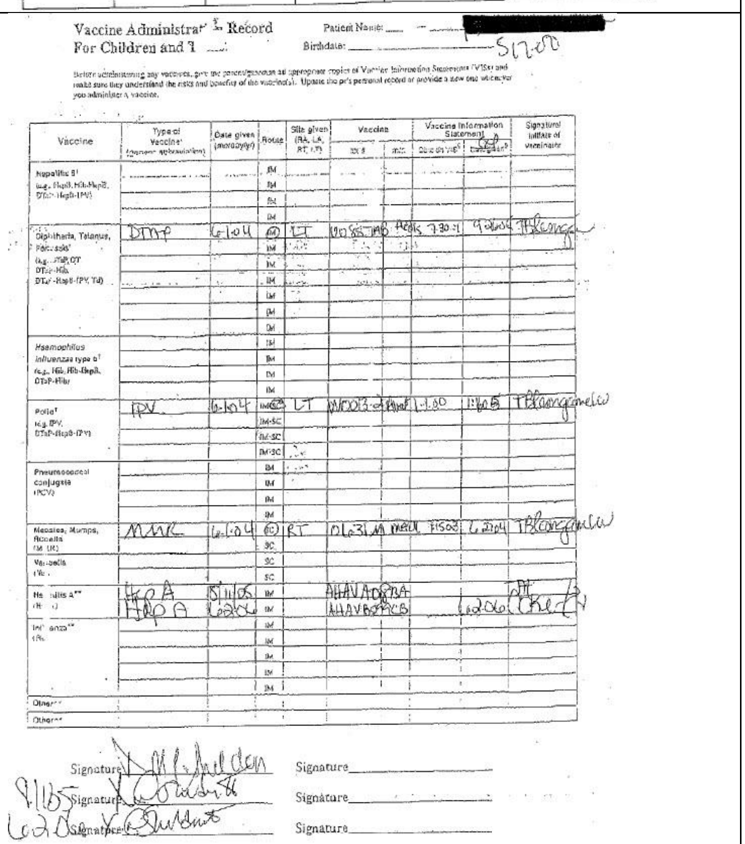
CONFIDENTIAL - Do not re-release without proper authorization

***Immunization Record-2011**

Immunization Record for: [redacted]

Vaccine	1	2	3	4	5	6
HepB Hepatitis B	01/18/2007	03/16/2007	05/24/2007	07/19/2007		
DTP Diphtheria, Tetanus, Pertussis	03/15/2007	05/24/2007	07/19/2007	05/06/2008	02/02/2011	
HIB Haemophilus influenzae Type b	03/15/2007	05/24/2007	07/19/2007	04/14/2010		XXXXXXXXXX
IPV Inactivated Poliovirus	03/15/2007	05/24/2007	07/19/2007	02/02/2011		
MMR Measles, Mumps, Rubella	05/06/2008	02/02/2011		XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX
Varicella Varivax	#1 given 05/06/2008	#2 given 02/02/2011		XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX
Pneumococcal	03/15/2007	05/24/2007	07/19/2007	05/06/2008		
Hep A Hepatitis A				XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX
Tetanus Booster Date and Type of Last: Tdap Given: Tdap: may be due	Flu Shot Date of Last Flu Vax: 11/11/2009 Flu Vax #2 Date of Last:	Last Two (2) Documented Flu Vax: Flu-Historical (11/11/2009)	H1N1 #1 Date of Last: H1N1 #2 Date of Last:	Pneumovax Date of Last:	Meningococcal Vaccine Given: Meningococcal #2	
			Other Vaccines			
HPV	Vaccine/ Date of Last:	Vaccine/ Date of Last:	Vaccine/ Date of Last:	XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX
Rotavirus	Vaccine/ Date of Last:	Vaccine/ Date of Last:	Vaccine/ Date of Last:	XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX
Zostavax	Vaccine/ Date of Last:	XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX

Written Immunization Record from a healthcare provider or clinic



Vaccine Administration Record For Children and T

Patient Name: [redacted]
Birthdate:

Before administering any vaccines, give the parent/guardian all appropriate copies of Vaccine Information Statements (VISs) and make sure they understand the risks and benefits of the vaccine(s). Update the pt's personal record or provide a new one whenever you administer a vaccine.

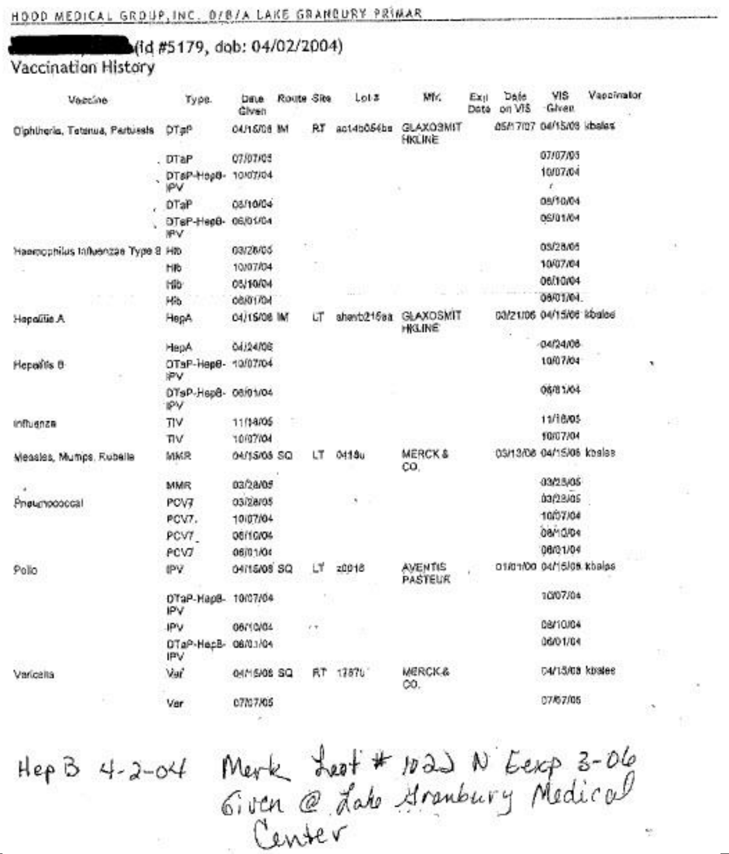
Vaccine | Type of Vaccine | Date given | Route | Site given | Vaccine | Vaccine Information Statement | Signature/ initials of vaccinator

Hepatitis B
Diphtheria, Tetanus, Pertussis — DTaP
Haemophilus influenzae type b
Polio — IPV
Pneumococcal conjugate (PCV)
Measles, Mumps, Rubella — MMR
Varicella
Hepatitis A — Hep A
Influenza
Other
Other

Signature
Signature
Signature
Signature
Signature
Signature

School Module

Immunization Record printed from a healthcare provider, clinic or hospital's Electronic Health Record with a written note or addition



HOOD MEDICAL GROUP, INC. D/B/A LAKE GRANBURY PRIMAR

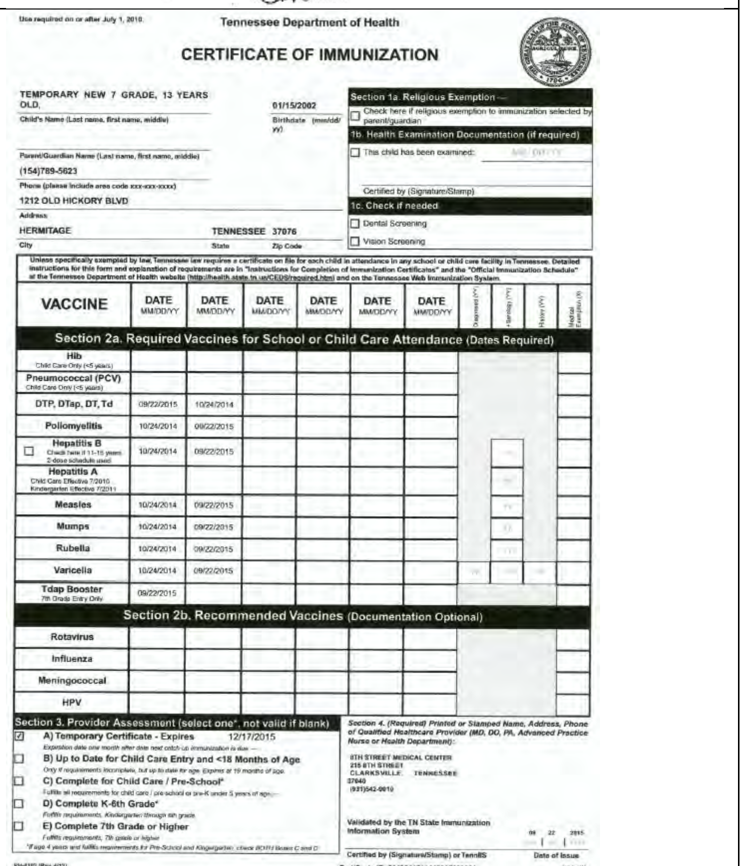
[redacted] (id #5179, dob: 04/02/2004)

Vaccination History

Vaccine	Type	Date Given	Route	Site	Lot #	Mfr.	Exp Date	Date on VIS	VIS Given	Vaccinator
Diphtheria, Tetanus, Pertussis	DTaP	04/15/08	IM	RT	ac14b054ba	GLAXOSMITHKLINE		05/17/07	04/15/08	kbales
	DTaP	07/07/05							07/07/05	
	DTaP-HepB-IPV	10/07/04							10/07/04	
	DTaP	08/10/04							08/10/04	
	DTaP-HepB-IPV	06/01/04							06/01/04	
Haemophilus Influenzae Type B	Hib	03/28/05							03/28/05	
	Hib	10/07/04							10/07/04	
	Hib	08/10/04							08/10/04	
	Hib	06/01/04							06/01/04	
Hepatitis A	HepA	04/15/08	IM	LT	ahavb215aa	GLAXOSMITHKLINE		03/21/06	04/15/08	kbales
	HepA	04/24/06							04/24/06	
Hepatitis B	DTaP-HepB-IPV	10/07/04							10/07/04	
	DTaP-HepB-IPV	06/01/04							06/01/04	
Influenza	TIV	11/18/05							11/18/05	
	TIV	10/07/04							10/07/04	
Measles, Mumps, Rubella	MMR	04/15/08	SQ	LT	0418u	MERCK & CO.		03/13/08	04/15/08	kbales
	MMR	03/28/05							03/28/05	
Pneumococcal	PCV7	03/28/05							03/28/05	
	PCV7	10/07/04							10/07/04	
	PCV7	08/10/04							08/10/04	
	PCV7	06/01/04							06/01/04	
Polio	IPV	04/15/08	SQ	LT	z0018	AVENTIS PASTEUR		01/01/00	04/15/08	kbales
	DTaP-HepB-IPV	10/07/04							10/07/04	
	IPV	08/10/04							08/10/04	
	DTaP-HepB-IPV	06/01/04							06/01/04	
Varicella	Var	04/15/08	SQ	RT	1787u	MERCK & CO.			04/15/08	kbales
	Var	07/07/05							07/07/05	

Hep B 4-2-04 Merk Lot # 1022 N Exp 3-06
Given @ Lake Granbury Medical Center

Immunization Record printed from the WA IIS or the IIS of another state



Use required on or after July 1, 2010. Tennessee Department of Health

CERTIFICATE OF IMMUNIZATION

TEMPORARY NEW 7 GRADE, 13 YEARS OLD,
Child's Name (Last name, first name, middle)

01/15/2002
Birthdate (mm/dd/yy)

Parent/Guardian Name (Last name, first name, middle)

(154)789-5623
Phone (please include area code xxx-xxx-xxxx)

1212 OLD HICKORY BLVD
Address

HERMITAGE — TENNESSEE — 37076
City — State — Zip Code

Section 1a. Religious Exemption —
☐ Check here if religious exemption to immunization selected by parent/guardian

1b. Health Examination Documentation (if required)
☐ This child has been examined: MM/DD/YY
Certified by (Signature/Stamp)

1c. Check if needed
☐ Dental Screening
☐ Vision Screening

Unless specifically exempted by law, Tennessee law requires a certificate on file for each child in attendance in any school or child care facility in Tennessee. Detailed instructions for this form and explanation of requirements are in "Instructions for Completion of Immunization Certificates" and the "Official Immunization Schedule" at the Tennessee Department of Health website (http://health.state.tn.us/CEDS/required.htm) and on the Tennessee Web Immunization System.

VACCINE	DATE MM/DD/YY	DATE MM/DD/YY	DATE MM/DD/YY	DATE MM/DD/YY	DATE MM/DD/YY	DATE MM/DD/YY	Diagnosed (Y/Y)	+Serology (Y/Y)	History (Y/Y)	Medical Exemption (X)
Section 2a. Required Vaccines for School or Child Care Attendance (Dates Required)										
Hib (Child Care Only (<5 years))										
Pneumococcal (PCV) (Child Care Only (<5 years))										
DTP, DTap, DT, Td	09/22/2015	10/24/2014								
Poliomyelitis	10/24/2014	09/22/2015								
☐ Hepatitis B (Check here if 11-15 years 2-dose schedule used)	10/24/2014	09/22/2015								
Hepatitis A (Child Care Effective 7/2010, Kindergarten Effective 7/2011)										
Measles	10/24/2014	09/22/2015								
Mumps	10/24/2014	09/22/2015								
Rubella	10/24/2014	09/22/2015								
Varicella	10/24/2014	09/22/2015								
Tdap Booster (7th Grade Entry Only)	09/22/2015									
Section 2b. Recommended Vaccines (Documentation Optional)										
Rotavirus										
Influenza										
Meningococcal										
HPV										

Section 3. Provider Assessment (select one*, not valid if blank)

- ☑ A) Temporary Certificate - Expires 12/17/2015
  Expiration date one month after date next catch-up immunization is due —
- ☐ B) Up to Date for Child Care Entry and <18 Months of Age
  Only if requirements incomplete, but up to date for age. Expires at 19 months of age.
- ☐ C) Complete for Child Care / Pre-School*
  Fulfills all requirements for child care / pre-school or pre-K under 5 years of age —
- ☐ D) Complete K-6th Grade*
  Fulfills requirements, Kindergarten through 6th grade
- ☐ E) Complete 7th Grade or Higher
  Fulfills requirements, 7th grade or higher

*If age 4 years and fulfills requirements for Pre-School and Kindergarten, check BOTH boxes C and D

Section 4. (Required) Printed or Stamped Name, Address, Phone of Qualified Healthcare Provider (MD, DO, PA, Advanced Practice Nurse or Health Department):

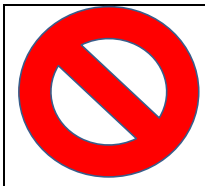
8TH STREET MEDICAL CENTER
215 8TH STREET
CLARKSVILLE TENNESSEE
37040
(931)542-0010

Validated by the TN State Immunization Information System — 09 22 2015

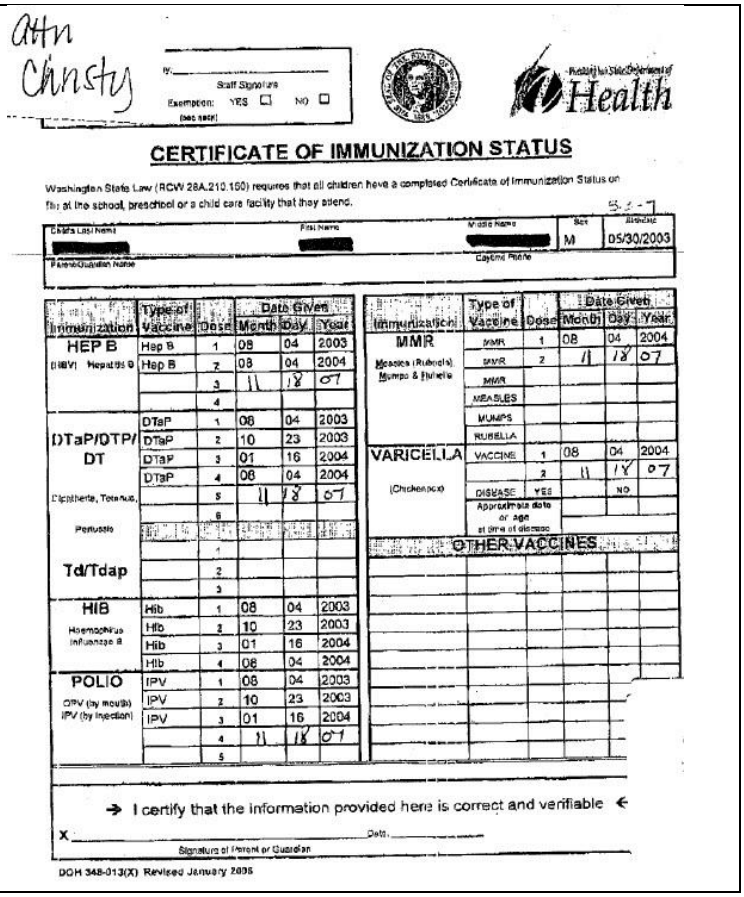
Certified by (Signature/Stamp) or TennIIS — Date of Issue

PH-4103 (Rev. 4/13) — Certificate ID: 9149811711442927109884 — RDA-N/A

School Module



A CIS with either typed or written dates **is NOT** medically verified *unless* it has a healthcare provider stamp of signature



Attn Christy

Staff Signature
Exemption: YES ☐ NO ☐

Washington State Department of Health

CERTIFICATE OF IMMUNIZATION STATUS

Washington State Law (RCW 28A.210.100) requires that all children have a completed Certificate of Immunization Status on file at the school, preschool or a child care facility that they attend.

5-7

Child's Last Name	First Name	Middle Name	Sex	Birthdate
[redacted]	[redacted]	[redacted]	M	05/30/2003

Parent/Guardian Name — Daytime Phone

Immunization	Type of Vaccine	Dose	Date Given Month	Day	Year
HEP B (HBV) Hepatitis B	Hep B	1	08	04	2003
	Hep B	2	08	04	2004
		3	11	18	07
		4			
DTaP/DTP/DT Diphtheria, Tetanus, Pertussis	DTaP	1	08	04	2003
	DTaP	2	10	23	2003
	DTaP	3	01	16	2004
	DTaP	4	08	04	2004
		5	11	18	07
		6			
Td/Tdap		1			
		2			
		3			
HIB Haemophilus influenzae B	Hib	1	08	04	2003
	Hib	2	10	23	2003
	Hib	3	01	16	2004
	Hib	4	08	04	2004
POLIO OPV (by mouth) IPV (by injection)	IPV	1	08	04	2003
	IPV	2	10	23	2003
	IPV	3	01	16	2004
		4	11	18	07
		5			

Immunization	Type of Vaccine	Dose	Date Given Month	Day	Year
MMR Measles (Rubeola), Mumps & Rubella	MMR	1	08	04	2004
	MMR	2	11	18	07
	MMR				
	MEASLES				
	MUMPS				
	RUBELLA				
VARICELLA (Chickenpox)	VACCINE	1	08	04	2004
		2	11	18	07
	DISEASE	YES		NO	
	Approximate date of age at time of disease				

OTHER VACCINES

→ I certify that the information provided here is correct and verifiable ←

X _____ Date: _____
Signature of Parent or Guardian

DOH 348-013(X) Revised January 2005