

HERPES SIMPLEX (Fever blisters)

Virus is spread by contact with saliva of an infected person.

Incubation Period: 2 to 12 days.

Period of Communicability: Generally 2 weeks, but may be as long as 7 weeks.

May Return To School: Students with herpes simplex should not be excluded from school.

IMPETIGO (Pus pimples, sand sores)

Impetigo is spread by contact with drainage from sore or nasal secretions.

Incubation Period: Variable and indefinite, commonly 4 to 10 days

Period of Communicability: While sores are draining.

May Return To School: Students with impetigo should be excluded from school for 24 hours after initiation of treatment.

INFLUENZA

Influenza (commonly referred to as the “flu”) is a viral disease of the respiratory tract. There are two main types of influenza virus: type A and B and one uncommon type: type C. Type A includes different subtypes that commonly, but not always, change each year. Type A is usually the strain associated with widespread epidemics and pandemics. Type B is infrequently associated with regional or widespread epidemics. Type C has been associated with sporadic cases and minor localized outbreaks.

Signs and Symptoms:

Illness is usually characterized by the sudden onset of high fever or chills, headache, congestion, muscle aches and a dry cough. The clinical picture may be indistinguishable from other respiratory tract infections such as the common cold, croup, bronchiolitis, viral pneumonia, etc. Nausea, vomiting, and/or diarrhea are rarely seen with influenza. Most people are ill with the “flu” for a week or less. Individuals with lung disease, heart disease, cancer, emphysema, diabetes, or those with weakened immune systems may have more serious illness and at times, may need to be hospitalized. Influenza occurs most often in the late fall and winter months.

Transmission:

The viruses that cause influenza are highly communicable - the organisms are readily transmitted from one individual to another through contact with droplets from the nose and throat of an infected person during coughing and sneezing, particularly in confined spaces such as school buses and small classrooms. The incubation period for influenza is short, usually 1 to 3 days. Individuals are most infectious in the 24 hours before the onset of symptoms and during the period of peak symptoms. The virus is spread in the secretions for up to 3 - 5 days after the onset of symptoms, but it may last up to 7 days in young children. Individuals with weakened immune systems may have a

more prolonged course of infection. The virus that causes influenza frequently changes, thus infection with the “flu” does not make a person immune.

Diagnosis:

Diagnosis is generally made presumptively based on symptoms. However, laboratory tests can be obtained to confirm this diagnosis.

Treatment:

While anti-viral drugs are available for the treatment of influenza, these drugs are ONLY an adjunct to control influenza and should not substitute for vaccination. The mainstay of influenza control and prevention is vaccination. In general, healthcare providers advise otherwise healthy individuals with influenza to drink plenty of fluids and get plenty of rest. Prescription antiviral medications are available and may be used by your healthcare provider to treat influenza. Many of these drugs are not approved for use in children.

School Exclusion Guidelines

Young children may transmit influenza virus for up to 7 days. Adults probably transmit the virus for 3 to 5 days. School exclusion is not indicated as long as a student or staff member feels well enough to attend school and is fever-free (without fever reducing medicines) for 24 hours.

High-risk populations (see listing below) should be vaccinated on an annual basis. If an outbreak of influenza is identified in the school or community, high-risk individuals should consult with their healthcare provider regarding possible prophylaxis.

Reporting Requirements

Influenza is not a reportable disease. Florida participates in the annual sentinel physician surveillance program of the Centers for Disease Control and Prevention. These physicians report “influenza-like” illnesses and take cultures for influenza typing.

Notification Requirements

None usually indicated unless an outbreak occurs in the school. If an outbreak of influenza occurs within the school population, the school nurse should notify the Clay County Health Department. The health department, in consultation with school administrators, will determine whether some or all parents should be notified.

Prevention Guidelines

Annual influenza vaccination is strongly recommended for any person > 6 months who, because of age or underlying medical condition, is at increased risk for complications of influenza. The following groups are targeted to receive the influenza vaccine yearly:

Persons at Increased Risk for Complications

- Adults and children with chronic disorders of the pulmonary or cardiovascular systems, including asthma.

- Adults and children who require regular medical follow-up or hospitalization during the preceding year because of chronic diseases (including diabetes), kidney dysfunction, certain blood disorders called hemoglobinopathies (including sickle cell disease) or immunosuppression (persons on medications such as prednisone or being treated for HIV infection)
- Children and teenagers (age 6 months - 18 years) who are receiving long-term aspirin therapy
- Females who will be in the second or third trimester of pregnancy during the influenza season
- All people 65 years of age and older
- Residents of nursing homes or other long-term chronic care facilities
- Persons who can transmit influenza to those at high risk, such as:
 - Healthcare personnel
 - Household contacts of high risk persons

JUVENILE RHEUMATOID ARTHRITIS (JRA)

Juvenile rheumatoid arthritis is a general term for the most common types of arthritis in children. It is a long term disease resulting in joint pain and inflammation.

KIDNEY DISEASE

The kidneys are two bean-shaped organs located near the middle of the back, just below the rib cage. They are responsible for filtering water and waste products from the blood. There are multiple reasons for kidney failure in children, both acute and chronic. Some problems are resolved when treated. Others progress to chronic failure and may necessitate dialysis or transplant.

Signs and Symptoms:

Signs and symptoms are diverse and may include: fever, swelling especially of the feet, face, ankles and eyes, painful urination, changes in urine flow, hematuria, “accidents” in previously toilet trained children, high blood pressure and, especially in chronic disease, poor growth.

Treatment:

Children may be on various medications and may need to be out of school on a regular basis for dialysis.

LACERATION

A laceration is a wound that breaks the skin with either smooth or irregular edges and may bleed freely.

Intervention:

- Wear gloves.
- Control bleeding by applying direct pressure.
- Clean minor cuts with soap and water.

- Cover the wound with a sterile dressing.
- Recommend that parent/guardian contact licensed healthcare provider for further instruction if bleeding does not resolve with pressure or if sutures are indicated.
- Give the parent/guardian the date of the student's last tetanus booster to take to the licensed healthcare provider.

MENINGITIS

Meningitis can be bacterial or viral. Bacterial meningitis is a serious infection of the spinal cord and brain. It has a rapid onset and causes severe illness in a short time with fever, headache and stiff neck, which are the most common symptoms.

Viral Meningitis is usually less severe but may have similar symptoms of headache, fever or stiff neck.

Meningitis is spread through the exchange of respiratory and throat secretions through kissing and sharing eating utensils or drinks. People who are close contacts of those infected will be treated with antibiotics.

Good health habits including frequent hand washing and not eating or drinking after others including family, may help prevent the transmission of meningitis.

MONONUCLEOSIS (MONO)

Infectious mononucleosis sometimes called "mono" or "the kissing disease," is an infection usually caused by the Epstein-Barr virus (EBV), which may cause fever, sore throat or swollen lymph nodes. It is spread through direct contact with the infected person's saliva, such as by kissing, sharing a straw, a toothbrush or an eating utensil.

Signs and Symptoms:

Symptoms usually begin to appear 4 to 7 weeks after infection with the virus. Signs that you may have mono include:

- constant fatigue
- fever
- sore throat
- loss of appetite
- swollen lymph nodes (commonly called glands, located in your neck, underarms, and groin)
- headaches
- sore muscles
- larger-than-normal liver or spleen
- skin rash
- abdominal pain

Treatment:

There is no cure for mono. But the good news is that even if you do nothing, the illness will go away by itself, usually in 3 to 4 weeks. The best treatment is to get plenty of rest, especially during the beginning stages of the illness when your symptoms are the worst.

For the fever and aching muscles, try taking acetaminophen or ibuprofen. Prevention includes good hygiene practices including not sharing saliva of infected people.

May Return To School: Children may attend school if afebrile and feeling well. Parents should consult with their doctor if the child is easily fatigued or symptoms are prolonged.

NOSEBLEED

Intervention:

- Place student in sitting position with the head slightly forward.
- *Observe Universal Precautions!*
- Apply firm pressure on both sides of the nose for five minutes. (Student can do this by him/herself.)
- If necessary, apply cold pack to the nose. Provide tissues.
- Reassure student.
- Keep student quiet for 10 - 15 minutes after the bleeding stops.
- If bleeding continues, notify Parent/Guardian.

Note: Nosebleeds may be caused by a blow to the nose or the head. If fracture is suspected, refer for medical attention. Students with repeated nosebleeds should be referred for medical evaluation.

PEDICULOSIS (Head Lice)

A resurgence of head lice in the 1970s has placed head lice infestation as one of the largest and most exasperating issues in schools today. **Head lice do not spread any disease.** Head lice are tiny gray insects (about 1/16" long) that live in human hair and feed on human blood. The head louse crawls quickly but **cannot fly or jump**. They multiply rapidly, laying little silvery colored oval-shaped eggs (called nits), at the base of the hair shaft very close to the scalp. Usually nits are laid within 1/4" of the scalp. The nits appear glued to the base of the hair. **Egg casings located farther out on a hair shaft are not viable and should not be considered an infestation.** Nits are most often found in the hair behind the ears and at the back of the head and neck. Nits should not be confused with dandruff. Dandruff can easily be flicked off the hair; nits cannot because they are firmly attached to individual hairs. One telltale sign of head lice is an intensely itchy scalp, which is caused by the bite of the louse. The itchy scalp is sometimes accompanied by infected scratch marks or what appears to be a rash. A secondary bacterial infection can occur, causing oozing or crusting. Swollen neck glands may also develop. Anyone can get head lice. Head lice are not a sign of being dirty and should not be considered a sign of an unclean house. Head lice, not nits, can be shared from person to person but only by direct contact, such as sharing the same bed.

Transmission:

Head lice are transmitted through direct contact with an infested person through shared bedding and less frequently through shared items, such as combs, brushes, towels, and hats. Head lice are more common in warm weather months. The life cycle is composed of three phases: eggs, nymphs (3 stages), and adult head lice. The most suitable temperature for the life cycle is 89.6°F. Eggs of head lice do not hatch at temperatures less than 71.6°F. Under optimal conditions, lice eggs hatch in 7 to 10 days. The

nymphal stages last 7 to 13 days depending on temperatures. The egg-to-egg cycle averages about 3 weeks.

Diagnosis:

When a child is referred for possible head lice, the health room designee will check that student for signs of infestation such as presence of lice insects and/or nits. Diagnosis is usually made by detecting nits, which appear as tiny, pearly-gray, oval-shaped specks attached to the hair near the scalp (within 1/4" of scalp). Use a magnifying glass and natural light when searching for nits on the hair at the back of the neck, behind the ears and on the top of the head. If no evidence is found, the student should be returned to class. He/she should not be rechecked by the teacher or returned to the health room. If evidence is found, parent/guardian must be notified. However, the student may return to class at the discretion of the school nurse. The parent should be provided with the necessary steps to clear the infestation. Absences due to head lice will be excused, up to 2 days per incident and for a total of 10 days per school year. After a student has accumulated 10 excused absences due to head lice during a school year, further absences due to head lice will be considered unexcused. The principal may address unusual circumstances which go beyond these 10 days for excused absences. The parent should be instructed to return to the health room (upon completion of treatment) with the child for clearance to return to school. Parents will also be advised that the child may be rechecked in 7 - 10 days to ensure they are still free of live insects and/or nits.

Treatment:

Treatment consists of getting rid of the lice from infested individuals and their personal items. All household members and individuals with close physical contact should be examined for lice and if infested, treated with one of the recommended shampoos or hair rinses. Individuals in a household without signs of lice or nits should NOT be treated to prevent possible infestation.

For individuals who have an infestation:

Treatment should be given only to people who have active lice or nits (present within 1/4" of the scalp). Treatment should NOT be done to prevent infestation. Everyone with head lice or nits within 1/4" of the scalp in the same household should be treated on the same day. The recommended treatment is a medicated shampoo that contains an agent that is "ovicidal." Ovicidal products kill both the active lice and the eggs. Permethrin (1%) products (such as Nix®) kill both the active lice and the eggs. Permethrin may continue to kill newly hatched lice for several days after treatment. This type of product is available without a prescription and should be used as instructed on the package. Pyrethrins (such as Rid®) only kill live lice, not unhatched eggs (nits). A second treatment with either of the above products often is necessary in 9 - 10 days to kill any newly hatched lice before they can produce new eggs.

After shampooing, parents should attempt to remove the remaining nits (eggs) with a special nit comb or fine-tooth metal comb, or by using the fingernail to dislodge the nit from the hair follicle. This is not always possible since the nits (eggs) are so close to the scalp and firmly attached. Therefore, parents should carefully check the hair for active lice every day for 2 weeks to be sure the infestation has not returned. Removal of dead nits is also recommended during this 2-week period. Checking hair, a small

section at a time, under a fluorescent light and using a magnifying glass makes the nit casings easier to find. Kerosene, oil, or pet shampoo should NOT be used to treat a lice infestation.

Note: More people are starting to report cases that might be resistant to treatment. Studies are underway to determine if some of the current remedies are no longer effective. If infestation is still suspected after 2 rounds of treatment, parents should contact their local healthcare provider.

An additional lice treatment information source can be found at www.headliceinfo.com.

Reducing fomite transmission with supplemental measures:

Although fomite transmission is less important than head-to-head transmission, the following steps are encouraged to help avoid lice re-infestation that have recently fallen off the hair or crawled onto clothing or furniture:

1. Towels used to dry the hair after treatment with the lice shampoo should be washed in hot water immediately.
2. All bedding used by persons with the infestation should be washed on the hot water laundry cycle and dried on the high heat cycle.
3. If possible, dry-clean clothing. Items that cannot be washed or dry-cleaned can be placed in a sealed plastic bag for 2 weeks.
4. Floors, furniture, and carpeting should be vacuumed. Be sure to throw away the vacuum cleaner bag in the outside trash can when finished.
5. Soak combs and brushes in lice shampoo for 4 minutes, boil for 20 minutes or place small non-metal items in the microwave for 60 seconds.
6. Insecticide sprays are not recommended. Fumigation of the home or school with general insecticides by a pest control company is not necessary.
7. Children need to be encouraged not to share headgear, coats, combs and other articles at school, especially during the warm weather months.

School Exclusion Guidelines

Communicable: Transmission is rare in a school setting. Head-to-head transmission is most frequent with fomite transmission being rare.

May Return To School: Clearance is given by the school nurse for the child to return to class.



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HEAD LICE TREATMENT VERIFICATION FORM

This form must be completed and brought to Health Room before your child returns to the classroom.

Student Name: _____ Grade: _____ Teacher: _____

Mark (X) the appropriate box and write in requested information when applicable.

I have treated my child according to the directions on the product written below.

Date of treatment: _____ Name of product: _____

I am not treating my child with any product but have manually removed all lice and nits and agree to check and remove all lice and nits every day until none are found, and then every 2 – 3 days for the next 3 weeks.

Mark (X) that you have completed all four of the following steps to eliminating head lice.

All lice and nits have been physically removed.

My child's head has been inspected and there is no evidence of nits within ½" from the scalp on hair shafts or live lice.

Household cleaning measures have been completed to prevent reinfestation.

My child's household members have been checked.

Mark (____) that you understand that your child will be rechecked in the School Health Room in 7 – 10 days.

SIGN and DATE:

Name: _____

Date: _____

School Nurse/Designee: _____

Lice/ Nit Follow- Up Check Tickler Sheet

Date Lice/ Nits Found	Student Name	Teacher	10 day lice/ nit recheck due	Recheck Pos.	Recheck Neg.



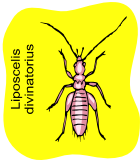
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Head Lice Treatment Pediculocide

Your child has been found to have head lice. The following steps should be followed **TODAY** to rid your child and household of the problem. Make this a family project.

1. CHECK



Check every member of the family. Use a strong light or go outside in bright light. Lice are hard to spot. Look for tiny white or dark specks (eggs or nits) stuck on hair shaft. Head lice are small, wingless bugs.

5. REMOVE NITS



Comb/pick out all nits. Use a regular comb to remove tangles, and then use a nit comb. Section the hair in one inch widths. Concentrate on one section at a time and comb through a small amount of hair. Remove all nits using the comb or fingernails by sliding it off the hair shaft.

2. WASH



Wash bedding, towels and clothes that have been in contact with infected person. Use hot, soapy water and dry in hot dryer.

6. CLEAN



Clean the environment thoroughly. Vacuum carpet, upholstery, stuffed animals, etc. Use a lint removal brush for hard to reach areas. Be sure to discard vacuum bag outside.

3. SOAK



Soak combs, brushes and hair items in hot water and lice shampoo.

7. RETURN TO SCHOOL



Parents must bring their child to school health room to be cleared by the nurse for re-entry to school.

4. TREAT



Use head lice treatment shampoo. **FOLLOW PACKAGE DIRECTIONS.**

8. RECHECK



Check your child's hair every few days- comb through with a nit comb to ensure your child is free of head lice.



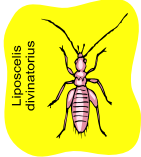
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**Head Lice Treatment
Olive Oil**

Your child has been found to have head lice. The following steps should be followed **TODAY** to rid your child and household of the problem. Make this a family project.

1. CHECK



Check every member of the family. Use a strong light or go outside in bright light. Lice are hard to spot. Look for tiny white or dark specks (eggs or nits) stuck on hair shaft. Head lice are small, wingless bugs.

2. WASH



Wash bedding, towels and clothes that have been in contact with infected person. Use hot, soapy water and dry in hot dryer.

3. SOAK



Soak combs, brushes and hair items in hot water and shampoo.

4. MASSAGE



Massage olive oil into hair and scalp. Be sure to saturate completely. Leave olive oil on child's hair for up to 8 hours (or overnight). The oil suffocates the lice and must be left on the full time.

5. CLEAN



Clean the environment thoroughly. Vacuum carpet, upholstery, stuffed animals, etc. Use a lint removal brush for hard to reach areas.

6. REMOVE NITS



Comb/pick out all nits. Use a regular comb to remove tangles, and then use a nit comb. Section the hair in one inch widths. Concentrate on one section at a time and comb through a small amount of hair. Remove all nits using the comb or with your fingernails by sliding it off the hair shaft.

7. SHAMPOO



Shampoo the hair with regular shampoo, preferably over a sink instead of the bathtub or shower. Use a clarifying shampoo and work the shampoo into the hair without wetting it. This will help break down the oil for easier removal. You may need to shampoo more than once to completely remove the oil. Check the hair for nits after drying. Repeat the sectioning process described above.

8. RETURN TO SCHOOL



Parents must bring their child to school health room to be cleared by the nurse for re-entry to school.

9. REPEAT



Repeat the olive oil treatment (not pediculicide shampoo) and nit removal every 4 days for 3 weeks. This will kill all newly hatched lice before they mature and lay more eggs.

Parents' Guide on 10 Ways to Keep Lice Out of Hair

1. Teach kids not to share personal grooming items, hair decorations, clips/headbands, hats or clothing.
 2. Store coats, hats, backpacks, etc. separately.
 3. Ask kids with long hair to pull hair back into braided ponytails or pigtails. Store hair care items separately from each other.
 4. Do not allow kids to lie down or place their heads on the carpets. Vacuum daily.
 5. Encourage kids to use only their own pillows, blankets, etc.
 6. Discuss with kids how lice are spread.
 7. Look around. What items are shared by kids - i.e. headsets, helmets, costumes – that lice can grab onto?
 8. Screen suspected cases immediately. Note scratching.
 9. Notify other parents with whom your kids have had contact.
1. Recheck (rescreen) at least once a week – make it a routine personal care activity.





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Date _____

Dear Parent,

Lice/nits were found in your child's hair today. I was unable to reach you by phone. Please read the attached information and take the steps required to treat it. Please come to the health room on the first day back after treatment so I can check your child's hair. A parent or adult must bring the child to the health room. I am here at _____ am and can help you at any time.

Thank you for understanding our school board policies regarding lice. If you have any questions or concerns, please feel free to call me at _____.

School Nurse

PINWORMS

Pinworm infection is caused by a small white worm that lives in the rectum of the infected person. While that person sleeps, the females lay their eggs on the skin surrounding the rectum. This causes severe itching and disturbed sleep. Pinworms are common in school age children and preschoolers. You can become infected by swallowing eggs from the contaminated surfaces, including fingers.

Pinworms are treated with prescription or over the counter drugs. A doctor should be consulted if you are uncertain. Treatment involves two doses of the medicine given 2 weeks apart.

Prevention:

- Changing and washing underwear daily and after each treatment
- Frequent hand washing
- Keeping nails trimmed short and discouraging nail biting

May Return To School: Children may return to school after first dose of treatment and scrubbing nails and bathing.

RASHES (Dermatitis)

A rash is an area of irritated or swollen skin. It might be red and itchy, bumpy, scaly, crusty or blistered. Rashes are a symptom of many different medical conditions. Diseases, irritating substances, allergies and heredity can cause rashes. There are two types of dermatitis – contact and atopic.

- Contact dermatitis is a rash that results from either repeated contact with irritants or contact with allergy-producing substances, such as poison ivy.
- Atopic dermatitis, more commonly known as eczema is a chronic itchy rash that tends to come and go.

Some rashes develop immediately. Others form over several days. Scratching the rash might take it longer to heal. The treatment for a rash usually depends on its cause. Options include moisturizers, lotions, baths and cortisone creams that relieve swelling, and antihistamines, which relieve itching. If a rash is oozing or suspected to be infectious, the child should be evaluated by a medical provider who will authorize the child's return to school, and whether the rash should be covered (i.e. shingles).

RINGWORM

Ringworm is a common fungal infection causing patches of red, scaly skin. The lesions are generally circular and red with a scaly border. Ringworm can affect people and pets and is generally transmitted by close contact. It is treated with over the counter anti-fungal creams (ask the pharmacist) or prescription medications, especially if on the scalp.

May Return To School: Children may attend school if ringworm is being treated. If lesions are wet or oozing, they should be covered. If there are scalp lesions, the child must be seen by a physician for proper treatment before returning to school.

SCABIES

Scabies is a very contagious skin condition caused by a mite. The rash is extremely itchy and can be difficult to diagnose. It can affect both humans and animals. The mite causes symptoms such as itching and bumpy tracks when it digs a tunnel below the skin (a burrow) and causes a type of allergic reaction. Scabies can affect anyone regardless of age, gender or personal hygiene. It is almost always contracted by close human contact.

Signs and Symptoms:

Sufferers experience severe continuous itching, especially at night. If several members of the same family or close contacts have the same symptoms, it is a good indicator that scabies is the cause. There may be small insect bites or tracks visible, especially between finger or toes, the waist area or under the breasts.

Treatment:

Lotions containing 5% permethrin, which are available over the counter, or prescription medications are applied to a clean body from the neck down to the toes. It is left on overnight (8 hours) and then washed off. This application is usually repeated in seven days. All clothes, bedding and towels should be washed in hot water and dried.

May Return To School: Once treated, children may attend school although the rash and itching may persist for 1 - 2 weeks.

SCARLET FEVER

Scarlet fever is a rash that sometimes occurs in people who have strep throat.

Symptoms:

The rash starts as tiny red bumps on the chest and abdomen and spreads to the rest of the body. It looks like sunburn and feels like sandpaper. It generally lasts 2 - 5 days. Sometimes, after the rash is gone, the skin on the tips of the fingers and toes peel. The throat is very red and sore. There is generally a fever and swollen glands.

Treatment:

If the throat culture is strep positive, antibiotics will be prescribed.

May Return To School: Children may return to school 24 hours after starting the antibiotic and 24 hours after the temp is normal (less than 100 °) without fever reducing medicines for 24 hours.

SEIZURE/EPILEPSY

Note: Epilepsy is a medical condition in which a person has the likelihood to suffer repeated convulsions. Such individuals require medical diagnosis, management and follow-up. A child with epilepsy should have an Emergency Information Card and cumulative folder clearly marked.

Signs and Symptoms:

Rigidity and/or jerking of body muscles, possible loss of consciousness and possible loss of bowel or bladder control. After the seizure, there may be a period of profound relaxation, exhaustion and stupor.

Call 9-1-1 when:

- Seizures last more than five minutes
- Seizures in a child who has never experienced one before
- Rapid sequence of seizures
- There is doubt as to whether or not the student is continuing to seize
- There is an excessive number of seizures

Treatment:

1. Prevent student from hurting him/herself by removing nearby objects and breaking fall, if possible.

2. If vomiting occurs, turn the student onto his/her side with face to the side to allow drainage.
3. Observe breathing. Resuscitate if necessary. (The need for resuscitation would be extremely rare.)
4. DO NOT restrain student.
5. DO NOT place your fingers or any object in mouth.
6. If student is a known epileptic patient and this is normal seizure pattern, allow him/her to rest following seizure. Notify Parent/Guardian and Principal. Student may be allowed to return to class if he/she feels well enough and parent gives permission. If this is an abnormally prolonged seizure and Diastat is required, the student will usually be sent home.
7. If student is NOT known to be epileptic, notify principal and call parent to transport child immediately (providing child is alert and oriented). If parent does NOT respond in a timely manner or child is listless, call 9-1-1 IMMEDIATELY!!!!

VAGUS NERVE STIMULATION THERAPY

Vagus nerve stimulation therapy is another form of treatment that may be tried when medications fail to stop seizures. It is currently approved for use in adults and children over the age of 12. The therapy prevents seizures by sending regular small pulses of electrical energy to the brain via the vagal nerve, in the neck. The energy is delivered by a flat, round battery, about the size of a silver dollar, which is surgically implanted in the left chest wall (opposite of a pacemaker). These wires (electrodes) are threaded under the skin and around the vagal nerve in the neck. The battery is programmed by the health team to send a few seconds of electrical energy to the vagal nerve every few minutes. If the person with the system feels a seizure coming on, he or she can activate the discharge by passing a small magnet over the battery. In some people, this has the effect of stopping the seizure. It is also possible to turn the device off by holding the magnet over it. In the event that a student needs assistance in using this device, a doctor's order will need to be provided by parent/guardian and kept in Medication record. Parent permission to apply this intervention will be required. Parent and school nurse may train non-nursing staff to apply this procedure if needed. Written record of this training will be kept on file in student's record.

VAGUS NERVE STIMULATOR (VNS) PROCEDURE

PURPOSE: To prevent or stop a seizure

ACTION TO BE PERFORMED BY: Person trained by a Registered Nurse.

DOCTORS ORDERS: *REQUIRED*

STEPS:

1. Know the particular signs for impending or occurring seizures as listed in the student. Individualized healthcare plan Examples: High-pitched crying, rigid arms and legs. Provide for students safety. Assist to floor and place on side, pad area to prevent injury. Assess airway, breathing, and circulation. Call for assistance.
2. Know location of special magnets. Location(s) will be listed in the student Individualized healthcare plan.
3. At the very beginning of a seizure look for VNS special magnet usually worn on wrist or clipped to a belt like a pager. Look for bulging area on the left side of the chest wall (implanted generator under skin). The magnet should be used as soon as possible after onset of seizure or aura.
4. Touch the smooth flat side of the magnet to the generator with a swiping motion and pass the magnet over the generator, then pull it away. You may notice a change in the child's voice, hoarseness or coughing this is a normal response. Potential adverse affects include ataxia, dyspnea, numbness and tingling, spasms of throat, nausea, and pain.
5. Call school registered nurse to assess the student immediately. (Have someone else call RN if possible). RN will take over care of student.
6. Return special magnet to belt or wrist. Keep special magnet at least 10 inches away from credit cards, computer disks, and other magnets. The magnet will damage credit cards. Computer and televisions will not affect the simulator. Older microwaves or posted microwave danger areas should be avoided.
7. Do not drop magnet as this may damage it.
8. Document what time magnet was swiped over generator and the outcome. Documentation of episode may be done on seizure observation form.

VAGUS NERVE STIMULATOR SKILLS CHECKLIST

**Contact your school RN for your performance check and form completion.*

Name: _____ School: _____

SKILL	Performs skill in accordance to written guidelines	Requires further instruction & supervision
	Date	Date
1. Know the particular signs for impending or occurring seizures as listed in the Seizure Care Plan for the student. Examples: High-pitched crying, rigid arms and legs.		
2. Know location of special magnets. Location(s) will be listed in Individual Health Care plan.		
3. At the very beginning of a seizure look for VNS special magnet usually worn on wrist or clipped to a belt like a pager. Look for bulging area on the left side of the chest wall (implanted generator under skin).		
4. Touch the smooth flat side of the magnet to the generator with a swiping motion and pass the magnet over the generator, then pull it away.		
5. Call school registered nurse to assess the student immediately. (Have someone else call RN if possible).		
6. Return special magnet to belt or wrist. Keep special magnet at least 10 inches away from credit cards, televisions, computer disks, microwave ovens and other magnets.		
7. Do not drop magnet.		
8. Document what time magnet was swiped over generator and the outcome.		

Preceptor's Signature: _____ Initials _____ Date _____

Preceptor's Signature: _____ Initials _____ Date _____

**Initial and date in space beside each skill indicates procedure has been demonstrated in a competent manner.*

DIASTAT ADMINISTRATION

Purpose:

Diastat is a gel formula of Valium intended for rectal use in patients with a seizure disorder, who, despite a daily anti-seizure regimen, have bouts of increased seizure activity. It should be administered by caregivers who are able to recognize the need for the medication based on individual orders. The caregiver should be trained and periodically monitored in the administration of the drug and the need to call 9-1-1 if it is administered, or as physician orders indicate.

Procedure:

1. Turn person to their side.
2. Assemble all equipment.
 - a. Diastat
 - b. Gloves
 - c. Lubricant
3. Explain procedure to patient.
4. Put gloves on.
5. Provide privacy by using curtain; forming a human barrier around the child; having someone hold up a sheet to screen the child.
6. Push up with your thumb and remove the cap from the syringe. Be sure the seal pin is removed with the cap.
7. Lubricate the tip with the lubricant provided.
8. Facing the patient, bend the upper leg forward and separate the buttocks.
9. Gently insert the syringe.
10. Count to 3 while pushing the plunger until it stops.
11. Count to 3 again before removing the syringe.
12. Count to 3 while holding buttocks together.
13. Do not reuse the syringe.
14. Monitor the child until 9-1-1 personnel and/or parents arrive.
15. Unless ordered otherwise, a child who receives Diastat in school should be transported home or to a medical facility for further monitoring. The most common side effect is drowsiness.

Note: Diastat Acudial must be properly dialed and locked before use. This should be done before leaving the pharmacy so the correct dose is received. A display window on the syringe indicates the dose and a green band at the base of the tip indicates it is ready for use.

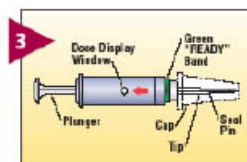
DIASTAT® AcuDial™ (diazepam rectal gel)
Administration Instructions



1 Put person on their side where they can't fall.



2 Get medicine.



3 Get syringe.
 Note: Seal Pin is attached to the cap.



4 Push up with thumb and pull to remove cap from syringe.
 Be sure Seal Pin is removed with the cap.



5 Lubricate rectal tip with lubricating jelly.



6 Turn person on side facing you.



7 Bend upper leg forward to expose rectum.



8 Separate buttocks to expose rectum.



9 Gently insert syringe tip into rectum.
 Note: Rim should be snug against rectal opening.



10 SLOWLY... Slowly count to 3 while gently pushing plunger in until it stops.



11 COUNT OUT LOUD TO THREE...1...2...3 Slowly count to 3 before removing syringe from rectum.



12 Slowly count to 3 while holding buttocks together to prevent leakage.



13 ONCE DIASTAT® IS GIVEN Keep person on side facing you, note time given and continue to observe.

DISPOSAL INSTRUCTIONS FOR DIASTAT ACUDIAL

14a

- Pull on plunger until it is completely removed from the syringe body.
- Point tip over sink or toilet.

14b

- Replace plunger into syringe body, gently pushing plunger until it stops.
- Flush toilet or rinse sink with water until gel is no longer visible.

This step is for Diastat® AcuDial™ users only
 At the completion of step 14a:
 • Discard all used materials in the garbage can.
 • Do not reuse.
 • Discard in a safe place away from children.

DISPOSAL FOR DIASTAT 2.5 MG
 At the completion of step 13:
 • Discard all used materials in the garbage can.
 • Do not reuse.
 • Discard in a safe place away from children.

Diastat® AcuDial™ (diazepam rectal gel)



**DIASTAT and DIASTAT ACUDIAL
SKILLS CHECKLIST**

*Contact your school RN for a performance check and form completion.



Name: _____

School: _____

SKILL	Performs skill in accordance to written guidelines	Requires further instruction & supervision
	Date	Date
1. Describes purpose of the procedure.		
2. Assembles equipment: <ul style="list-style-type: none"> • Gloves • Lubricant • Diastat or Diastat Acudial 		
3. Prepares Medication <ul style="list-style-type: none"> • Removes cap from Diastat syringe • Places on clean surface 		
4. Prepares student <ul style="list-style-type: none"> • Provides privacy • Exposes buttocks • Positions student with slight knee to chest • Obtains assistance as needed 		
5. Puts on gloves.		
6. Lubricates syringe tip.		
7. Insert syringe into rectum.		
8. Push plunger in, counting 1-2-3; count again 1-2-3.		
9. Withdraws syringe, holds buttocks together counting 1-2-3.		
10. Releases buttocks. Discards syringe.		
11. Covers buttocks with clothing and remove gloves.		

Clay County School Health Services Manual

SKILL	Performs skill in accordance to written guidelines	Requires further instruction & supervision
	Date	Date
12. Monitors student and call 9-1-1 as per Medical Management Plan and if seizures fail to resolve.		
13. Wash hands after procedure and student is stable.		
14. Document procedure		
15. Notify parent/ guardian when seizure occurs that necessitated the use of Diastat or Diastat Acudial.		

RN Signature _____ Initials _____ Date _____

Staff Signature _____ Initials _____ Date _____

**Initial and date in space beside each skill indicates procedure has been demonstrated in a competent manner.*



**CHILD SPECIFIC TRAINING
DIASTAT and DIASTAT ACUDIAL**

*Delegation can only be done by an RN.
The school RN is responsible for training and providing ongoing supervision of the unlicensed assistive personnel (UAP).



Unlicensed Assistive Personnel (UAP)

Delegating School RN

Student

School Year

SKILL	Training Date / Initial	Return Demonstration	
		Date	Date
1. Identifies signs and symptoms of seizures.			
2. Assembles equipment: <ul style="list-style-type: none"> • Gloves • Lubricant • Diastat or Diastat Acudial 			
3. Prepares Medication <ul style="list-style-type: none"> • Removes cap from Diastat syringe • Places on clean surface 			
4. Prepares student <ul style="list-style-type: none"> • Provides privacy • Exposes buttocks • Positions student with slight knee to chest • Obtains assistance as needed 			
5. Puts on gloves.			
6. Lubricates syringe tip.			
7. Insert syringe into rectum.			
8. Push plunger in, counting 1-2-3; count again 1-2-3.			
9. Withdraws syringe, holds buttocks together counting 1-2-3.			
2. Releases buttocks. Discards syringe.			

Clay County School Health Services Manual

SKILL	Training Date / Initial	Return Demonstration	
		Date	Date
11. Covers buttocks with clothing and remove gloves.			
12. Monitors student and call 9-1-1 as per Medical Management Plan and if seizures fail to resolve.			
13. Wash hands after procedure and student is stable.			

Improvement Plan:

RN Signature _____ Initials _____ Date _____
 RN Signature _____ Initials _____ Date _____
 RN Signature _____ Initials _____ Date _____
 Staff Signature _____ Initials _____ Date _____
 Staff Signature _____ Initials _____ Date _____
 Staff Signature _____ Initials _____ Date _____

**Initial and date in space beside each skill indicates procedure has been demonstrated in a competent manner.*



CLAY COUNTY DISTRICT SCHOOLS and
CLAY COUNTY HEALTH DEPARTMENT
SCHOOL HEALTH SERVICES



SEIZURE MEDICAL MANAGEMENT PLAN

(MUST be **FILLED OUT COMPLETELY** by PHYSICIAN/ HEALTHCARE PROVIDER)

Name: _____ D.O.B. _____ School Yr. _____

Parent: _____ Primary Phone # _____

Physician _____ Phone _____

Seizure Information: Aura before seizure? Yes No Age when diagnosed: _____

Seizure Triggers or Warning Signs: _____

Student's Response after a seizure: _____

**PLACE
I.D.
PHOTO
HERE**

Seizure Type	Length	Frequency	Description	Last Seizure Date

Treatment Protocol During School Hours:

Daily Medication	Dosage & Time of Day Given	Common Side Effects & Special Instructions

Basic First Aid and Comfort: *(Please describe additional first aid procedures).*

Does student need to leave the classroom after a seizure? Yes No
If YES, describe process for returning student to classroom: _____

Emergency Response:

A "seizure emergency" for this student is defined as: _____

Seizure Emergency Protocol:

- Call 911 for transport to _____
- Notify parent or emergency contact
- Notify doctor
- Administer Diastat _____ mg: Give _____ mg per rectum for seizures > _____ minutes; or in clusters > _____ seizures in 1 hour. Call 911 if the seizures do not stop _____ minutes after you give the rescue medication or if child has problems breathing during or after a seizure.
- Other _____

Does the student have a Vagus Nerve Stimulator? Yes No If yes, describe magnet use: _____

Call 911 if still seizing after _____ swipes. Wait _____ minutes between swipes. Give _____ swipes before any emergency medication.

Special Considerations and Precautions: *(regarding school activities, sports, field trips, helmet use, etc.)*

Authorization for Health Care Provider and School Nurse to Share Information:

I authorize my child's school nurse to assess my child as regards his/her special health care needs and to discuss these needs with my child's physician as needed throughout the school year. I understand this is for the purpose of generating a health care plan for my child. I understand I may withdraw this authorization at any time and that this authorization must be renewed annually.

Parent/Guardian Signature _____ Date _____

Doctor's Signature _____ Date _____

(Required)
Signature below indicates that the plan is reviewed and appropriate documentation is complete.

School Nurse Signature _____ Date _____

Rev. 4/11

Office Stamp



CLAY COUNTY SCHOOL DISTRICT
 CLAY COUNTY HEALTH DEPARTMENT
 SCHOOL HEALTH SERVICES



SEIZURE CARE PLAN

SCHOOL YEAR _____

Student Name: _____
 Parent / Guardian: _____
 Other Emergency Contacts: _____
 Physician: _____
 Parent Signature _____ Date _____
 Nurse Signature _____ Date _____
 DOB: _____ School: _____
 Contact # 's: Home _____ Cell _____ Work _____
 Home _____ Cell _____
 Contact # 's: _____
 Contact # 's: _____
 Contact #: Phone _____ Fax _____

Nursing Diagnosis / Concern	Goals	Plan of Action	By Whom / When
1. Potential for seizures at school	Student will maintain optimum health, safety and well-being during the school day	Kind of seizure: _____ Usual frequency of seizures: _____ Date of last seizure: _____ Events which may precipitate a seizure: _____ 1. Student will be monitored for signs of seizure activity including: • Blank/fixed eyes • Aimless movements • Loss of awareness/consciousness • Sudden drop to floor / quick falls • Whole body tremors and shakes, loss of consciousness • Other _____ 2. If seizure activity is noted, the seizure management procedure will be followed to maintain open airway and prevent injury: • Do not restrict movement. • Clear area of hazards • Prepare to protect from a sudden drop to the floor • Protect head. • Roll to side • Other _____ 3. Student's privacy and dignity will be maintained during a seizure at school.	School personnel – ongoing School personnel – ongoing All school staff and personnel.

Nursing Diagnosis / Concern	Goals	Plan of Action	By Whom / When									
		<p>4. All seizure activity will be recorded on individual student log.</p> <p>5. After a seizure, student will:</p> <ul style="list-style-type: none"> <input type="checkbox"/> rest in Nurse's office <input type="checkbox"/> rest in Nurse's office, then return to classroom <input type="checkbox"/> go home <p>6. Parent/guardian will be called if seizure is unusual or lasts more than _____ minutes.</p> <p>7. Diastat will be administered:</p> <ul style="list-style-type: none"> <input type="checkbox"/> at onset of seizure <input type="checkbox"/> at _____ minutes after onset of seizure <p>8. CALL 911 EMERGENCY MEDICAL SERVICES:</p> <ul style="list-style-type: none"> <input type="checkbox"/> at onset of seizure <input type="checkbox"/> at _____ minutes after onset of seizure <input type="checkbox"/> at _____ minutes after Diastat is given, if seizure activity is still present 	<p>School nurse, other school personnel – ongoing</p> <p>School nurse, all school personnel who has been trained in the administration of Diastat according to school policy.</p> <p>School nurse, other school personnel as necessary.</p>									
<p>2. Potential for accidents or injury related to seizures.</p>	<p>Student will maintain safety while increasing independence in self-health management.</p>	<p>1. Student will participate fully in the educational program.</p> <p>2. Parents will be informed of potential risks for injury on this school campus.</p> <p>3. The following adaptations or precautions will be needed during times of minimal adult supervision; such as; when student is on playground, walking across campus, in the cafeteria, on a field trip, etc.</p> <p>_____</p> <p>_____</p>	<p>Student/School Nurse - ongoing</p> <p>School Nurse, Teacher -- ongoing</p> <p>Instructional personnel -- as needed.</p>									
<p>3. Potential need for medication management for seizures.</p>	<p>Student will cooperate with medical treatment plan during the school day.</p>	<p>1. Student will come to the Nurse's office for supervised administration of the following medication(s) according to written physician's orders:</p> <table border="1" data-bbox="1104 504 1185 1108"> <thead> <tr> <th>Medication(s)</th> <th>Dose</th> <th>Time</th> </tr> </thead> <tbody> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> </tbody> </table> <p>2. This plan of care also covers field trips and/or any after school-based activity.</p> <p>3. Trained personnel must accompany student on bus, field trips, or any other school-based activity off school grounds.</p>	Medication(s)	Dose	Time	_____	_____	_____	_____	_____	_____	<p>School Nurse, as ordered by physician.</p> <p>Teachers/Classroom instructors</p> <p>Trained personnel.</p>
Medication(s)	Dose	Time										
_____	_____	_____										
_____	_____	_____										

Nursing Diagnosis / Concern	Goals	Plan of Action	By Whom / When
<p>4. Knowledge deficit and loss of self-esteem related to seizure disorder.</p>	<p>Student will increase / maintain self-esteem and effective seizure management at school.</p>	<ol style="list-style-type: none"> 1. Student will be given information and health counseling related to seizure disorder and management appropriate to level of understanding. 2. Classroom presentations will be given on seizure disorders as appropriate and when requested. 3. Student's medical condition will be discussed with him/her as needed to assure that appropriate level of knowledge is being maintained. 4. The classroom teacher will be provided information, support, consultation regarding management of student's health needs. 5. A copy of emergency action plan will be included in substitute teacher folder. 	<p>School nurse – ongoing</p> <p>Classroom teacher.</p>
<p>5. Potential for change in medical status</p>	<p>The student will, age appropriate, collaborate with the facilitation of his/her optimum health and safety necessary for learning.</p>	<ol style="list-style-type: none"> 1. Parents/Guardians will provide school nurse with a current Medical Management Plan at the beginning of each school year and as change in status occurs. 2. The school nurse will call the student's doctor to obtain current medical information verbally when this is necessary to manage the student's condition at school. <p>Physician or PCP Name: _____ Phone number: _____</p>	<p>School nurse—as needed</p>
<p>6. The Individual Health Plan (IHP) will be reviewed annually with the parent/guardian as well as appropriate staff members. This plan may be revised/updated as appropriate to ensure the most current treatment modalities for the student. The school nurse, in collaboration with parent/guardian, will train (or arrange for training) and supervise all non-medically licensed school personnel who are delegated responsibility for implementing any portion of this plan as appropriate.</p>	<p>The IHP will be updated/revised annually to meet the health needs of the student.</p>	<p>Review Date: RN Initials: Parent Initials:</p> <p>Review Date: RN Initials: Parent Initials:</p> <p>Review Date: RN Initials: Parent Initials:</p>	<p>Parent/Guardian, School Nurse, appropriate staff members.</p>



CLAY COUNTY DISTRICT SCHOOLS and
CLAY COUNTY HEALTH DEPARTMENT
SCHOOL HEALTH SERVICES



SEIZURE DISORDER EMERGENCY ACTION PLAN

(To be completed by Registered Nurse)

Name: _____ D.O.B. _____ Grade: _____ Teacher: _____

Parent's Name: _____ Phone _____

SYMPTOMS OF SEIZURE EMERGENCY:

- Seizure lasting 5 minutes or more
- Repeated seizures without gaining consciousness
- Breathing problems



MANAGEMENT OF SEIZURE EMERGENCY:

- CALL 911 IMMEDIATELY.**
- Call school nurse at ext. _____.
- Call Administration at ext. _____
- Turn student on his or her side.
- Do not insert anything into the mouth.
- Protect from injury (clear surrounding area of potential objects that might injure student).
- Vagal Nerve Stimulator: Give _____ swipes. Wait _____ minutes between swipes.
- Administer Diastat if ordered by physician.
- Stay with student.
- Call parents.
- Monitor student for type of seizure, duration of seizure.

NOTES:

RN Signature _____ Date _____

Copies given to:

- Parent
- Teacher 1st ___ 2nd ___ 3rd ___ 4th ___ 5th ___ 6th ___ 7th ___
- PE
- Library
- Computer
- Cafeteria
- Music
- Art
- Bus Driver
- Coach
- Other _____



CLAY COUNTY DISTRICT SCHOOLS and
CLAY COUNTY HEALTH DEPARTMENT
SCHOOL HEALTH SERVICES



SEIZURE OBSERVATION FORM

Student Name _____

School Grade _____

Location of seizure _____

Date _____ Time _____

1. What was the student doing BEFORE the seizure?

A. Was the student: Alert Drowsy Sleeping Other (describe) _____

B. How long did the seizure last? _____ (Do not include time sleeping after the seizure).

C. Did the student experience a warning? Yes No. If YES, describe it _____

2. Check the events you saw DURING the seizure:

- Eyes turned up
- Impaired speech
- Lost consciousness
- Stiffening
- Confusion or disorientation. How long? _____
- Other _____
- Picking movements
- Blank stare
- Unresponsive
- Jerking
- Respective lip smacking or chewing
- Fell
- Cried out

3. Check the things you saw DURING the seizure:

- Drooling
- Became pale or turned blue
- Walked around
- Other _____
- Lost bladder control
- Bit tongue
- Became flushed
- Lost bowel control
- Blinked eyes

4. Check the things you saw AFTER the seizure:

- Confusion or disorientation. How long?
- Complained of headache
- Nausea
- Complained of weakness
- Injuries. Describe _____
- Other _____
- Complained of body aches
- Vomited
- Slept. How long?

Name of person who saw the seizure and filled out this form _____

Name



CLAY COUNTY DISTRICT SCHOOLS and
CLAY COUNTY HEALTH DEPARTMENT
SCHOOL HEALTH SERVICES



SEIZURE FLOW CHART

Student Name: _____

FILL APPROPRIATE BOXES		DATE	DATE	DATE	DATE	DATE	DATE	DATE	DATE
Time seizure starts									
Behavior	Cry or other sound								
	Changes in facial expression								
Position of body	Arms flexed and drawn up								
	Legs flexed and drawn up								
Face	Color change								
	Teeth clenched								
Position of eyes	Straight ahead								
	Deviated upward								
	Deviated outward								
Length of seizure									
Other observations									

SHINGLES (SEE CHICKEN POX)

SICKLE CELL ANEMIA/DISEASE

Sickle cell anemia is an inherited blood disorder where the red blood cells become sickle shaped (like a crescent moon) rather than round like a doughnut. Sickle cells cannot move easily through blood vessels and thus tend to clump and reduce blood flow to limbs and organs. Sickled cells also die faster than normal red blood cells, and the body is unable to make enough to replace the dying ones, leading to anemia. Reduced oxygen flow increases sickling and cell destruction and the cycle continues.

Symptoms:

Acute symptoms (“crises”) include pain associated with blocked vessels, fever, swollen hands and feet. Anemia causes pallor, weakness, limited exercise tolerance, delayed growth and other development problems.

SORE THROAT

Intervention:

- Take temperature to rule out fever.
- Gargling with warm salt water (1/4 tsp. in 8 oz. of water) may relieve discomfort.
- May check throat for redness with tongue blade.

If temperature is elevated:

- Call Parent/Guardian.

If temperature is not elevated:

- Send student back to class.

SPINA BIFIDA

Spina Bifida is a failure of the spinal column to fuse, leaving the enclosed spinal cord unprotected. This may occur anywhere from the neck to the tailbone, the most common location is the lower part of the spine just above the buttocks. The skin and the spinal cord do not develop properly and a pouch is present where the bones fail to fuse.

Treatment:

A typical Spina Bifida child of school age will already have had back surgery to repair the skin defect, a shunt in the brain to prevent or arrest hydrocephalus, and braces or crutches for walking.

Limits:

In a typical case, the child has no control over bowel or bladder function. Usually both legs are completely paralyzed. Unless there are associated abnormalities of the brain, children with Spina Bifida are emotionally or intellectually normal. With proper treatment and training they should be able to attend school. They have excellent potential for learning. Most can be mainstreamed into regular classes. Because of subtle cerebral

defects, learning problems and fine motor control disturbances may occur in some children.

Management:

- **Bowel Care** – due to lack of muscular control of the anal opening, fecal soiling is often seen. Changes of diapers or other appropriate clothing must be kept at the school.
- **Bladder Care** – due to lack of nerve supply to the bladder, the urge to urinate does not exist. The bladder fills till it can hold no more, and eventually urine dribbles out of the urethra and keeps the clothes or diapers constantly wet. Since the bladder never empties, the remaining urine and bladder wall may become infected. Management requires that the bladder be emptied periodically to prevent infection. Most urologist feel that intermittent catheterizations every four to six hours is the preferred method. It is usually performed once a day at school at about noon. Self-catheterization is encouraged to ensure self-sufficiency.
- Safety issues specific to child's activities.

SPINAL INJURIES – BACK OR NECK

If spinal cord injury is suspected, **DO NOT MOVE** student!

Description:

Damage to the spinal cord that protects the nerves of the spine; most often caused from motor vehicle or bicycle accidents, sports injuries or falls involving bending, twisting or jolting of the body. The pain is usually made worse by pressure or movement and may radiate to arm or leg; may have weakness, numbness or inability to move arm or leg.

Intervention:

- Call 9-1-1.
- Do not move the student.
- Do not bend, twist or rotate the neck or body of the student.

If the Student is Unconscious:

- Check Airway, Breathing and Circulation and initiate the steps in CPR as needed (use jaw thrust, not head tilt/chin lift, to open airway) - ALWAYS CALL 9-1-1 immediately.

*Unless CPR is necessary or the student must be moved from fire or other life-threatening situation, **DO NOT MOVE THE STUDENT.***

NOTE:

- If you must move the student, be sure to support the head, neck, and body as one unit.
- Minimize movement of the head, neck, and spine in the position found. Place rolled up clothing, blankets, towels, etc. around the head and sides. If necessary to place student on his/her back for CPR, roll the head, neck and spine as one unit.
- Call parent/guardian and notify principal.

- Document date, time, nature of injury and interventions.

If the Student Regains Consciousness:

Instruct the student not to move until help arrives.

Minimize movement. **DO NOT MOVE THE HEAD OR NECK.**

Ask the student what happened and where it hurts.

Call 9-1-1 for assessment.

Call Parent/Guardian and notify Principal.

SPLINTERS/PENCIL “LEAD”

Pencils no longer contain lead, but graphite.

Intervention:

If the splinter/pencil lead is protruding above the surface of the skin:

- Remove by grasping with tweezers and pulling out.
- Wash with soap and water.
- Cover with sterile bandage.
- Return student to class.

If the splinter/pencil lead is imbedded:

- DO NOT try to remove.
- Cover with bandage.
- Call Parent/Guardian or advise student to show to parent

TICK REMOVAL

Ticks embedded in the skin should NOT be removed by school personnel. Notify parent.

UPPER RESPIRATORY INFECTIONS

Children frequently come to the health room complaining of stuffy/runny nose, coughing, congestion and other symptoms of the common cold. Children who are ill are not productive and are not learning. They will likely also infect other children in the class since the virus is transmitted through direct contact with nasal/oral secretions.

Intervention:

- Check the temperature-if greater than 100° oral, contact parent. If coughing is persistent, and disruptive to the class, the child should go home.
- If child has no fever but appears ill with red eyes, nose, periodic cough, lack of energy; or frequent thick nasal discharge-especially if other than clear-the parent should be encouraged to take the child home.

VOMITING

Nausea and vomiting are symptoms of an underlying disease and not a specific illness. Nausea is the sensation that the stomach wants to empty itself, while vomiting (emesis) or throwing up, is the act of forcible emptying of the stomach.

Vomiting is a violent act in which the stomach has to overcome the pressures that are normally in place to keep food and secretions within the stomach. The stomach almost turns itself inside out - forcing itself into the lower portion of the esophagus (the tube that connects the mouth to the stomach) during a vomiting episode.

There are numerous causes of nausea and vomiting. These symptoms may be due to the following:

- acute gastritis due to infections, stomach flu, food poisoning, gastroesophageal reflux disease (GERD), peptic ulcer disease, or other stomach irritants from medications
- central causes (signals from the brain) such as headaches, inner ear problems, head injuries and heat related illnesses
- atypical symptom of another disease: Some illnesses will cause nausea and vomiting, even though there is no direct involvement of the stomach or gastrointestinal tract such as heart attacks, sepsis, bulimia
- side effects from medications and medical treatments
- mechanical obstruction of the bowel
- pregnancy

If the student is vomiting at school, the parent should be called and the child taken home. The child may return to school when symptoms are gone and fever free (without fever reducing medicines) for 24 hours. If multiple cases of vomiting occur in one classroom, the Clay County Health Department should be notified.

WHOOPING COUGH (PERTUSSIS)

Pertussis, commonly called whooping cough, is a bacterial infection of the throat and lungs. The cough can last for weeks or months. Most children are vaccinated against Pertussis with 4 or 5 doses before starting school. A booster dose of vaccine is recommended as well, with the required 7th grade immunizations, or with an adult tetanus booster.

Pertussis is diagnosed with a nasopharyngeal culture. If someone is diagnosed, other family members, especially children under the age of 7 that have not been vaccinated, should be vaccinated and/or treated with antibiotics. Pertussis is a reportable disease.

May Return To School: Children may return to school after being on antibiotics for 5 days.

NOTES
