



UTAH DEPARTMENT OF  
**HEALTH**

Healthy Living Through Environment  
Policy and Improved Clinical Care (EPICC)

# Utah School Nurse Resource Manual

## 2017



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Through Environment, Policy, and Improved  
Clinical Care (EPICC)  
6/1/2017

## ACKNOWLEDGMENTS

Thanks to the many people who took time to review sections of this manual and provide input, and to the school districts, health departments, and school nurses who willingly shared various experiences and resource materials they have developed in their respective areas for inclusion in this manual. I specifically would like to thank Caroline Green, former School Nurse Consultant, who produced the previous Resource Manual in 2003.

This resource manual is dedicated to all Utah school nurses who dedicate their professional and personal lives to helping to keep Utah children healthy, safe, and ready to learn.

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## INTRODUCTION TO MANUAL

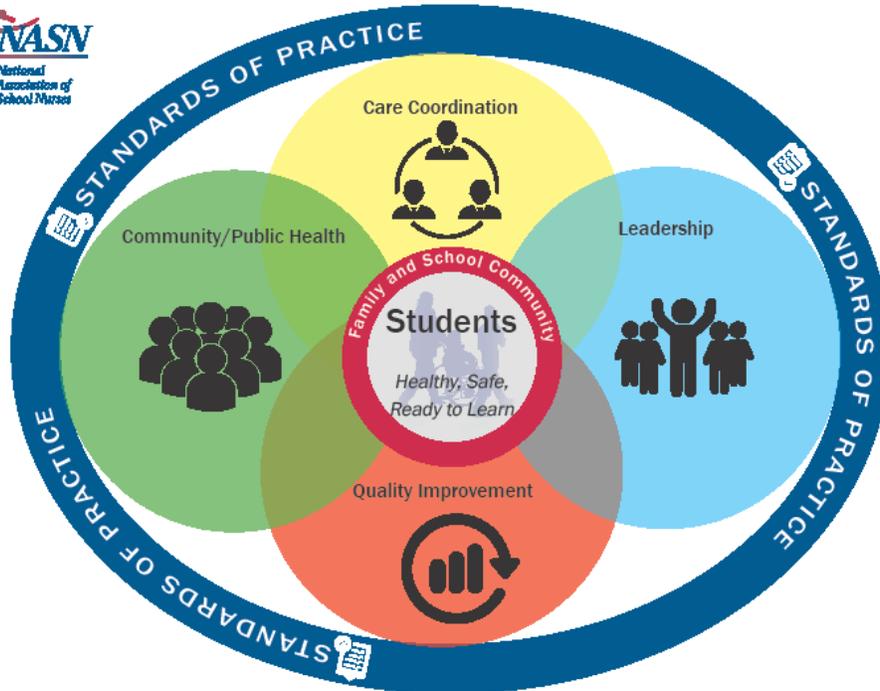
The purpose of this resource manual is to provide current, up-to-date information regarding school nursing practice in Utah. Just as there are geographical and population differences among school districts, it is understood that roles and responsibilities of school nurses may vary as well. It is impossible to provide specifics for each school district. This is provided to help school nurses understand the goal we are all striving for which is that all Utah students will be healthy, safe, and ready to learn.

This manual begins with the National Association of School Nurses (NASN) Framework for 21<sup>st</sup> Century School Nursing Practice™ (2015) which includes leadership, quality improvement, community and public health, care coordination, and standards of practice, with student-centered care at the core.

## FRAMEWORK FOR 21<sup>ST</sup> CENTURY SCHOOL NURSING PRACTICE

In 2015, the Framework for the 21<sup>st</sup> Century School Nursing Practice™ was introduced. The Framework gives guidance on the different areas of responsibility of a typical school nurse. The Framework shows the student at the center surrounded by the overlapping circles of leadership, quality improvement, community and public health, and care coordination. Standards of practice surround these as the frame that holds the entire picture together. The Framework is shown below, along with more details of each section.

## Framework for 21<sup>st</sup> Century School Nursing Practice™



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BETTER HEALTH. BETTER LEARNING.™

Rev. 9/28/15

The following sections are taken directly from NASN’s Framework for 21<sup>st</sup> Century School Nursing Practice (2016). (*Re-printed with permission by the National Association of School Nurses.*)

### Care Coordination

#### Case Management

According to Engelke, Guttu, Warren, and Swanson (2008), case management is defined as follows:

“A process in which the school nurse identifies children who are not achieving their optimal level of health or academic success because they have a chronic illness that is limiting their potential. It is based on a thorough assessment by the school nurse and involves activities that not only help the child deal with problems but also prevent and reduce their occurrence. Case management includes direct nursing care for the child and coordination and communication with parents, teachers, and other care providers. Interventions are goal oriented based on the specific needs of the child and evaluated based on their impact on the child” (p. 205).

#### Chronic disease management

School nurses engage in chronic disease management activities to provide for the best health,

academic, and quality-of life outcomes possible, with emphasis on efficient care and student education leading to self- management. School nurses must communicate effectively to coordinate care.

### Standards of Care

The following standards of care have been developed. These can be found in the Appendix of this resource manual.

- Allergy and anaphylaxis
- Asthma
- Diabetes
- Seizures/epilepsy
- Head lice
- Outside food in schools

### Healthcare Plans

Student educational and health care plans are integral to the process of care coordination. School nurses develop health care plans, including the Individualized Health Care Plan (IHP) and Emergency Care Plan (ECP), and contribute to the development of student educational plans (e.g., 504 Plan, Individualized Education Program). Student-centered health documents are developed by the school nurse, based on his or her assessment and healthcare provider orders, and they follow the nursing process to address concerns and established goals and the interventions to address those goals (NASN, 2015). An IHP may include activities related to direct care, delegation, student self-empowerment, case management, chronic disease management, and transition planning. An ECP flows from the IHP and addresses what to do during a health emergency/ crisis situation.

### Direct Care

Care coordination provides for the direct care needs of the student. The specific care that nurses and others provide to students includes routine treatments, medication administration, and addressing acute/urgent needs.

### Education

Student-centered care also includes providing the individual education and support that students/families need to be decision makers in their own care, including health promotion and disease prevention behaviors.

### Delegation

The school nurse's coordination of care may include the delegation of nursing tasks. Nursing delegation is a process used by the nurse to lead another person to perform nursing tasks (ANA & National Council of State Boards of Nursing, 2006). In the school setting, nursing delegation requires the registered professional school nurse to assign a specific nursing task—in a specific situation for an individual student—to unlicensed assistive personnel (UAP), while providing

ongoing supervision and evaluation of the unlicensed assistive personnel and the student's health outcomes (Bobo, 2015). Delegation is further defined and regulated by state nurse practice acts and state laws.

### Leadership

Leadership is a mind-set, not a formal position. School nurses are well positioned in schools to lead in the development of school health policies, programs, and procedures for the provision of health services, as they often represent the only health care professional in the educational setting (NASN, 2011). Leadership is a standard of professional performance for school nursing practice (ANA & NASN, 2011) with competencies closely related to the practice components of this principle.

### Policy Development and Implementation

When school nurses participate on interdisciplinary teams, their perspectives on health promotion, disease prevention, and care coordination for students and the school community bring about change in policy development and implementation related to plans and protocols that address children's health issues within the school and community setting (ANA & NASN, 2011; IOM, 2010; Robert Wood Johnson Foundation [RWJF], 2009).

### Professionalism

Professionalism includes the attributes of accountability, maturity, problem solving, collaboration, proactivity, positivity, professional speech, appropriate dress, and activities that align with current, evidence-based, student-centered practice. Professional behaviors were identified by principals, educators, and others as the most influential factor when school nurses were seen and understood as valuable members of the educational team (Maughan & Adams, 2011).

### Advocacy

Advocacy is the ability to successfully support a cause or interest on one's own behalf or that of another, and it requires skill in problem solving, communication, influence, and collaboration (ANA, 2015). As advocates for students, the school nurse provides skills and education that support self-management, problem solving, effective communication, and collaboration with others (ANA, 2015).

### Lifelong Learner

Being aware of evolving trends in reform and practice requires school nurses to be lifelong learners. The school nurse shows commitment to lifelong learning when engaging in advanced academic education, certification, and activities that support competent professional practice, knowledge development, and skills acquisition (ANA, 2015; ANA & NASN, 2011).

## Technology

Professional growth also involves staying current with both medical and information technology. In school nursing, technology encompasses telehealth, computer skills, and the use of web-based resources to collect and manage data (e.g., electronic health records, immunization information systems), overlapping with the quality improvement principle and data collection practice component. Technology allows for retrieving evidence-based education, communicating through social media, and using practice applications (i.e., apps; Anderson & Enge, 2012; NASN, 2012).

## Quality Improvement

Quality Improvement (QI) is a continuous and systematic process that leads to measurable improvements and outcomes and is an integral part of current standards of practice (Agency for Healthcare Research and Quality, 2011; Health Resources and Services Administration [AHRQ], n.d.). If school nurses make the QI process part of their daily practice, they will better understand which of their activities have the greatest impact on student health and outcomes and which do not. This knowledge will help school nurses prioritize activities amid very busy schedules and time demands and better explain their choices to administration. QI will help change practice and build the critical evidence base for school nursing practice. QI is really the nursing process in action: assessment, identification of the issue, developing a plan, implementing the plan, and evaluating if the goals/outcomes are achieved (AHRQ, n.d.; ANA & NASN, 2011).

## Documentation/Data Collection

Data is the cornerstone of QI (Health Resources and Services Administration, n.d.). Data collection includes school nurse documentation of daily activities, progress toward meeting student health goals, and other events. Through documentation, the variety of roles and activities of school nurses are illustrated (such as how time is spent), the impact that nursing care has on students' health and readiness for school is shown, and trends over time are identified. Data can clearly show educators and policymakers the impact of school nursing on the health and academic success of students. Electronic health records can save school nurses time by helping them manage and share data.

Data collection includes participation in *Step Up and Be Counted!*, a joint initiative between NASN and the National Association of State School Nurse Consultants to develop a uniform data set so that all school nurses across the country collect data the same way (Maughan et al., 2014). The ability to combine data will allow researchers to determine which school nurse interventions are most effective and to better understand models of school nursing practice and workforce models and their impact on student health.

## Evaluation

Evaluation is the sixth step of the nursing process and sixth standard of school nursing practice (ANA & NASN, 2011). Generally speaking, evaluation is the assessment of the attainment of

outcomes. For school nurses, evaluation includes measuring meaningful health and academic outcomes and determining whether the processes and interventions used were appropriate. Evaluation should occur for all the components of the student's IHP, which is a practice component of the Framework principle of care coordination. Data and evaluation should also be used for performance appraisal of the school nurse's work goals and job performance.

#### Research

Research is included in the principle of QI. Many of the concepts of research and QI overlap, yet QI and research are different. QI determines if evidence based practice standards are effective. Research is a more formal process for testing an intervention to gain new knowledge that is, hopefully, generalizable beyond the given situation (AHRQ, 2011; IOM, 2001a; U.S. Department of Health and Human Services [USDHHS], 2009). Formal school nursing research is needed to ensure that school nurse practice is based on the best current evidence. Data from research are also needed by school nurses as they advocate and illustrate how they impact student health and academic outcomes. School nurses can and should be involved in research by identifying research questions, completing research surveys, collecting data for research projects, or assisting expertly trained researchers to design studies appropriate for school settings and students.

#### Community and Public Health

School nursing practice is grounded in community/public health and is consistent with the core functions of public health, even though not all school nurses are fully aware of this (Schaffer, Anderson, & Rising, 2015). Including community/public health as one of the five principles of the framework helps school nurses recognize how they include community/public health in their specialty practice of school nursing (ANA & NASN, 2011; NASN, 2013).

#### Cultural competency

School nurses must continually work at obtaining cultural competency, which is a set of behaviors, attitudes, and skills that allow effective care to be delivered in cross-cultural situations (Office of Minority Health, 2013). Failure to be culturally sensitive to students and families can decrease trust, leading to decreased communication and management of health condition and adverse student health outcomes.

#### Disease prevention

Primary prevention aims to prevent disease before it happens. Secondary prevention focuses on risk reduction once a disease occurs. Tertiary prevention includes strategies that limit further negative effects from an existing health problem and promote optimal functioning. School nurses provide care at all three levels but place extra emphasis on primary prevention.

#### Health education

Health education is one example of implementing primary prevention. Other examples include promoting immunizations, health promotion programming, and advocating for a positive school

environment. The activities of primary prevention overlap with the principle of leadership and the component of advocacy.

#### Health equity

School nurses are in the critical position to address health disparities of students and families and provide equitable health services (health equity) because of their intimate knowledge of the environments where students and families live, play, and access care.

#### Screenings

Screenings, referrals, and follow-up activities are secondary prevention strategies that detect and treat health concerns in their early stages often before signs and symptoms appear—and modify, remove, or treat them before the health concerns become serious.

#### Social determinants of Health

Social determinants are factors that impact health, such as income/social status, housing, transportation, employment/working conditions, social support networks, education/literacy, neighborhood safety/physical environment, access to health services, and culture (USDHHS, 2010c). Social determinants are important because they are known to cause 80% of health concerns (Booske, Athens, Kindig, Park, & Remington, 2010).

#### Surveillance

Surveillance, closely aligned with nursing assessment, is a key school nursing and community/public health practice component. Surveillance is the ongoing, systematic collection, analysis, and interpretation of health-related data essential to planning, implementation, and evaluation of health interventions. It is usually proactive and includes disseminating the data to those who need it to prevent or control health conditions (CDC, n.d.). School nurses practice surveillance when they monitor and describe an increase in strep throat cases or influenza-like illness. Surveillance and use of the data overlap with the principle of *QI*.

#### Standards of Practice

Standards of practice for school nursing direct and lead every part of the Framework. It incorporates a wide range of practice and performance standards that are essential in the specialty of school nursing, regardless of the role, population served, or specialty within school nursing (ANA & NASN, 2011). Specialized knowledge, skills, decision making, and standards of practice are required to provide the best possible nursing care with the best possible outcomes. The Standards of Practice and the related practice components are vital and overarching for the other principles of the Framework.

#### Clinical Competence

Clinical competence means that the school nurse successfully performs at an expected professional level that integrates knowledge, skills, abilities, and judgment. The school nurse maintains a high level of competency and professional knowledge and skills through continuing

education and collaboration with peers and community health professionals, all while adhering to the standards of school nursing practice (ANA & NASN, 2011).

#### Clinical Guidelines

Clinical guidelines are determined by the systematic review of the evidence and direct the practice of school nursing. Clinical guidelines assist school nurses to provide best practice and facilitate positive health outcomes that influence academic outcomes (Maughan & Schantz, 2014). Following clinical guidelines advances the professional practice of school nursing.

#### Code of Ethics

Code of ethics is a part of every nurse's professional life (ANA, 2015). School nurses provide care, advocate for families, outreach to those at risk, and collect data with compassion, honesty, and integrity that protect the student/family's dignity, autonomy, rights, and client confidentiality within the legal limit of the health and educational systems (ANA, 2015; ANA & NASN, 2011).

#### Critical Thinking

Critical thinking is a dynamic, vital, and continuing part of every step in the nursing process. Critical thinking uses knowledge and reasoning skills to make sound clinical decisions that influence nursing practice (ANA & NASN, 2011; Weismuller, Willgerodt, McClanahan, & Helm-Remund, 2015).

#### Evidence-based Practice

Evidence-based practice incorporates the best available research and scientific evidence that informs decision making and promotes best practices for optimal health outcomes (Jacobs et al., 2012). School nurses are obligated to recognize that evidence-based practice replaces empirical and authority-based care (Bultas & McLaughlin, 2013) and that it is the basis and standard of health care practice (Adams & McCarthy, 2007) for the 21st-century school nurse.

#### NASN Position Statements

Position statements from the NASN are documents that present the official position of the NASN Board of Directors. These position statements include historical, political, and scientific facets of topics relevant to school nursing, school health services, and children's health care (<http://www.nasn.org/PolicyAdvocacy/PositionDocuments>).

#### Nurse Practice Acts and Rules

Nurse Practice Acts (NPAs) are guiding and governing laws that determine the lawful scope of practice of nursing. NPAs have authority to develop rules and regulations for the practice and licensing of nursing to protect the health of society. Nurses must follow the NPAs of their state, commonwealth, or territory (National Council of State Boards of Nursing, n.d.). It is NPAs and state guidelines that determine if nursing delegation can occur, and they greatly impact the framework's principle of Care Coordination.

### Scope and Standards of Practice

Scope and standards of practice define the practices that school nurses are expected to perform competently. The scope affirms the broad range, essence, and evolving boundaries of school nursing practice. The standards of practice describe the level of competency expected for each step of the nursing process. The standards of professional performance describe the competent level of behavior in the professional school nurse role (ANA & NASN, 2011).

### Student-Centered Care

Student-centered care is provided at the individual or schoolwide level (e.g., caring for students with special health care needs, promoting a positive school climate). School nurses work in partnership with students and their families and caregivers to ensure that decisions include students' needs and that desires are addressed (Institute of Medicine [IOM], 2001b). Student-centered care also includes providing the individual education and support that students/families need to be decision makers in their own care, including health promotion and disease prevention behaviors. Student-centered care promotes student self-empowerment by respecting student autonomy and by helping students realize their own power and capabilities in managing their health conditions (Tengland, 2012).

## SCHOOL NURSE JOB DESCRIPTION

The NASN defines school nursing as

“a specialized practice of nursing, protects and promotes student health, facilitates optimal development, and advances academic success. School nurses, grounded in ethical and evidence-based practice, are the leaders that bridge health care and education, provide care coordination, advocate for quality student-centered care, and collaborate to design systems that allow individuals and communities to develop their full potentials” (<http://www.nasn.org/RoleCareer>).

School nursing practice requires the combination of professional clinical nursing practice with a specialized component that promotes the health, well-being, academic achievement, and success of the school-age student. The school nurse is often the only health care provider in the school setting; therefore, school nurses may be called upon to work closely with teachers, classroom assistants, office personnel, and other unlicensed staff in order to carry out a wide range of school health activities.

Knowledge of the applicable practice laws and regulations is essential for the school nurse to practice within the scope of the registered nurse (RN) license.

Some of the most common duties of the school nurse may include (NASN 2016c):

- Leadership
  - Policy development
  - Advocating for individual students

- Community and public health
  - Disease prevention
  - Health education
  - Screenings (vision, dental, hearing, etc.)
  - Home visits
  - Health fairs
- Care coordination
  - Case management
  - Writing IHP/EAPs
  - Delegation and supervision
  - Medication administration and procedures
  - Medical referrals
  - CPR and first aid training
- Quality improvement
  - Data collection and evaluation
  - Research
- Standards of practice
  - Evaluation

## Requirements

A school nurse must be qualified to practice as a Registered Nurse in the State of Utah (or a compact state) and hold an unrestricted license. They must also be certified in cardiopulmonary resuscitation (CPR) or basic life support (BLS). It is recommended that the school nurse have a minimum of one year’s prior experience in nursing before becoming a school nurse.

The registered school nurse should have a minimum of a baccalaureate degree in nursing (BSN). Those currently practicing school nurses with an associate degree in nursing (ADN) should be considered ‘grandfathered in’, and not be at risk for losing their jobs due to their education level. All new hires should be BSN prepared (at a minimum). According to NASN (2016b), “Baccalaureate nursing education develops competencies in leadership, critical thinking, quality improvement, systems thinking ... the ability to practice autonomously, supervise others, and delegate care in a community”.

The NASN recommended that all school nurses be Nationally Certified School Nurses (NCSN). Those who are nationally certified should be acknowledged by an increase in salary and responsibilities.

## School Nurse Supervision and Evaluation

The registered school nurse should be clinically supervised and evaluated by a registered nurse who understands the scope and standards of practice for school nursing (NASN, 2013). Annual evaluation should be three-fold and include the following:

- Self-evaluation completed by the school nurse
- Clinical evaluation performed by another registered nurse
- A non-clinical evaluation which may be completed by LEA administration

## SCHOOL PHYSICIAN

The role of the school physician is to serve in the capacity of consulting medical director to provide medical evaluation, consultation, and support to nursing personnel. The American Academy of Pediatrics states, “health services in schools must be supervised by a physician, preferably one who is experienced in the care of children and adolescents” (AAP, Policy Statement “Role of the School Physician”, 2013). The duties or role of the school physician are varied and may include (but are not limited to):

- Develop, review, and direct policies related to school health
- Supervise and provide consultation to the school nurse, including overseeing mandated screenings
- Serve as a liaison to other healthcare providers in the community to meet the health needs of school children
- Provide standing orders for medication, such as epinephrine auto-injectors and potentially acetaminophen and/or ibuprofen.

Each school district should have a medical advisor who can advise or consult on medical matters. The school district medical advisor should be a local MD, DO, or APRN with experience in pediatrics. A Memorandum of Agreement may be used to secure services.

## SURVIVING THE FIRST YEAR: HOW TO BEGIN

How does a new school nurse begin when there is no nurse supervisor or plans for an orientation by another nurse? First, the superintendent or a designee should explain the school district’s school health program philosophy and describe expectations of the school nurse’s role in the program. If the school nurse is serving more than one building, the number of schools, the age/grade levels, the number and health needs of the students should be considered in developing the school nurse’s schedule.

The school nurse who will be practicing in isolation is encouraged to contact the local and/or state health department or a school nurse in a nearby school district, inquire about a state orientation program, and join the state and national school nurse organizations.

Before school starts, or as soon as the school nurse starts work, the school nurse should:

- Meet the principal and the office staff. Confer with the secretary about securing health information and immunization data on all new students. Ask how compliance with the immunization law is ensured. Arrange for a method of receiving messages. Obtain access to the copy machine, computer and printer, a map of the school, and class

rosters. Discuss working schedule, lunch breaks and coverage, and procedure to follow when the school nurse is not in the building.

- Find the health records. Determine what type of health information is available, how confidentiality is maintained, who records the health information, how current the records are, what students have significant health problems, and what system is in place for notifying the school nurse of any newly registered or newly diagnosed students with health conditions.
- Inspect the health office. The school nurse should ask what clinic space, supplies, and equipment are available, assess what is needed, and ask how supplies are ordered.
- Meet the faculty. Describe the school nurse's role and when and how students should be referred to the school nurse. Provide a copy of the school nurse's schedule. Ask who is prepared and available to assist if there is a crisis in the building (first aid and CPR certified).
- Meet with the cafeteria manager and staff. Find out the procedure for notifying them of student diet restrictions and how to obtain nutritional information (i.e. carb counts).
- Meet with the custodian and discuss how to work together when planning events like vision screenings, maturation programs, etc.

After becoming familiar with this basic information, the school nurse should plan a tentative schedule of programs, including vision screening, hearing screening (if done by the school nurse), spinal screening (if done in the school), and maturation programs (if done in the school). The new school nurse should familiarize themselves with policies in the school district that deal with medication; immunization; communicable disease and infection control; child protection (abuse and neglect); screening programs; health services/nursing care for illness, injury, and special health care needs; and general school health program.

## HEIGHT/WEIGHT SCREENING

Beginning in 2006, and biennially since then, the Utah Department of Health along with the participation of 69 randomly selected elementary schools in Utah have been assessing health status and growth pattern trends among youth.

One class of 1<sup>st</sup>, 3<sup>rd</sup>, and 5<sup>th</sup> grade students is randomly selected in each of the participating schools. Consent forms are distributed by the school to the student's parent or legal guardian for signature. The individual schools or districts can determine whether to use active or passive consent. These forms will be provided by the Utah Department of Health (UDOH), or schools can use their own.

Data will be collected by school nurses or trained volunteers at a convenient time within the designated three-month time frame of the study. Information gathered will consist of height, weight, sex, school grade, and birth date. Special measures will be taken to protect students' privacy and their height and weight information. No individuals will be identified or singled out.

The following protocol will be used to train data collectors and a standard collection form will be used including: grade, birth date, sex, height, and weight. Student names will not be recorded. Volunteers will receive training before height and weight measurement takes place, which will include sensitivity training.

## Weight

Equipment needed (provided by UDOH): Tanita Digital Scale

Place on hard surface. Remote should be placed on a small table next to the scale platform or mounted on the wall if in a permanent location.

Exceptions: Children who cannot stand without assistance are excluded.

1. Child removes shoes & jackets and heavy sweaters (if wearing another shirt).
2. To turn the scale on, press the on/zero button. Make sure the unit of display is in pounds (lb) not kilograms (kg). Press the lb/kg button to switch over to pounds if needed.
3. Child stands on the center of the platform.
4. Examiner waits for weight to display.
5. Examiner records weight to one tenth of a pound (e.g. 72.1 lb).
6. Examiner records sex, birthday and grade of the child.
7. Examiner makes sure the display turns to zero prior to weighing another child.
8. At the end of the weighing session, press the off switch.

## Height

Equipment needed (provided by UDOH): A measuring tape taped straight to a wall or door that has no trim, and a wooden 90-degree angle portable stadiometer device will be used on top of head to measure height.

Exceptions: Children who cannot stand without assistance are excluded.

1. Child removes shoes.
2. Child stands with heels against the wall, arms at their sides, shoulders relaxed, and legs straight.
3. Child is instructed to look straight ahead (chin at a 90-degree position with floor) and take a deep breath.
4. Height is measured at top of inspiration by placing a measuring board at the top of the child's head.
5. Height is recorded in inches to the nearest .25 inches (e.g. 42.25 inches), measured at the point where the top of the child's head hits the measuring board.

## Equipment

Equipment is provided by UDOH to each participating school, including:

- 1 Tanita Digital Scale

1 metal measuring tape

1 right-angle leveling board designed for measuring height

### Analysis

Data will be analyzed using CDC growth charts, students between the 85<sup>th</sup> percentile and 95<sup>th</sup> percentile for age and gender will be defined as “overweight” and students greater than the 95<sup>th</sup> percentile will be defined as “obese” as defined by CDC. Results will be compared to national trends and statewide data collected in 1994, 2006, 2008, 2010, 2012, 2014, 2016, 2018, and 2020.

### Participating Schools

Specific schools were contacted prior to 2006 and agreed to be included in the ongoing study.

## PROFESSIONAL SCHOOL NURSE ORGANIZATIONS

### Utah School Nurse Association

The Utah School Nurse Association is the professional organization for Utah school nurses. More information can be obtained by going to [www.utahschoolnurse.org](http://www.utahschoolnurse.org). The Utah School Nurse Association is a unified affiliate of the National Association of School Nurses. This means paid annual dues allows membership in both organizations.

The Utah School Nurse Association typically holds two conferences per year; a one-day conference in the fall, and a two-day conference in the spring. Locations for these conferences vary. See their website for more information.

### National Association of School Nurses

The National Association of School Nurses (NASN) provides many tools to practicing school nurses. These tools are available both online and in print. They can be accessed at [www.nasn.org](http://www.nasn.org).

The National Association of School Nurses holds a large conference each summer, usually the end of June. The locations vary. More information is available on their website.

Position Statements: <http://www.nasn.org/advocacy/professional-practice-documents>

Back to school toolkit: <https://www.pathlms.com/nasn/categories/687/courses>

## STANDARDS OF SCHOOL NURSING PRACTICE

These standards describe a competent level of school nursing practice demonstrated by the critical thinking model known as the nursing process (ANA and NASN, 2011).

#### Standard 1. Assessment

The school nurse collects pertinent data and information relative to the healthcare consumer's health or the situation.

#### Standard 2. Diagnosis

The school nurse analyzes the assessment data to determine the diagnoses or issues.

#### Standard 3. Outcomes Identification

The school nurse identifies expected outcomes for a plan individualized to the healthcare consumer or the situation.

#### Standard 4. Planning

The school nurse develops a plan that prescribes strategies and alternatives to attain expected outcomes.

#### Standard 5. Implementation

The school nurse implements the identified plan.

#### Standard 5a. Coordination of Care

The school nurse coordinates care delivery.

#### Standard 5b. Health Teaching and Health Promotion

The school nurse uses strategies to promote a healthy and a safe environment, especially regarding health education.

#### Standard 5c. Consultation

The school nurse provides consultation to influence the identified plan, enhance the abilities of others, and effect change.

#### Standard 5d. Prescriptive Authority and Treatment

The advanced practice nurse uses prescriptive authority, procedures, referrals, treatments, and therapies in accordance with state and federal laws and regulations.

#### Standard 6. Evaluation

The school nurse evaluates progress toward attainment of outcomes.

### Standards of Professional Performance for School Nursing

These standards describe a competent level of behavior in the professional role for school nurses appropriate to their education and position.

#### Standard 7. Ethics

The school nurse practices ethically.

#### Standard 8. Education

The school nurse attains knowledge and competency that reflect current nursing practice.

#### Standard 9. Evidence-Based Practice and Research

The school nurse integrates evidence and research findings into practice.

#### Standard 10. Quality of Practice

The school nurse contributes to quality nursing practice.

#### Standard 11. Communication

The school nurse communicates effectively in a variety of formats in all areas of nursing practice.

#### Standard 12. Leadership

The school nurse demonstrates leadership in the professional practice setting and the profession.

#### Standard 13. Collaboration

The school nurse collaborates with the healthcare consumer, family, and others in the conduct of nursing practice.

#### Standard 14. Professional Practice Evaluation

The school nurse evaluates one's own nursing practice in relation to professional practice standards and guidelines, relevant statutes, rules, and regulations

#### Standard 15. Resource Utilization

The school nurse utilizes appropriate resources to plan and provide nursing services that are safe, effective, and financially responsible.

#### Standard 16. Environmental Health

The school nurse practices in an environmentally safe and healthy manner.

#### Standard 17. Program Management

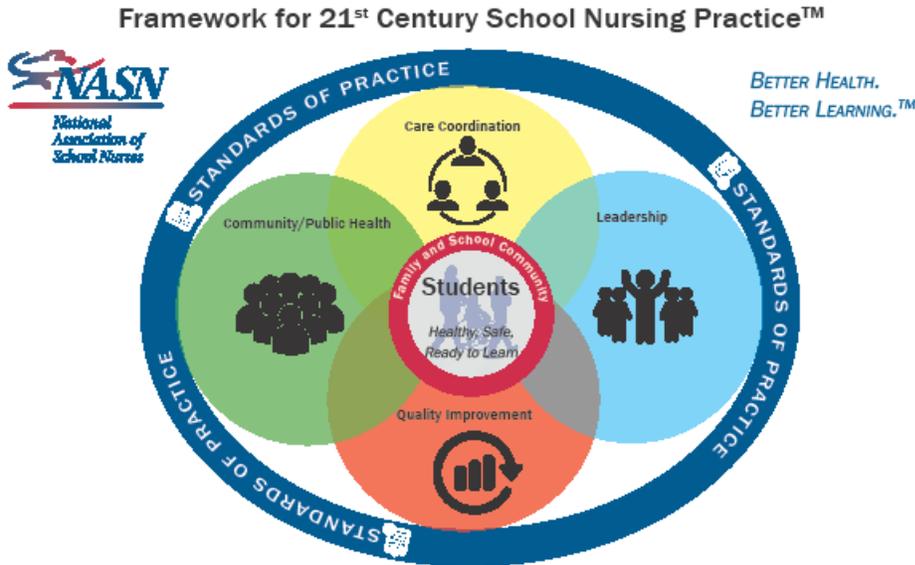
The school nurse manages school health services.

## HEALTH AND SAFETY OF SCHOOLS

The Utah Health and Safety Rule (R392-200, Design, Construction, Operation, Sanitation, and Safety of Schools) sets requirements for the school health office. This Rule states there must be a clinic room that has a cot or bed and a "sink with hot and cold running water, soap, individual towels, first aid supplies, and lockable cabinet space for storage of first-aid supplies" (R392-200-9). Each school or school district must have a policy in place which states how a nurse or doctor can be contacted while school is in session. The Rule further states there must be two individuals on site who have CPR and first aid certification. Additionally, in areas of schools that are considered high-risk injury areas (shops, laboratories, life skills, gymnasiums, theater prop building area, etc.) there must be a teacher who has CPR and first aid certification in these locations.

APPENDIX

# Framework for the 21<sup>st</sup> Century School Nursing Practice



NASN's *Framework for 21st Century School Nursing Practice* (the *Framework*) provides structure and focus for the key principles and components of current day, evidence-based school nursing practice. It is aligned with the Whole School, Whole Community, Whole Child model that calls for a collaborative approach to learning and health (ASCD & CDC, 2015). Central to the *Framework* is student-centered nursing care that occurs within the context of the students' family and school community. Surrounding the students, family, and school community are the non-hierarchical, overlapping key principles of *Care Coordination*, *Leadership*, *Quality Improvement*, and *Community/Public Health*. These principles are surrounded by the fifth principle, *Standards of Practice*, which is foundational for evidence-based, clinically competent, quality care. School nurses daily use the skills outlined in the practice components of each principle to help students be healthy, safe, and ready to learn.

Standards of Practice	Leadership	Quality Improvement	Community/Public Health	Care Coordination
<ul style="list-style-type: none"> <li>Clinical Competency</li> <li>Clinical Guidelines</li> <li>Code of Ethics</li> <li>Critical Thinking</li> <li>Evidence-based Practice</li> <li>NASN Position Statements</li> <li>Nurse Practice Acts</li> <li>Scope and Standards of Practice</li> </ul>	<ul style="list-style-type: none"> <li>Advocacy</li> <li>Change Agents</li> <li>Education Reform</li> <li>Funding and Reimbursement</li> <li>Healthcare Reform</li> <li>Lifelong Learner</li> <li>Models of Practice</li> <li>Technology</li> <li>Policy Development and Implementation</li> <li>Professionalism</li> <li>Systems-level Leadership</li> </ul>	<ul style="list-style-type: none"> <li>Continuous Quality Improvement</li> <li>Documentation/Data Collection</li> <li>Evaluation</li> <li>Meaningful Health/Academic Outcomes</li> <li>Performance Appraisal</li> <li>Research</li> <li>Uniform Data Set</li> </ul>	<ul style="list-style-type: none"> <li>Access to Care</li> <li>Cultural Competency</li> <li>Disease Prevention</li> <li>Environmental Health</li> <li>Health Education</li> <li>Health Equity</li> <li>Healthy People 2020</li> <li>Health Promotion</li> <li>Outreach</li> <li>Population-based Care</li> <li>Risk Reduction</li> <li>Screenings/Referral/Follow-up</li> <li>Social Determinants of Health</li> <li>Surveillance</li> </ul>	<ul style="list-style-type: none"> <li>Case Management</li> <li>Chronic Disease Management</li> <li>Collaborative Communication</li> <li>Direct Care</li> <li>Education</li> <li>Interdisciplinary Teams</li> <li>Motivational Interviewing/Counseling</li> <li>Nursing Delegation</li> <li>Student Care Plans</li> <li>Student-centered Care</li> <li>Student Self-empowerment</li> <li>Transition Planning</li> </ul>

ASCD & CDC. (2014). *Whole school whole community whole child: A collaborative approach to learning and health*. Retrieved from <http://www.ascd.org/ASCD/pdf/siteASCD/publications/wholechild/wsc-a-collaborative-approach.pdf>

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Rev. 9/28/15

# School Nursing Activities Calendar

## SCHOOL NURSING ACTIVITIES CALENDAR

This is an example of an activities calendar for the school-year. Use it as a guide to create one that meets your individual district/school needs. Share it with administrators to illustrate the variety of responsibilities.

Framework	AUGUST/SEPTEMBER	COMPLETED/NOTES
<i>Standards of Practice</i>	<ul style="list-style-type: none"> <li>• Identify and review new practice guidelines, policies and documents. Identify any changes needed</li> </ul>	
<i>Care Coordination</i>	<ul style="list-style-type: none"> <li>• Set up health room</li> <li>• Work with students/parents/guardians to update or develop individual health care plans (IHPs) and emergency action plans (EAPs)</li> <li>• Train school staff as appropriate regarding health and emergency action plans</li> <li>• Obtain necessary provider information and forms for medications and health procedures to be administered in schools</li> <li>• Train other school staff as appropriate regarding medications and procedures to be administered in schools</li> </ul>	
<i>Leadership</i>	<ul style="list-style-type: none"> <li>• Confirm forms, IHPs/EAPs, and training methods are current, evidence-based</li> <li>• Identify student-based and personal growth goals for the school year</li> <li>• Identify required and self-imposed reporting deadlines for the year</li> <li>• Send a message to teachers and parents/guardians introducing yourself and sharing about your role keep students and schools health</li> </ul>	
<i>Quality Improvement</i>	<ul style="list-style-type: none"> <li>• Set up documentation system for the year; include state workload census</li> <li>•</li> </ul>	
<i>Community/ Public Health</i>	<ul style="list-style-type: none"> <li>• Case-find and prioritize students with special health care needs/chronic conditions. Plan accordingly to work with those students, their parents/guardians, and appropriate staff as needed</li> <li>• Provide training to school staff and others regarding universal precautions, cardiopulmonary resuscitation, first aid, and other potential health emergencies according to needs in your school (i.e. seizures, food allergies, stock emergency medication and other training)</li> <li>• Work with parents/guardians, school staff, and community health care providers to identify and follow up with students needing required immunizations</li> </ul>	

	<b>SEPTEMBER</b>	<b>COMPLETED/NOTES</b>
<i>Standards of Practice</i>	<ul style="list-style-type: none"> <li>• Review evidence-based guidelines regarding screenings/referrals</li> </ul>	
<i>Care Coordination</i>	<ul style="list-style-type: none"> <li>• Continue to complete student IHPs/EAPs and training</li> </ul>	
<i>Leadership</i>	<ul style="list-style-type: none"> <li>• Continue to advocate for student needs</li> <li>• Develop a plan for accomplishing yearly personal/professional goals</li> </ul>	
<i>Quality Improvement</i>	<ul style="list-style-type: none"> <li>• Review monthly data for trends and make adjustments as needed</li> </ul>	
<i>Community/ Public Health</i>	<ul style="list-style-type: none"> <li>• Work with administrators regarding required and recommended screening activities, and the process of obtaining appropriate parental consents.</li> </ul>	
	<b>OCTOBER</b>	<b>COMPLETED/NOTES</b>
<i>Standards of Practice</i>	<ul style="list-style-type: none"> <li>• Review an evidence-based practice that pertains to your students' needs</li> <li>• Plan to attend USNA Fall Conference</li> </ul>	
<i>Care Coordination</i>	<ul style="list-style-type: none"> <li>• Continue ongoing supervision of delegation, according to health care and procedure plans and as needed</li> </ul>	
<i>Leadership</i>	<ul style="list-style-type: none"> <li>• Continue to advocate for students' needs</li> <li>• Include short message in PTA/school newsletter and make yourself available to teachers and parent groups for information.</li> </ul>	
<i>Quality Improvement</i>	<ul style="list-style-type: none"> <li>• Review monthly data for trends and make adjustments as needed</li> <li>• Prepare the state immunization report due November 30</li> </ul>	
<i>Community/ Public Health</i>	<ul style="list-style-type: none"> <li>• Continue screenings and referrals</li> <li>• Ensure state immunization report completed by schools</li> <li>• Schedule health education classes, as appropriate (tie into current events, season, school needs)</li> <li>• Identify students who have been absent for more than 5 days and follow up</li> <li>• Encourage flu vaccinations of staff/students (with appropriate timing according to your location)</li> </ul>	

	<b>NOVEMBER</b>	<b>COMPLETED/NOTES</b>
<i>Standards of Practice</i>	<ul style="list-style-type: none"> <li>• Review an evidence-based practice that pertains to your students' needs</li> </ul>	
<i>Care Coordination</i>	<ul style="list-style-type: none"> <li>• Continue ongoing supervision of delegation, as appropriate</li> <li>• Outreach to teachers regarding students' health concerns</li> </ul>	
<i>Leadership</i>	<ul style="list-style-type: none"> <li>• Identify a professional development opportunity to meet your needs/goals</li> </ul>	
<i>Quality Improvement</i>	<ul style="list-style-type: none"> <li>• Review monthly data for trends and make practice adjustments as needed</li> <li>• Submit the required State immunization report due November 30</li> </ul>	
<i>Community/ Public Health</i>	<ul style="list-style-type: none"> <li>• Continue referrals and follow-up of screening results</li> <li>• Encourage flu vaccinations of staff/students</li> <li>• Continue to review students who have been absent or consistently late and follow up</li> </ul>	
	<b>DECEMBER</b>	<b>COMPLETED/NOTES</b>
<i>Standards of Practice</i>	<ul style="list-style-type: none"> <li>• Review one new guideline or standard or evidence-based material related to your practice and identify one area to incorporate into practice</li> </ul>	
<i>Care Coordination</i>	<ul style="list-style-type: none"> <li>• Continue ongoing supervision of delegation, as appropriate</li> <li>• Outreach to teachers regarding student health concerns</li> <li>• Review student progress on plan goals and adjust as needed</li> </ul>	
<i>Leadership</i>	<ul style="list-style-type: none"> <li>• Prepare for upcoming legislative session/district yearly planning and advocating for policies impacting school nursing</li> </ul>	
<i>Quality Improvement</i>	<ul style="list-style-type: none"> <li>• Review monthly data for trends and make practice adjustments as needed</li> <li>• Identify particular groups who are seen more often as well as identify health disparities</li> </ul>	
<i>Community/ Public Health</i>	<ul style="list-style-type: none"> <li>• Complete referrals and follow up of screening results</li> <li>• Send health message to staff/parents on appropriate topic</li> <li>• Monitor flu/communicable diseases</li> <li>• Develop plan to work with students who have been absent, consistently late, leave early or other concern to support them staying in school</li> <li>• Plan biennial height/weight screening if with a participating school and if it is a screening year</li> </ul>	

	<b>JANUARY</b>	<b>COMPLETED/NOTES</b>
<i>Standards of Practice</i>	<ul style="list-style-type: none"> <li>• Continue working on implementation plan</li> </ul>	
<i>Care Coordination</i>	<ul style="list-style-type: none"> <li>• Continue ongoing supervision of delegation, as appropriate</li> <li>• Outreach to teachers regarding student health concerns</li> </ul>	
<i>Leadership</i>	<ul style="list-style-type: none"> <li>• Participate, as appropriate, advocating for policies/legislature as related to student health and/or updated evidence-based guidelines</li> </ul>	
<i>Quality Improvement</i>	<ul style="list-style-type: none"> <li>• Review monthly data for trends and make practice adjustments as needed</li> <li>• Submit mid-year report to administration</li> <li>• Prepare Q90 vision report due by April 30</li> </ul>	
<i>Community/ Public Health</i>	<ul style="list-style-type: none"> <li>• Monitor flu/communicable diseases</li> <li>• Submit short message for PTA/school newsletter regarding flu season</li> <li>• Continue to work with students at risk (absent, late/leave early, disparity)</li> <li>• Continue follow-up on any screenings</li> <li>• Conduct biennial height/weight screening if with a participating school, and if an even year.</li> </ul>	
	<b>FEBRUARY</b>	<b>COMPLETED/NOTES</b>
<i>Standards of Practice</i>	<ul style="list-style-type: none"> <li>• Continue working on implementation plan</li> <li>• Make plans to attend NASN Summer Conference</li> </ul>	
<i>Care Coordination</i>	<ul style="list-style-type: none"> <li>• Continue ongoing supervision of delegation, as appropriate</li> <li>• Outreach to teachers regarding student health concerns</li> <li>• Work with teachers to identify students at risk</li> </ul>	
<i>Leadership</i>	<ul style="list-style-type: none"> <li>• Participate, as appropriate, advocating for policies/legislature as related to student health and/or updated evidence-based guidelines</li> <li>• Identify new community resources needed to meet student needs</li> </ul>	
<i>Quality Improvement</i>	<ul style="list-style-type: none"> <li>• Review monthly data for trends and make practice adjustments as needed. Look particularly at health disparities that can be addressed</li> </ul>	
<i>Community/ Public Health</i>	<ul style="list-style-type: none"> <li>• Monitor flu/communicable diseases</li> <li>• Provide classroom, staff and parent/guardian education on appropriate topics</li> <li>• Begin kindergarten registration to identify incoming students with health needs.</li> <li>• Continue to work with students at risk (absent, late/leave early, disparity)</li> </ul>	

	<b>MARCH</b>	<b>COMPLETED/NOTES</b>
<i>Standards of Practice</i>	<ul style="list-style-type: none"> <li>• Continue working on implementation plan</li> </ul>	
<i>Care Coordination</i>	<ul style="list-style-type: none"> <li>• Continue ongoing supervision of delegation, as appropriate</li> <li>• Outreach to teachers regarding student health concerns</li> <li>• Work with teachers to ensure appropriate accommodations for students participating in field trips/camps that may have health concerns.</li> </ul>	
<i>Leadership</i>	<ul style="list-style-type: none"> <li>• Identify new community resources needed to meet student needs</li> <li>• Continue to advocate for students needs and as appropriate budget for new school year</li> </ul>	
<i>Quality Improvement</i>	<ul style="list-style-type: none"> <li>• Review monthly data for trends and make adjustments as needed</li> </ul>	
<i>Community/ Public Health</i>	<ul style="list-style-type: none"> <li>• Provide classroom, staff and parent education on appropriate topics</li> <li>• Monitor flu/communicable diseases</li> <li>• Continue to work with students at risk (absent, late/leave early, disparity)</li> </ul>	
	<b>APRIL</b>	<b>COMPLETED/NOTES</b>
<i>Standards of Practice</i>	<ul style="list-style-type: none"> <li>• Continue working on implementation plan</li> <li>• Make plans to attend USNA Spring Conference</li> </ul>	
<i>Care Coordination</i>	<ul style="list-style-type: none"> <li>• Continue ongoing supervision of delegation, as appropriate</li> <li>• Outreach to teachers regarding student health concerns</li> <li>• Inventory supplies needed for next year</li> <li>• Work with teachers to ensure appropriate accommodations for students participating in field trips/camps that may have health concerns</li> </ul>	
<i>Leadership</i>	<ul style="list-style-type: none"> <li>• Continue to advocate for students needs and (as appropriate) budget for new school year</li> </ul>	
<i>Quality Improvement</i>	<ul style="list-style-type: none"> <li>• Review monthly data for trends and make adjustments as needed</li> <li>• Set up an appointment with principal/district supervisor, board of education and local health department to share data and activities for the year</li> <li>• Submit Q90 vision report by April 30</li> </ul>	
<i>Community/ Public Health</i>	<ul style="list-style-type: none"> <li>• Provide classroom, staff and parent/guardian education on appropriate topics</li> <li>• Continue to work with students at risk (absent, late/leave early, disparity)</li> </ul>	

	<b>MAY/JUNE</b>	<b>COMPLETED/NOTES</b>
<i>Standards of Practice</i>	<ul style="list-style-type: none"> <li>• Evaluate implementation plan. Conduct environmental scan of potential standards or guideline updates that will be forthcoming for next year.</li> <li>• Attend NASN Summer Conference</li> </ul>	
<i>Care Coordination</i>	<ul style="list-style-type: none"> <li>• Begin updating student care plans for summer programs and in preparation for next school year (including transition planning for students)</li> <li>• Work with teachers regarding appropriate student field trip/camp health concerns/accommodations</li> <li>• Send parental/guardian notification for updated chronic health conditions that occur during summer</li> <li>• Notify parent of process to pick up any unused student medication at the end of the school year</li> </ul>	
<i>Leadership</i>	<ul style="list-style-type: none"> <li>• Send message to school staff and parents/guardians of year's health accomplishments and trends</li> </ul>	
<i>Quality Improvement</i>	<ul style="list-style-type: none"> <li>• Review year's data for trends and identify needs for next year</li> <li>• Submit Utah School Health Workload Census due May 31</li> <li>• Meet with principal/district supervisor to share data, activities and plans for next year.</li> <li>• Meet with board of education and board of health/local health department to share data and trends.</li> <li>• Prepare and submit State immunization report due June 15</li> </ul>	
<i>Community/ Public Health</i>	<ul style="list-style-type: none"> <li>• Send notification to parents/guardians of immunizations that will be needed for school entry in the fall.</li> <li>• Share tips with staff and parents/guardians for remaining healthy during summer</li> <li>• Evaluate plan with student at risk (absent, late/leave early, disparity)</li> </ul>	

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# Delegation

## Delegation of School Nursing Tasks in Utah

All students attending public schools must have access to health care during the school day and for extracurricular school activities if necessary to enable the student to participate fully in the program. The federal laws include the Americans with Disabilities Act (ADA), Individuals with Disabilities Education Act (IDEA), and Section 504 of the Rehabilitation Act of 1973. Since most schools in Utah do not have a full time nurse in each school it is often necessary to delegate specific nursing tasks to Unlicensed Assistive Personnel (UAP) so that children with special healthcare needs can attend school. Knowing when and how to delegate specific nursing tasks is essential for the school nurse. Only a professional nurse can delegate nursing care. Further, nursing delegation is not appropriate for all students, all nursing tasks, or all school settings (NASN, 2014). Tasks commonly performed by a parent/guardian at home take on a more complex dimension in the school setting. What appears to be a simple task is held to a much higher standard at school. Any health-related procedure in school requires medical orders, and licensed nurses are held to a higher standard than a parent would be for the same procedure (Resha, 2010).

Delegate means to transfer to an unlicensed person the authority to perform a task that, according to generally-accepted industry standards or law, does not require a nursing assessment (R156-31b-102 SS 10,C)

Assessment, planning, evaluation and nursing judgment cannot be delegated. Delegation is a student and situation specific activity in which the nurse must consider all components of the delegation process for each delegation decision.

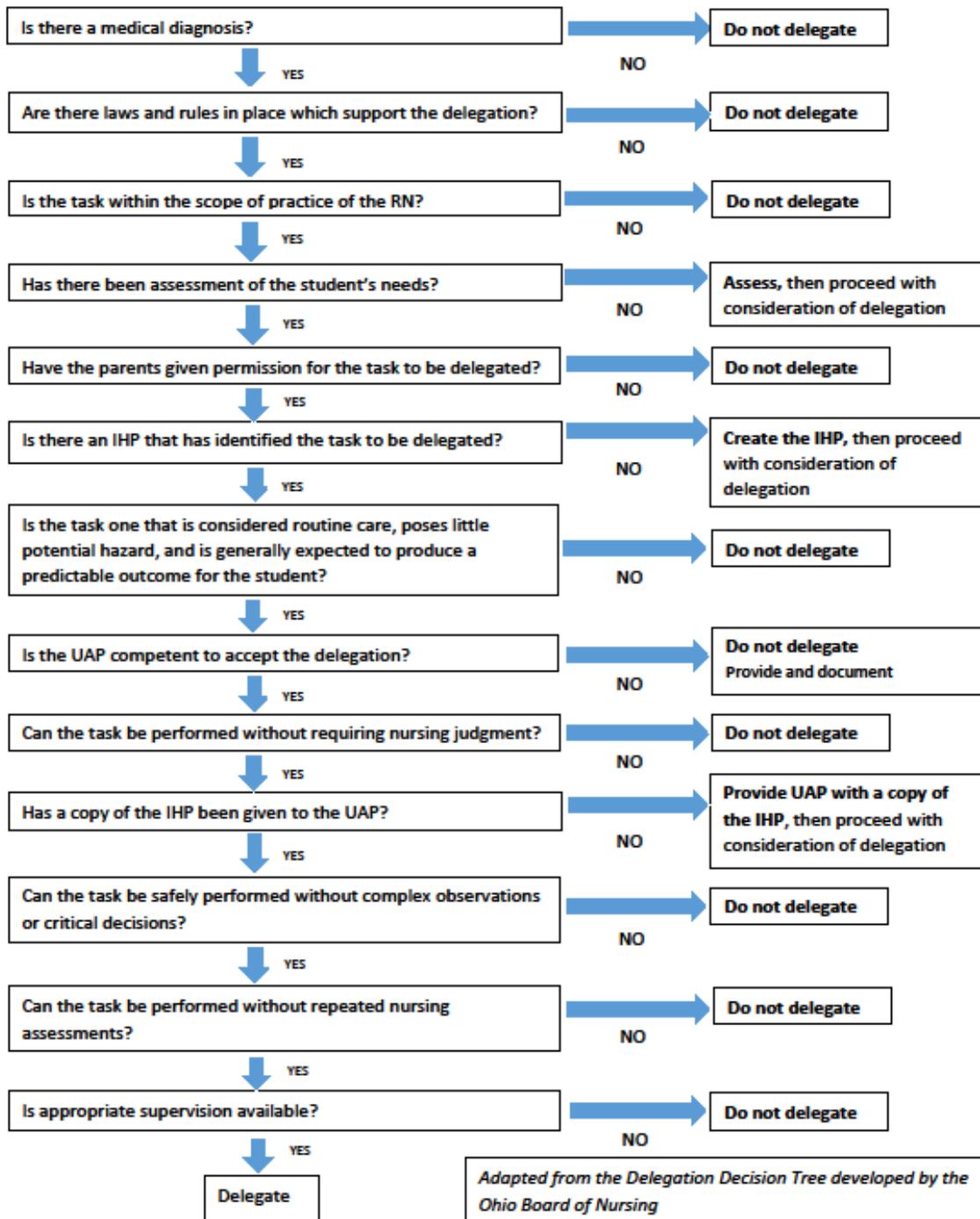
*The above was adapted from a similar tool previously developed by Colorado titled "Guidance on Delegation for Colorado School Nurses & Child Care Consultants".*

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## Delegation Decision-making Tree





## Medication Administration



2017

# Guidelines for Medication Administration in Schools

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# GUIDELINES REGARDING ADMINISTRATION OF STUDENT MEDICATION

The administration of medication to a student while he is at school should be a rare occurrence. However, there are circumstances that require medication be given during school hours. Each request for medication will be evaluated individually by the school nurse and school authorities. Utah statute UCA 53A-11-601 requires local education agencies (LEA) to adopt policies for:

- Designation of volunteer employees who may administer medication;
- Proper identification and safekeeping of medication;
- The training of designated volunteer employees by the school nurse;
- Maintenance of records of administration; and
- Notification to the school nurse of medication that will be administered to students once:
  - Student's parent/guardian has provided a current written and signed request
  - Documentation from the student's healthcare provider that the medication has been prescribed, and is medically necessary when the student is under the control of the school

The Utah Department of Health recommends the following guidelines:

An "AUTHORIZATION OF STUDENT MEDICATION" form (M-1), or similar LEA approved form, should be completed and signed before medication can be administered. This authorization must be updated annually and as needed when there is a change in a doctor's orders for a student medication. This form should include:

- A signature from parent requesting medication be administered during regular school hours to their student, and
- A signature from the student's licensed health care provider that they have prescribed the medication including documentation as to the method, amount, and time schedule for administration, and
- A statement from the licensed health care provider that administration of medication is medically necessary during periods when the student is under the control of the school.

## School Nurse Responsibility

The school nurse should be responsible to oversee medication administration in schools to ensure that medications are administered safely. These responsibilities should include:

- Consulting with LEA administration and/or boards in development/revision of medication administration policy

- Develop and maintain a record keeping system for obtaining parental consent and healthcare provider order, receiving and counting medications, administering medication, training of unlicensed assistive personnel (UAP), documenting medication errors, and disposal of medication not retrieved by parent
- Develop and conduct training of UAP who are to be trained to administer medications. The school nurse is responsible for training and for determining the competency of the UAP. The school nurse is also responsible for ongoing supervision of the UAP in task of medication administration.
- Evaluate a student's ability to carry and self-administer emergency medication
- Develop procedure for administering medication on a field trip.

## Parental Responsibility

It is the responsibility of the parent to:

- Give the first dose of a new medication at home, including a dosage change.
- Provide the school with medication in the original container, transported to the school by a responsible adult.
- Provide the written M-1 Medication Authorization (or other LEA approved) form with any new medication, or when the dosage changes.
- Inform the school nurse of any changes in the student's health status.

## School Responsibility

A daily medication administration log shall be kept for each student receiving medication. Each dose of medicine given must be charted by indicating the date, time given, and the signature or initials of the person giving the medication.

The medication shall be accepted only in a container that is labeled by a pharmacy or manufacturer. The label must include the name of the medication, route of administration, the time of administration, and the physician's name. Over-the-counter medication should come in the originally manufactured container, have legible administration and dosage instructions, and not be expired.

A parent or other responsible adult shall bring the medication to the school and take home any left over at the end of the school year. The medication should be counted by the adult and the school person receiving the medication, and the number recorded on the medication administration log (L-2) (or other LEA approved form) along with the names of those who counted the medication.

## Coordination and Oversight of Unlicensed Staff – Responsibility of Nursing

In Utah, RNs can oversee medication administration of UAP as permitted in the Utah Nurse Practice Act Rule (R156-31b-701a). According to R-156-31b-701 the registered nurse is the person to determine whether the delagatee can safely provide the requisite care, and if not, the nurse cannot delegate the task. The delegator retains accountability for appropriate delegation.

It is the responsibility of the school nurse to inform the school administrator if, in the opinion of the school nurse, the UAP delegated by the administrator is not competent to carry out the task of administering medication. Furthermore, the school nurse may not provide oversight or coordination of this task when the school nurse is of the opinion that the UAP is not competent to carry out this task.

## Training of Unlicensed Assistive Personnel

According to the Nurse Practice Act Rule (2015) a registered nurse shall personally train UAP who will be delegated the task of administering routine medication(s). Training must be done at least annually. The delegation of a first dose of medication cannot be done, including any dosage changes (which will be treated as a first dose).

## Individualized Healthcare Plans (IHP) and Emergency Action Plans (EAP)

The individualized healthcare plan (IHP) is required by professional standards of practice and uses the nursing process (assessment, diagnosis, planning, implementation, and evaluation) to determine a plan of action that meets the health care needs of a student during the school day. This plan is developed by the school nurse and provides written directions for school staff to follow in meeting the individual student's health care needs.

The emergency action plan (EAP) is also required by professional standards of practice and provides steps for school personnel in dealing with a life threatening or seriously harmful health situation for an individual student. This plan is developed by the school nurse and may be a part of the IHP.

According to the Utah Nurse Practice Act Rule (2015) all delegated tasks, including medication administration should be identified within the student's current healthcare plan (R156-31b-701a). The healthcare plans can be a detailed IHP or a simplified EAP, but should describe the conditions when medication should be administered to the student, whether routine or in an emergency situation.

## Standing Orders

Standing orders are medical orders written by the school's physician. These orders may authorize administration of specific over-the-counter (OTC) medication such as

acetaminophen or ibuprofen and emergency medications such as epinephrine to students according to a defined protocol.

Although parent or guardian approval (consent) is not needed for the administration of medications during a life threatening emergency, consent is required for the administration of OTC medications.

## Homeopathic and Herbal Remedies

Herbal medicine has its foundation in plants (also known as botanicals) and can be taken in several forms, including pills, powders, and essential oils. Although herbal remedies are considered “natural”, they can cause side effects, and may interact with other drugs being taken for other conditions.

Dietary supplements include vitamins and minerals and have a place in both conventional and complementary medicine. For example, a student with cystic fibrosis may need to take enzymes and vitamins with every meal. These should be addressed in the medication policies, and would also need to be treated as any other medication, requiring a licensed prescriber’s order and parent/guardian permission.

According to the National Association of School Nurses (NASN) “Registered nurses possess the knowledge about how to comply with NPAs and issues such as over-the-counter medications, off-label usage, and alternative medications, in a safe, evidence-based manner (2017-proposed)”. Schools must decide whether to develop policies that permit or prohibit the use of these substances within the school setting. If a school policy permits the administration of alternative medications, they should be treated as any other medication requiring a licensed prescriber’s order and parent/guardian permission.

As with any therapeutic intervention, when complementary and/or alternative medicines are requested to be administered, the first consideration is the health and safety of the student. When considering the administration of these substances in school, the following questions should be addressed:

- Does this substance need to be given during school hours?
- Is there documentation regarding the safety and efficacy of the substance?
- Has the parent or guardian provided written permission for the substance to be administered in school?
- Has a licensed prescriber written an order for this substance?

## Off-Label and Research Medications

Off-label medications are Federal Drug Administration (FDA) approved medications prescribed for non-approved purposes. Research or investigational medications are substances undergoing formal study, are currently involved in clinical trials, but don’t have FDA approval. If a school policy permits the administration of off-label and research medications, it requires a licensed prescriber’s order and parent/guardian consent.

## Who Can Prescribe Medication in Utah?

A licensed authorized prescribing professional is a physician (MD or DO), advanced practice registered nurse (APRN) with prescriptive authority, Physician Assistant (PA) who has direction from a physician or written protocol, dentist, or a podiatrist. Those that are not permitted to prescribed medications in Utah are licensed practical nurses (LPN), registered nurses (RN), medical assistants (MA), nutritionists, psychologists, naturopathic physicians (NP), and chiropractors.

## Specific Medications Laws

Utah has several laws that directly address emergency medications in the schools. Please see those specific laws (listed below) for more detailed information.

### Asthma Medications

Utah Code 53A-11-602 addresses asthma medications, and requires public schools to permit a student to possess and self-administer asthma medication if:

- The parent or guardian signs a statement authorizing the student to self-administer the medication, and that the student is responsible for, and capable of, self-administering the asthma medication; and
- The student's healthcare provider provides a written statement that it is medically appropriate for the student to self-administer and be in possession of the asthma medication at all times, and the name of the asthma medication authorized for the student's use.

The Utah Department of Health has developed an Asthma Action Plan (IHP 101.1 or IHP 101.2) that includes sections for both the healthcare provider and the parent required signatures. Students carrying asthma medication must have a completed medication authorization form submitted to the school (either the state form or an LEA approved form with the same information included).

### Epinephrine

Utah Code 26-41-101 requires schools to have at least one epinephrine auto-injector (EAI) available. Section 104 of this chapter requires schools to permit a student to possess an EAI if:

- The parent or guardian signs a statement authorizing the student to possess and self-administer the EAI, and that the student is responsible for, and capable of possessing or possessing and self-administering an EAI; and
- The student's healthcare provider provides a written statement that it is medically appropriate for the student to possess or possess and self-administer the EAI at all times.

The Utah Department of Health has developed an Allergy & Anaphylaxis Emergency Action Plan (IHP 104.1) that includes sections for both the healthcare provider and the parent required signatures. Students carrying EAI must have a completed medication authorization form submitted to the school (either the state form or an LEA approved form with the same information included). The emergency 911

number and parent or guardian should always be called if an EAI is administered to the student.

### Glucagon and Diabetes Medications

Glucagon is a hormone that must be injected to treat severe low blood glucose, or hypoglycemia. It works to release glucose into the bloodstream to bring the blood glucose level back up.

Utah Code 53A-11-603 requires schools to permit a student to possess or possess and self-administer diabetes medication if:

- The parent or guardian signs a statement authorizing the student to possess or possess and self-administer diabetes medication, including glucagon, and that the student is responsible for, and capable of possessing or possessing and self-administering the diabetes medication; and
- The student's healthcare provider provides a written statement that it is medically appropriate for the student to possess or possess and self-administer the diabetes medication at all times, and the name of the diabetes medication(s) authorized for student's use.

The Utah Department of Health and local diabetes physicians have developed a Diabetes Medication Management Order (DMMO) (M-2) that includes sections for both the healthcare provider and the parent required signatures. Students carrying diabetes medication must have a completed medication authorization form submitted to the school (either the state form or an LEA approved form with the same information included). The emergency 911 number and parent or guardian should always be called in glucagon is administered to the student.

### Seizure Rescue Medication

Utah Code 53A-11-603.5 requires schools to attempt to identify and train school employees who are willing to volunteer to receive training to administer seizure rescue medication to a student if:

- A prescribing healthcare provider has prescribed a seizure rescue medication to the student; and
- The student's parent or guardian has previously administered the student's seizure rescue medication in a nonmedically-supervised setting without a complication; and
- The student has previously ceased having a full body prolonged convulsive seizure activity as a result of receiving the seizure rescue medication.

The Utah Department of Health and the local pediatric neurology physicians have developed a Seizure Medication Management Order (SMMO) (M-3) that includes sections for both the healthcare provider and the parent required signatures. This form is required if seizure rescue medication is ordered for administration in the schools. The emergency 911 number and parent or guardian should always be called if any seizure rescue medication is administered to the student.

## Opiate Overdose (Naloxone)

Utah Code 26-55-101 allows organizations (including schools) to obtain and administer an opiate antagonist (naloxone) in an opiate-related drug overdose event. This medication can be obtained at certain pharmacies in Utah without a prescription. If a school chooses to house naloxone, their medication policy should address this.

## Student Self-Administration of Medication

Students may be allowed to assume responsibility for carrying and administering their own medications (excluding controlled substances), provided that self-administration is approved in writing by the prescribing health care provider, the parent or guardian, and the school or district policy. If the student will be carrying asthma medication, epinephrine, diabetes medication, or if seizure rescue medication is to be administered at school there must be a completed authorization form submitted to the school (either the state form(s) or an LEA approved form with the same information included).

## Storage

Medication must be stored in a secure refrigerator, drawer, or cabinet accessible only by those authorized to administer the medication. An exception to this would be asthma inhalers, epinephrine auto-injectors, and glucagon, which must not be stored in a locked area so they are readily available in an emergency. Seizure rescue medication should be kept locked, but accessible.

## Transportation of Medications To/From School

Each LEA should develop a written policy to ensure the safe and secure transporting of medication. Issues to address in this policy should include:

- Medications transported to school
- Medications transported from school
- Medication transportation for emergency evacuation during the school day
- Medication transportation during field trips

## Disposal of Unused Medication

Parent or guardian should be informed that it is their responsibility to retrieve any unused medication if the student is withdrawn from the school and/or at the end of the school year. The school should maintain a written policy to cover the following issues regarding those medications that are not retrieved.

- Written communication should be sent to the parent or guardian prior to the end of the school year with notification that unused medications must be retrieved by a specified date. The same communication needs to occur for any student who withdraws during the school year.
- Any medications not picked up by the designated date should be disposed of by the school nurse in the presence of another school employee in a manner

to prevent any possibility of further use of the medications. Environmental considerations should be kept in mind when disposing of unused medications.

- The school nurse and the school employee in charge of the disposal of unused medications should document the name of the medication and the amount disposed of along with the name of the student for which it was prescribed. Both individuals should sign the documentation.

## Six Rights of Medication Administration

The six rights of assisting with medication include the following:

- Right student
- Right medication
- Right dosage
- Right time
- Right route
- Right documentation

These should be triple checked each and every time medication is administered. This includes:

- First, when taking the medication out of storage area; and
- Second, prior to administering the medication to the student; and
- Third, when returning the medication to the storage area.

## Medication Errors

A medication incident or error report form (M-4 or other LEA approved form) should be used to report medication errors and must be filled out every time a medication error occurs. Routine errors include the following:

- Wrong student
- Wrong medication
- Wrong dosage
- Wrong time
- Wrong route

All medication incident or error reports should be shared between the school nurse, the parent or guardian, and other appropriate school and health care personnel according to school policy.

The Poison Control number is (800) 222-1222 and may need to be consulted for medication errors.

## Students Who Forget to Take Their Medication

Schools have a responsibility to administer ordered and authorized medication. They can fulfill their obligation to provide health-related services to all children under the Individuals with Disabilities Education Improvement Act (2004) and Section 504 of the Rehabilitation Act (1973) as amended through the Americans

with Disabilities Amendment Act [ADAA] in 2008. A forgetful student must be sent for, or medication taken to their classroom. If a student forgets or refuses to come for medications, a conference with parent, counselor, nurse, and student should be arranged. A care plan should be developed that includes strategies to help forgetful students remember to come to the designated location for their medication. Some students may need help with problem solving.

## Documentation

Documentation of medication given at school should be part of the school's written policy and practice for administering medications. Each dose of medication administered or witnessed by school staff should be documented on a medication log (L-1 or other LEA approved form) in ink or electronically. This log becomes a permanent health record for parents and health care providers, and provides legal protection to those who assist with medications at school. It also helps ensure that students receive medications as prescribed, and can help reduce medication errors.

Any hand-written error should be corrected by drawing a single line through the error, recording the correct information, then initialing and dating the corrected entry, as with any medical record.

The medication log should contain the following information:

- Student name
- Prescribed medication and dosage
- Schedule for medication administration
- Name(s) and signature(s)/initial(s) or electronic identification of individual(s) authorized and trained to supervise administration of medications

## Definitions

Administration: the provision of prescribed medication to a student according to the orders of a healthcare provider, and as permitted by Utah law.

Asthma Inhaler: a device for the delivery of prescribed asthma medication which is inhaled. It includes metered dose inhalers (MDI), dry powder inhalers, and nebulizers.

Epinephrine Auto Injector: a device to deliver the correct epinephrine dose parenterally and is used as a treatment for symptoms of an allergic reaction.

Healthcare Provider: a medical/health practitioner who has a current license in the State of Utah with a scope of practice that includes prescribing medication.

Local Education Agency (LEA): the school district, charter or private school.

Medication: prescribed drugs and medical devices that are controlled by the U.S. Food and drug Administration and are ordered by a healthcare provider. It includes over-the-counter medications prescribed through a standing order by the school physician or prescribed by the student's healthcare provider.

Medication Authorization Form: A form required before medication can be stored, administered, or carried by a student. This form can be the M-1 form designed by the State, or a form created by the LEA.

Medication Error: occurs when a medication is not administered as prescribed. This includes when the medication prescribed is not given to the correct student, at the correct time, in the dosage prescribed, by the correct route, or when the wrong medication is administered.

Medication Log: a form that provides required documentation when medication is administered to a student. This form can be the M-2 form designed by the State, or a form created by the LEA.

Parent: a natural or adoptive parent, a guardian, or person acting as a parent of a child with legal responsibility for the child's welfare.

School Nurse: A registered professional nurse with a current nursing license who practices in a school setting.

Self-Administration: when the student administers medication independently to themselves under indirect supervision of the school nurse.

Unlicensed Assistive Personnel: a school employee who does not have a professional license that allows them to administer medication.

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# ATTACHMENTS

ATTACHMENT A - Medication Authorization Form (Sample)

SCHOOL MEDICATION AUTHORIZATION FORM In Accordance with UCA 53A-11-601				Date:	Student Picture
<b>STUDENT INFORMATION</b>					
Student:	DOB:	Grade:	School:		
Parent:	Phone:		Email:		
Prescriber Name:	Phone:		Fax:		
School Nurse:	School Phone:		Fax:		
<p>Parent: complete the above section, read and sign below, obtain signature from Health Care Provider and As parent/guardian I request the medication(s) listed below be given to my student during regular school hours.</p> <p><input type="checkbox"/> I understand medication will be administered by trained school employee volunteers.</p> <p><input type="checkbox"/> I understand a new medication authorization form will be required each school year, and whenever there is a dosage change.</p> <p><input type="checkbox"/> I understand parent or guardian is responsible for maintaining necessary supplies, medications, and equipment.</p> <p><input type="checkbox"/> I understand prescription medication must be transported to and from school by an adult*.</p> <p><input type="checkbox"/> I understand all medication, both prescription and over-the-counter, must be in the current original pharmacy container and label, with the child's name, medication name, administration time, dosage, and health care provider's name.</p> <p><input type="checkbox"/> I understand over-the-counter medication must be in the original manufacture container.</p> <p><input type="checkbox"/> I understand the information contained in this order will be shared with school staff on a need-to-know basis.</p> <p><input type="checkbox"/> I understand it is my responsibility to notify the school nurse of any change in my student's health status, care or medication order.</p> <p>I give permission for my child's healthcare provider to share information with the school nurse for the</p>					
Parent Name (print):		Signature:		Date:	
Emergency Contact Name:		Relationship:		Phone:	
<b>MEDICATION INFORMATION</b>					
<p>If a request is being made for school staff to <u>administer</u> asthma medication, epinephrine auto-injector, diabetes medication, or seizure rescue medication, an additional specific form(s) will be required, and must be signed by the parent and physician, and kept on file at the school. These supplemental forms will also be required for students who <u>carry and self-administer</u> asthma medication, epinephrine auto-injectors, and diabetes medications.</p>					
Name of Medication	Indication/Diagnosis	Dosage	Route	Time	Side Effects
Additional Instructions to the school:					
<p><b>SIGNATURE</b> This order can only be signed by an MD/DO; Nurse Practitioner, Certified Physician's Assistant or a provider with prescriptive practice.</p> <p>The above named student is under my care. It is medically necessary for medication administration while student is under the control of the school.</p> <p><input type="checkbox"/> It is medically appropriate for the student to self-carry* this medication, <u>when able and appropriate</u>, and be in possession of this medication and supplies at all times (see statement above under Medication Information). This student has been trained to self-administer the medication and is capable of doing this safely.</p> <p><input type="checkbox"/> It is <u>not</u> medically appropriate to carry and self-administer this medication. Please have the appropriate/designated school personnel maintain this student's medication for use if needed.</p>					
Prescriber Name:			Phone:		
Prescriber Signature:			Date:		
CONTINUED ON NEXT PAGE:					

<b>School Nurse</b>		
<input type="checkbox"/> Signed by physician and parent	<input type="checkbox"/> Medication appropriately labeled	<input type="checkbox"/> Medication log generated
Medication is kept: <input type="checkbox"/> Front office <input type="checkbox"/> Health office <input type="checkbox"/> Classroom <input type="checkbox"/> Other* (specify):		
School Nurse Signature:		Date:
*Student may carry some medication in certain circumstances. This applies to asthma medication, epinephrine auto-injectors, and diabetes medications, and ONLY after supplemental forms are completed and turned in to the school. <i>District and school medication policies have the final say on whether medication other than asthma medication, epinephrine auto-injectors, and diabetes medications can be self-carried.</i>		



ATTACHMENT C - Medication Error Reporting Form (Sample)

<b>UTAH MEDICATION ERROR REPORT FORM</b>		
<p>A medication error is defined as failure to administer the prescribed medication to the right student, at the right time, the right medication, the right dose or the right route. The person who administered the medication should complete this form and turn it in to the school nurse or school administrator. This form is not required if Local Education Agency (LEA) has developed their own Error or Incident form.</p>		
Date/Time:	Prepared by:	
School District:	School:	Date:
Student Name:	Student DOB:	Teacher/Grade:
Medication Name:	Dose Ordered:	Time Ordered:
Licensed Prescriber:	Phone:	
Parent/Guardian:	Phone:	
TYPE OF ERROR (Check all that apply)		
<input type="checkbox"/> Wrong student	Student on order:	Student given:
<input type="checkbox"/> Wrong Medication	Medication ordered:	Medication given:
<input type="checkbox"/> Wrong Dosage	Dosage ordered:	Dosage given:
<input type="checkbox"/> Wrong Time	Time ordered:	Time given:
<input type="checkbox"/> Wrong Route	Route ordered:	Route given:
<input type="checkbox"/> Medication not available	<input type="checkbox"/> Student refusal	<input type="checkbox"/> Medication wasted
<input type="checkbox"/> Expired Medication	<input type="checkbox"/> Omitted dose(s):	
<input type="checkbox"/> Possible adverse reaction	Describe:	
<input type="checkbox"/> Other:	Explain:	
Narrative description of error (use back of form if necessary):		
ACTION TAKEN		
Student transported by EMS? <input type="checkbox"/> No <input type="checkbox"/> Yes, Location:		
Persons notified:		
Licensed Prescriber Notified: <input type="checkbox"/> Yes <input type="checkbox"/> No	Date Notified:	Time Notified:
Parent/Guardian Notified: <input type="checkbox"/> Yes <input type="checkbox"/> No	Date Notified:	Time Notified:
School Administrator Notified: <input type="checkbox"/> Yes <input type="checkbox"/> No	Date Notified:	Time Notified:
School Nurse Notified: <input type="checkbox"/> Yes <input type="checkbox"/> No	Date Notified:	Time Notified:
FOLLOWUP INFORMATION		
Narrative of follow up:		
SIGNATURES		
Individual preparing report:	Date:	
School Nurse:	Date:	
Administrator:	Date:	

**Part 6**  
**Administration of Medication**

**53A-11-601 Administration of medication to students -- Prerequisites – Immunity from liability.**

- (1) A public or private school that holds any classes in grades kindergarten through 12 may provide for the administration of medication to any student during periods when the student is under the control of the school, subject to the following conditions:
  - (a) the local school board, charter school governing board, or the private equivalent, after consultation with the Department of Health and school nurses shall adopt policies that provide for:
    - (i) the designation of volunteer employees who may administer medication;
    - (ii) proper identification and safekeeping of medication;
    - (iii) the training of designated volunteer employees by the school nurse;
    - (iv) maintenance of records of administration; and
    - (v) notification to the school nurse of medication that will be administered to students; and
  - (b) medication may only be administered to a student if:
    - (i) the student's parent or legal guardian has provided a current written and signed request that medication be administered during regular school hours to the student; and
    - (ii) the student's licensed health care provider has prescribed the medication and provides documentation as to the method, amount, and time schedule for administration, and a statement that administration of medication by school employees during periods when the student is under the control of the school is medically necessary.
- (2) Authorization for administration of medication by school personnel may be withdrawn by the school at any time following actual notice to the student's parent or guardian.
- (3) School personnel who provide assistance under Subsection (1) in substantial compliance with the licensed health care provider's written prescription and the employers of these school personnel are not liable, civilly or criminally, for:
  - (a) any adverse reaction suffered by the student as a result of taking the medication; and
  - (b) discontinuing the administration of the medication under Subsection (2).

Amended by Chapter 173, 2008 General Session

**53A-11-602 Self-administration of asthma medication.**

- (1) As used in this section, "asthma medication" means prescription or nonprescription, inhaled asthma medication.
- (2) A public school shall permit a student to possess and self-administer asthma medication if:
  - (a) the student's parent or guardian signs a statement:
    - (i) authorizing the student to self-administer asthma medication; and
    - (ii) acknowledging that the student is responsible for, and capable of, self-administering the asthma medication; and
  - (b) the student's health care provider provides a written statement that states:
    - (i) it is medically appropriate for the student to self-administer asthma medication and be in possession of asthma medication at all times; and
    - (ii) the name of the asthma medication prescribed or authorized for the student's use.

- (3) The Utah Department of Health, in cooperation with the state superintendent of public instruction, shall design forms to be used by public schools for the parental and health care provider statements described in Subsection (2).
- (4) Section 53A-11-904 does not apply to the possession and self-administration of asthma medication in accordance with this section.

Enacted by Chapter 4, 2004 General Session

**53A-11-603 Administration of glucagon -- Training of volunteer school personnel -- Authority to use glucagon -- Immunity from liability.**

- (1) As used in this section, "glucagon authorization" means a signed statement from a parent or guardian of a student with diabetes:
  - (a) certifying that glucagon has been prescribed for the student;
  - (b) requesting that the student's public school identify and train school personnel who volunteer to be trained in the administration of glucagon in accordance with this section; and
  - (c) authorizing the administration of glucagon in an emergency to the student in accordance with this section.
- (2)
  - (a) A public school shall, within a reasonable time after receiving a glucagon authorization, train two or more school personnel who volunteer to be trained in the administration of glucagon, with training provided by the school nurse or another qualified, licensed medical professional.
  - (b) A public school shall allow all willing school personnel to receive training in the administration of glucagon, and the school shall assist and may not obstruct the identification or training of volunteers under this Subsection (2).
  - (c) The Utah Department of Health, in cooperation with the state superintendent of public instruction, shall design a glucagon authorization form to be used by public schools in accordance with this section.
- (3)
  - (a) Training in the administration of glucagon shall include:
    - (i) techniques for recognizing the symptoms that warrant the administration of glucagon;
    - (ii) standards and procedures for the storage and use of glucagon;
    - (iii) other emergency procedures, including calling the emergency 911 number and contacting, if possible, the student's parent or guardian; and
    - (iv) written materials covering the information required under this Subsection (3).
  - (b) A school shall retain for reference the written materials prepared in accordance with Subsection (3)(a)(iv).
- (4) A public school shall permit a student or school personnel to possess or store prescribed glucagon so that it will be available for administration in an emergency in accordance with this section.
- (5)
  - (a) A person who has received training in accordance with this section may administer glucagon at a school or school activity to a student with a glucagon authorization if:
    - (i) the student is exhibiting the symptoms that warrant the administration of glucagon; and
    - (ii) a licensed health care professional is not immediately available.
  - (b) A person who administers glucagon in accordance with Subsection (5)(a) shall direct a responsible person to call 911 and take other appropriate actions in accordance with the training materials retained under Subsection (3)(b).

- (6) School personnel who provide or receive training under this section and act in good faith are not liable in any civil or criminal action for any act taken or not taken under the authority of this section with respect to the administration of glucagon.
- (7) Section 53A-11-601 does not apply to the administration of glucagon in accordance with this section.
- (8) Section 53A-11-904 does not apply to the possession and administration of glucagon in accordance with this section.
- (9) The unlawful or unprofessional conduct provisions of Title 58, Occupations and Professions, do not apply to a person licensed as a health professional under Title 58, Occupations and Professions, including a nurse, physician, or pharmacist who, in good faith, trains nonlicensed volunteers to administer glucagon in accordance with this section.

Enacted by Chapter 215, 2006 General Session

**53A-11-603.5 Trained school employee volunteers -- Administration of seizure rescue medication -- Exemptions from liability.**

- (1) As used in this section:
  - (a) "Prescribing health care professional" means:
    - (i) a physician and surgeon licensed under Title 58, Chapter 67, Utah Medical Practice Act;
    - (ii) an osteopathic physician and surgeon licensed under Title 58, Chapter 68, Utah Osteopathic Medical Practice Act;
    - (iii) an advanced practice registered nurse licensed under Title 58, Chapter 31b, Nurse Practice Act; or
    - (iv) a physician assistant licensed under Title 58, Chapter 70a, Physician Assistant Act.
  - (b) "Section 504 accommodation plan" means a plan developed pursuant to Section 504 of the Rehabilitation Act of 1973, as amended, to provide appropriate accommodations to an individual with a disability to ensure access to major life activities.
  - (c) "Seizure rescue authorization" means a student's Section 504 accommodation plan that:
    - (i) certifies that:
      - (A) a prescribing health care professional has prescribed a seizure rescue medication for the student;
      - (B) the student's parent or legal guardian has previously administered the student's seizure rescue medication in a nonmedically-supervised setting without a complication; and
      - (C) the student has previously ceased having full body prolonged or convulsive seizure activity as a result of receiving the seizure rescue medication;
    - (ii) describes the specific seizure rescue medication authorized for the student, including the indicated dose, and instructions for administration;
    - (iii) requests that the student's public school identify and train school employees who are willing to volunteer to receive training to administer a seizure rescue medication in accordance with this section; and
    - (iv) authorizes a trained school employee volunteer to administer a seizure rescue medication in accordance with this section.
  - (d)
    - (i) "Seizure rescue medication" means a medication, prescribed by a prescribing health care professional, to be administered as described in a student's seizure rescue authorization, while the student experiences seizure activity.
    - (ii) A seizure rescue medication does not include a medication administered intravenously or intramuscularly.

- (e) "Trained school employee volunteer" means an individual who:
  - (i) is an employee of a public school where at least one student has a seizure rescue authorization;
  - (ii) is at least 18 years old; and
  - (iii) as described in this section:
    - (A) volunteers to receive training in the administration of a seizure rescue medication;
    - (B) completes a training program described in this section;
    - (C) demonstrates competency on an assessment; and
    - (D) completes annual refresher training each year that the individual intends to remain a trained school employee volunteer.
- (2)
  - (a) The Department of Health shall, with input from the State Board of Education and a children's hospital, develop a training program for trained school employee volunteers in the administration of seizure rescue medications that includes:
    - (i) techniques to recognize symptoms that warrant the administration of a seizure rescue medication;
    - (ii) standards and procedures for the storage of a seizure rescue medication;
    - (iii) procedures, in addition to administering a seizure rescue medication, in the event that a student requires administration of the seizure rescue medication, including:
      - (A) calling 911; and
      - (B) contacting the student's parent or legal guardian;
    - (iv) an assessment to determine if an individual is competent to administer a seizure rescue medication;
    - (v) an annual refresher training component; and
    - (vi) written materials describing the information required under this Subsection (2)(a).
  - (b) A public school shall retain for reference the written materials described in Subsection (2)(a)(vi).
  - (c) The following individuals may provide the training described in Subsection (2)(a):
    - (i) a school nurse; or
    - (ii) a licensed health care professional.
- (3)
  - (a) A public school shall, after receiving a seizure rescue authorization:
    - (i) inform school employees of the opportunity to be a school employee volunteer; and
    - (ii) subject to Subsection (3)(b)(ii), provide training, to each school employee who volunteers, using the training program described in Subsection (2)(a).
  - (b) A public school may not:
    - (i) obstruct the identification or training of a trained school employee volunteer; or
    - (ii) compel a school employee to become a trained school employee volunteer.
- (4) A trained school employee volunteer may possess or store a prescribed rescue seizure medication, in accordance with this section.
- (5) A trained school employee volunteer may administer a seizure rescue medication to a student with a seizure rescue authorization if:
  - (a) the student is exhibiting a symptom, described on the student's seizure rescue authorization, that warrants the administration of a seizure rescue medication; and
  - (b) a licensed health care professional is not immediately available to administer the seizure rescue medication.

- (6) A trained school employee volunteer who administers a seizure rescue medication shall direct an individual to call 911 and take other appropriate actions in accordance with the training described in Subsection (2).
- (7) A trained school employee volunteer who administers a seizure rescue medication in accordance with this section in good faith is not liable in a civil or criminal action for an act taken or not taken under this section.
- (8) Section 53A-11-601 does not apply to the administration of a seizure rescue medication.
- (9) Section 53A-11-904 does not apply to the possession of a seizure rescue medication in accordance with this section.
- (10)
  - (a) The unlawful or unprofessional conduct provisions of Title 58, Occupations and Professions, do not apply to a person licensed as a health care professional under Title 58, Occupations and Professions, including a nurse, physician, or pharmacist for, in good faith, training a nonlicensed school employee who volunteers to administer a seizure rescue medication in accordance with this section.
  - (b) Allowing a trained school employee volunteer to administer a seizure rescue medication in accordance with this section does not constitute unlawful or inappropriate delegation under Title 58, Occupations and Professions.

Enacted by Chapter 423, 2016 General Session

**53A-11-604 Diabetes medication -- Possession -- Self-administration.**

- (1) As used in this section, "diabetes medication" means prescription or nonprescription medication used to treat diabetes, including related medical devices, supplies, and equipment used to treat diabetes.
- (2) A public school shall permit a student to possess or possess and self-administer diabetes medication if:
  - (a) the student's parent or guardian signs a statement:
    - (i) authorizing the student to possess or possess and self-administer diabetes medication; and
    - (ii) acknowledging that the student is responsible for, and capable of, possessing or possessing and self-administering the diabetes medication; and
  - (b) the student's health care provider provides a written statement that states:
    - (i) it is medically appropriate for the student to possess or possess and self-administer diabetes medication and the student should be in possession of diabetes medication at all times; and
    - (ii) the name of the diabetes medication prescribed or authorized for the student's use.
- (3) The Utah Department of Health, in cooperation with the state superintendent of public instruction, shall design forms to be used by public schools for the parental and health care provider statements described in Subsection (2).
- (4) Section 53A-11-904 does not apply to the possession and self-administration of diabetes medication in accordance with this section.

Enacted by Chapter 215, 2006 General Session

**53A-11-605 Definitions -- School personnel -- Medical recommendations -- Exceptions -- Penalties.**

- (1) As used in this section:
  - (a) "Health care professional" means a physician, physician assistant, nurse, dentist, or mental health therapist.

- (b) "School personnel" means a school district or charter school employee, including a licensed, part-time, contract, or nonlicensed employee.
- (2) School personnel may:
  - (a) provide information and observations to a student's parent or guardian about that student, including observations and concerns in the following areas:
    - (i) progress;
    - (ii) health and wellness;
    - (iii) social interactions;
    - (iv) behavior; or
    - (v) topics consistent with Subsection 53A-13-302(6);
  - (b) communicate information and observations between school personnel regarding a child;
  - (c) refer students to other appropriate school personnel and agents, consistent with local school board or charter school policy, including referrals and communication with a school counselor or other mental health professionals working within the school system;
  - (d) consult or use appropriate health care professionals in the event of an emergency while the student is at school, consistent with the student emergency information provided at student enrollment;
  - (e) exercise their authority relating to the placement within the school or readmission of a child who may be or has been suspended or expelled for a violation of Section 53A-11-904; and
  - (f) complete a behavioral health evaluation form if requested by a student's parent or guardian to provide information to a licensed physician.
- (3) School personnel shall:
  - (a) report suspected child abuse consistent with Section 62A-4a-403;
  - (b) comply with applicable state and local health department laws, rules, and policies; and
  - (c) conduct evaluations and assessments consistent with the Individuals with Disabilities Education Act, 20 U.S.C. Sec. 1400 et seq., and its subsequent amendments.
- (4) Except as provided in Subsection (2), Subsection (6), and Section 53A-11a-203, school personnel may not:
  - (a) recommend to a parent or guardian that a child take or continue to take a psychotropic medication;
  - (b) require that a student take or continue to take a psychotropic medication as a condition for attending school;
  - (c) recommend that a parent or guardian seek or use a type of psychiatric or psychological treatment for a child;
  - (d) conduct a psychiatric or behavioral health evaluation or mental health screening, test, evaluation, or assessment of a child, except where this Subsection (4)(d) conflicts with the Individuals with Disabilities Education Act, 20 U.S.C. Sec. 1400 et seq., and its subsequent amendments; or
  - (e) make a child abuse or neglect report to authorities, including the Division of Child and Family Services, solely or primarily on the basis that a parent or guardian refuses to consent to:
    - (i) a psychiatric, psychological, or behavioral treatment for a child, including the administration of a psychotropic medication to a child; or
    - (ii) a psychiatric or behavioral health evaluation of a child.
- (5) Notwithstanding Subsection (4)(e), school personnel may make a report that would otherwise be prohibited under Subsection (4)(e) if failure to take the action described under Subsection (4)(e) would present a serious, imminent risk to the child's safety or the safety of others.

Utah Code

- (6) Notwithstanding Subsection (4), a school counselor or other mental health professional acting in accordance with Title 58, Chapter 60, Mental Health Professional Practice Act, or licensed through the State Board of Education, working within the school system may:
- (a) recommend, but not require, a psychiatric or behavioral health evaluation of a child;
  - (b) recommend, but not require, psychiatric, psychological, or behavioral treatment for a child;
  - (c) conduct a psychiatric or behavioral health evaluation or mental health screening, test, evaluation, or assessment of a child in accordance with Section 53A-13-302; and
  - (d) provide to a parent or guardian, upon the specific request of the parent or guardian, a list of three or more health care professionals or providers, including licensed physicians, psychologists, or other health specialists.
- (7) Local school boards or charter schools shall adopt a policy:
- (a) providing for training of appropriate school personnel on the provisions of this section; and
  - (b) indicating that an intentional violation of this section is cause for disciplinary action consistent with local school board or charter school policy and under Section 53A-8a-502.
- (8) Nothing in this section shall be interpreted as discouraging general communication not prohibited by this section between school personnel and a student's parent or guardian.

Amended by Chapter 335, 2013 General Session

## ATTACHMENT E - Epinephrine Law (UCA 26-41-101)

Utah Code

### Chapter 41 Emergency Injection for Anaphylactic Reaction Act

#### 26-41-101 Title.

This chapter is known as the "Emergency Injection for Anaphylactic Reaction Act."

Enacted by Chapter 17, 1998 General Session

#### 26-41-102 Definitions.

As used in this chapter:

- (1) "Anaphylaxis" means a potentially life-threatening hypersensitivity to a substance.
  - (a) Symptoms of anaphylaxis may include shortness of breath, wheezing, difficulty breathing, difficulty talking or swallowing, hives, itching, swelling, shock, or asthma.
  - (b) Causes of anaphylaxis may include insect sting, food allergy, drug reaction, and exercise.
- (2) "Epinephrine auto-injector" means a disposable drug delivery system with a spring-activated concealed needle that is designed for emergency administration of epinephrine to provide rapid, convenient first-aid for persons suffering a potentially fatal anaphylactic reaction.
- (3) "Qualified adult" means a person who:
  - (a) is 18 years of age or older; and
  - (b) has successfully completed the training program established in Section 26-41-104.
- (4) "Qualified entity":
  - (a) means a facility or organization that employs, contracts with, or has a similar relationship with a qualified adult who is likely to have contact with another person who may experience anaphylaxis; and
  - (b) includes:
    - (i) recreation camps;
    - (ii) an education facility, school, or university;
    - (iii) a day care facility;
    - (iv) youth sports leagues;
    - (v) amusement parks;
    - (vi) food establishments;
    - (vii) places of employment; and
    - (viii) recreation areas.

Amended by Chapter 332, 2015 General Session

#### 26-41-103 Voluntary participation.

- (1) This chapter does not create a duty or standard of care for:
  - (a) a person to be trained in the use and storage of epinephrine auto-injectors; or
  - (b) except as provided in Subsection (5), a qualified entity to store epinephrine auto-injectors on its premises.
- (2) Except as provided in Subsections (3) and (5), a decision by a person to successfully complete a training program under Section 26-41-104 and to make emergency epinephrine auto-injectors available under the provisions of this chapter is voluntary.
- (3) A school, school board, or school official may not prohibit or dissuade a teacher or other school employee at a primary or secondary school in the state, either public or private, from:
  - (a) completing a training program under Section 26-41-104;

- (b) possessing or storing an epinephrine auto-injector on school property if:
  - (i) the teacher or school employee is a qualified adult; and
  - (ii) the possession and storage is in accordance with the training received under Section 26-41-104; or
- (c) administering an epinephrine auto-injector to any person, if:
  - (i) the teacher or school employee is a qualified adult; and
  - (ii) the administration is in accordance with the training received under Section 26-41-104.
- (4) A school, school board, or school official may encourage a teacher or other school employee to volunteer to become a qualified adult.
- (5)
  - (a) Each primary or secondary school in the state, both public and private, shall make an emergency epinephrine auto-injector available to any teacher or other school employee who:
    - (i) is employed at the school; and
    - (ii) is a qualified adult.
  - (b) This section does not require a school described in Subsection (5)(a) to keep more than one emergency epinephrine auto-injector on the school premises, so long as it may be quickly accessed by a teacher or other school employee, who is a qualified adult, in the event of an emergency.
- (6) No school, school board, or school official shall retaliate or otherwise take adverse action against a teacher or other school employee for:
  - (a) volunteering under Subsection (2);
  - (b) engaging in conduct described in Subsection (3); or
  - (c) failing or refusing to become a qualified adult.

Amended by Chapter 332, 2015 General Session

**26-41-104 Training in use and storage of epinephrine auto-injector.**

- (1)
  - (a) Each primary and secondary school in the state, both public and private, shall make initial and annual refresher training, regarding the storage and emergency use of an epinephrine auto-injector, available to any teacher or other school employee who volunteers to become a qualified adult.
  - (b) The training described in Subsection (1)(a) may be provided by the school nurse, or other person qualified to provide such training, designated by the school district physician, the medical director of the local health department, or the local emergency medical services director.
- (2) A person who provides training under Subsection (1) or (6) shall include in the training:
  - (a) techniques for recognizing symptoms of anaphylaxis;
  - (b) standards and procedures for the storage and emergency use of epinephrine auto-injectors;
  - (c) emergency follow-up procedures, including calling the emergency 911 number and contacting, if possible, the student's parent and physician; and
  - (d) written materials covering the information required under this Subsection (2).
- (3) A qualified adult shall retain for reference the written materials prepared in accordance with Subsection (2)(d).
- (4) A public school shall permit a student to possess an epinephrine auto-injector or possess and self-administer an epinephrine auto-injector if:
  - (a) the student's parent or guardian signs a statement:

- (i) authorizing the student to possess or possess and self-administer an epinephrine auto-injector; and
- (ii) acknowledging that the student is responsible for, and capable of, possessing or possessing and self-administering an epinephrine auto-injector; and
- (b) the student's health care provider provides a written statement that states that:
  - (i) it is medically appropriate for the student to possess or possess and self-administer an epinephrine auto-injector; and
  - (ii) the student should be in possession of the epinephrine auto-injector at all times.
- (5) The Utah Department of Health, in cooperation with the state superintendent of public instruction, shall design forms to be used by public schools for the parental and health care providers statements described in Subsection (4).
- (6)
  - (a) The department:
    - (i) shall approve educational programs conducted by other persons, to train:
      - (A) people under Subsection (6)(b) of this section, regarding the proper use and storage of emergency epinephrine auto-injectors; and
      - (B) a qualified entity regarding the proper storage and emergency use of epinephrine auto-injectors; and
    - (ii) may, as funding is available, conduct educational programs to train people regarding the use of and storage of emergency epinephrine auto-injectors.
  - (b) A person who volunteers to receive training as a qualified adult to administer an epinephrine auto-injector under the provisions of this Subsection (6) shall demonstrate a need for the training to the department, which may be based upon occupational, volunteer, or family circumstances, and shall include:
    - (i) camp counselors;
    - (ii) scout leaders;
    - (iii) forest rangers;
    - (iv) tour guides; and
    - (v) other persons who have or reasonably expect to have contact with at least one other person as a result of the person's occupational or volunteer status.

Amended by Chapter 332, 2015 General Session

**26-41-105 Authority to obtain and use an epinephrine auto-injector.**

- (1) A qualified adult who is a teacher or other school employee at a public or private primary or secondary school in the state, or a school nurse, may obtain from the school district physician, the medical director of the local health department, or the local emergency medical services director a prescription for epinephrine auto-injectors.
- (2) A qualified adult may obtain from a physician, pharmacist, or any other person or entity authorized to prescribe or dispense prescription drugs, a prescription for an epinephrine auto-injector.
- (3) A qualified adult:
  - (a) may immediately administer an epinephrine auto-injector to a person exhibiting potentially life-threatening symptoms of anaphylaxis when a physician is not immediately available; and
  - (b) shall initiate emergency medical services or other appropriate medical follow-up in accordance with the training materials retained under Section 26-41-104 after administering an epinephrine auto-injector.
- (4)

- (a) A qualified entity that complies with Subsection (4)(b), may obtain from a physician, pharmacist, or any other person or entity authorized to prescribe or dispense prescription drugs, a prescription for a supply of epinephrine auto-injectors, for:
  - (i) storing the epinephrine auto-injectors on the qualified entity's premises; and
  - (ii) use by a qualified adult in accordance with Subsection (3).
- (b) A qualified entity shall:
  - (i) designate an individual to complete an initial and annual refresher training program regarding the proper storage and emergency use of an epinephrine auto-injector available to a qualified adult; and
  - (ii) store epinephrine auto-injectors in accordance with the standards established by the department in Section 26-41-107.

Amended by Chapter 332, 2015 General Session

**26-41-106 Immunity from liability.**

- (1) The following, if acting in good faith, are not liable in any civil or criminal action for any act taken or not taken under the authority of this chapter with respect to an anaphylactic reaction:
  - (a) a qualified adult;
  - (b) a physician, pharmacist, or any other person or entity authorized to prescribe or dispense prescription drugs;
  - (c) a person who conducts training described in Section 26-41-104; and
  - (d) a qualified entity.
- (2) Section 53A-11-601 does not apply to the administration of an epinephrine auto-injector in accordance with this chapter.
- (3) This section does not eliminate, limit, or reduce any other immunity from liability or defense against liability that may be available under state law.

Amended by Chapter 332, 2015 General Session

**26-41-107 Administrative rulemaking authority.**

The department shall adopt rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to:

- (1) establish and approve training programs in accordance with Section 26-41-104;
- (2) establish a procedure for determining who is eligible for training as a qualified adult under Subsection 26-41-104(6)(b)(v); and
- (3) establish standards for storage of emergency auto-injectors by a qualified entity under Section 26-41-104.

Enacted by Chapter 332, 2015 General Session

ATTACHMENT F - Opiate Overdose Response Act (UCA 26-55-101)

Utah Code

*Effective 5/10/2016*

**Chapter 55  
Opiate Overdose Response Act**

**26-55-101 Title.**

This chapter is known as the " Opiate Overdose Response Act."

Amended by Chapter 202, 2016 General Session

Amended by Chapter 207, 2016 General Session

Amended by Chapter 208, 2016 General Session

**26-55-102 Definitions.**

As used in this chapter:

- (1) "Controlled substance" means the same as that term is defined in Title 58, Chapter 37, Utah Controlled Substances Act.
- (2) "Dispense" means the same as that term is defined in Section 58-17b-102.
- (3) "Health care facility" means a hospital, a hospice inpatient residence, a nursing facility, a dialysis treatment facility, an assisted living residence, an entity that provides home- and community-based services, a hospice or home health care agency, or another facility that provides or contracts to provide health care services, which facility is licensed under Chapter 21, Health Care Facility Licensing and Inspection Act.
- (4) "Health care provider" means:
  - (a) a physician, as defined in Section 58-67-102;
  - (b) an advanced practice registered nurse, as defined in Section 58-31b-102;
  - (c) a physician assistant, as defined in Section 58-70a-102; or
  - (d) an individual licensed to engage in the practice of dentistry, as defined in Section 58-69-102.
- (5) "Increased risk" means risk exceeding the risk typically experienced by an individual who is not using, and is not likely to use, an opiate.
- (6) "Local health department" means:
  - (a) a local health department, as defined in Section 26A-1-102; or
  - (b) a multicounty local health department, as defined in Section 26A-1-102.
- (7) "Opiate" means the same as that term is defined in Section 58-37-2.
- (8) "Opiate antagonist" means naloxone hydrochloride or any similarly acting drug that is not a controlled substance and that is approved by the federal Food and Drug Administration for the diagnosis or treatment of an opiate-related drug overdose.
- (9) "Opiate-related drug overdose event" means an acute condition, including a decreased level of consciousness or respiratory depression resulting from the consumption or use of a controlled substance, or another substance with which a controlled substance was combined, and that a person would reasonably believe to require medical assistance.
- (10) "Overdose outreach provider" means:
  - (a) a law enforcement agency;
  - (b) a fire department;
  - (c) an emergency medical service provider, as defined in Section 26-8a-102;
  - (d) emergency medical service personnel, as defined in Section 26-8a-102;
  - (e) an organization providing treatment or recovery services for drug or alcohol use;
  - (f) an organization providing support services for an individual, or a family of an individual, with a substance use disorder;

- (g) an organization providing substance use or mental health services under contract with a local substance abuse authority, as defined in Section 62A-15-102, or a local mental health authority, as defined in Section 62A-15-102;
  - (h) an organization providing services to the homeless;
  - (i) a local health department; or
  - (j) an individual.
- (11) "Patient counseling" means the same as that term is defined in Section 58-17b-102.
- (12) "Pharmacist" means the same as that term is defined in Section 58-17b-102.
- (13) "Pharmacy intern" means the same as that term is defined in Section 58-17b-102.
- (14) "Prescribe" means the same as that term is defined in Section 58-17b-102.

Amended by Chapter 127, 2016 General Session  
Amended by Chapter 202, 2016 General Session  
Amended by Chapter 207, 2016 General Session  
Amended by Chapter 208, 2016 General Session

**26-55-103 Voluntary participation.**

This chapter does not create a duty or standard of care for a person to prescribe or administer an opiate antagonist.

Enacted by Chapter 130, 2014 General Session

**26-55-104 Prescribing, dispensing, and administering an opiate antagonist -- Immunity from liability.**

- (1)
- (a)
- (i) For purposes of Subsection (1)(a)(ii), "a person other than a health care facility or health care provider" includes the following, regardless of whether the person has received funds from the department through the Opiate Overdose Outreach Pilot Program created in Section 26-55-107:
    - (A) a person described in Subsections 26-55-107(1)(a)(i)(A) through (1)(a)(i)(F); or
    - (B) an organization defined by department rule made under Subsection 26-55-107(7)(e) that is in a position to assist an individual who is at increased risk of experiencing an opiate-related drug overdose event.
  - (ii) Except as provided in Subsection (1)(b), a person, including an overdose outreach provider, but not including a health care facility or health care provider, that acts in good faith to administer an opiate antagonist to an individual whom the person believes to be experiencing an opiate-related drug overdose event is not liable for any civil damages for acts or omissions made as a result of administering the opiate antagonist.
- (b) A health care provider:
- (i) does not have immunity from liability under Subsection (1)(a) when the health care provider is acting within the scope of the health care provider's responsibilities or duty of care; and
  - (ii) does have immunity from liability under Subsection (1)(a) if the health care provider is under no legal duty to respond and otherwise complies with Subsection (1)(a).
- (2) Notwithstanding Sections 58-1-501, 58-17b-501, and 58-17b-502, a health care provider who is licensed to prescribe an opiate antagonist may prescribe, including by a standing prescription drug order issued in accordance with Subsection 26-55-105(2), or dispense an opiate antagonist:

- (a)
    - (i) to an individual who is at increased risk of experiencing an opiate-related drug overdose event;
    - (ii) to a family member of, friend of, or other person, including a person described in Subsections 26-55-107(1)(a)(i)(A) through (1)(a)(i)(F), that is in a position to assist an individual who is at increased risk of experiencing an opiate-related drug overdose event; or
    - (iii) to an overdose outreach provider for:
      - (A) furnishing to an individual who is at increased risk of experiencing an opiate-related drug overdose event, or to a family member of, friend of, or other individual who is in a position to assist an individual who is at increased risk of experiencing an opiate-related drug overdose event, as provided in Section 26-55-106; or
      - (B) administering to an individual experiencing an opiate-related drug overdose event;
  - (b) without a prescriber-patient relationship; and
  - (c) without liability for any civil damages for acts or omissions made as a result of prescribing or dispensing the opiate antagonist in good faith.
- (3) A health care provider who dispenses an opiate antagonist to an individual or an overdose outreach provider under Subsection (2)(a) shall provide education to the individual or overdose provider that includes written instruction on how to:
- (a) recognize an opiate-related drug overdose event; and
  - (b) respond appropriately to an opiate-related drug overdose event, including how to:
    - (i) administer an opiate antagonist; and
    - (ii) ensure that an individual to whom an opiate antagonist has been administered receives, as soon as possible, additional medical care and a medical evaluation.

Amended by Chapter 202, 2016 General Session, (Coordination Clause)

Amended by Chapter 202, 2016 General Session

Amended by Chapter 207, 2016 General Session

Amended by Chapter 208, 2016 General Session

**26-55-105 Standing prescription drug orders for an opiate antagonist.**

- (1) Notwithstanding Title 58, Chapter 17b, Pharmacy Practice Act, a person licensed under Title 58, Chapter 17b, Pharmacy Practice Act, to dispense an opiate antagonist may dispense the opiate antagonist:
- (a) pursuant to a standing prescription drug order made in accordance with Subsection (2); and
  - (b) without any other prescription drug order from a person licensed to prescribe an opiate antagonist.
- (2) A physician who is licensed to prescribe an opiate antagonist, including a physician acting in the physician's capacity as an employee of the department, or a medical director of a local health department, as defined in Section 26A-1-102, may issue a standing prescription drug order authorizing the dispensing of the opiate antagonist under Subsection (1) in accordance with a protocol that:
- (a) limits dispensing of the opiate antagonist to:
    - (i) an individual who is at increased risk of experiencing an opiate-related drug overdose event;
    - (ii) a family member of, friend of, or other person, including a person described in Subsections 26-55-107(1)(a)(i)(A) through (1)(a)(i)(F), that is in a position to assist an individual who is at increased risk of experiencing an opiate-related drug overdose event; or
    - (iii) an overdose outreach provider for:

- (A) furnishing to an individual who is at increased risk of experiencing an opiate-related drug overdose event, or to a family member of, friend of, or other individual who is in a position to assist an individual who is at increased risk of experiencing an opiate-related drug overdose event, as provided in Section 26-55-106; or
- (B) administering to an individual experiencing an opiate-related drug overdose event;
- (b) requires the physician to specify the persons, by professional license number, authorized to dispense the opiate antagonist;
- (c) requires the physician to review at least annually the dispensing practices of those authorized by the physician to dispense the opiate antagonist;
- (d) requires those authorized by the physician to dispense the opiate antagonist to make and retain a record of each person to whom the opiate antagonist is dispensed, which shall include:
  - (i) the name of the person;
  - (ii) the drug dispensed; and
  - (iii) other relevant information; and
- (e) is approved by the Division of Occupational and Professional Licensing within the Department of Commerce by administrative rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

Amended by Chapter 202, 2016 General Session, (Coordination Clause)  
Enacted by Chapter 208, 2016 General Session

**26-55-106 Overdose outreach providers.**

Notwithstanding Sections 58-1-501, 58-17b-501, and 58-17b-502:

- (1) an overdose outreach provider may:
  - (a) obtain an opiate antagonist dispensed on prescription by:
    - (i) a health care provider, in accordance with Subsections 26-55-104(2) and (3); or
    - (ii) a pharmacist or pharmacy intern, as otherwise authorized by Title 58, Chapter 17b, Pharmacy Practice Act;
  - (b) store the opiate antagonist; and
  - (c) furnish the opiate antagonist:
    - (i)
      - (A) to an individual who is at increased risk of experiencing an opiate-related drug overdose event; or
      - (B) to a family member of, friend of, or other individual who is in a position to assist an individual who is at increased risk of experiencing an opiate-related drug overdose event; and
    - (ii) without liability for any civil damages for acts or omissions made as a result of furnishing the opiate antagonist in good faith; and
- (2) when furnishing an opiate antagonist under Subsection (1), an overdose outreach provider:
  - (a) shall also furnish to the recipient of the opiate antagonist:
    - (i) the written instruction under Subsection 26-55-104(3) received by the overdose outreach provider from the health care provider at the time the opiate antagonist was dispensed to the overdose outreach provider; or
    - (ii) if the opiate antagonist was dispensed to the overdose outreach provider by a pharmacist or pharmacy intern, any written patient counseling under Section 58-17b-613 received by the overdose outreach provider at the time of dispensing; and

- (b) may provide additional instruction on how to recognize and respond appropriately to an opiate-related drug overdose event.

Amended by Chapter 202, 2016 General Session, (Coordination Clause)  
Enacted by Chapter 207, 2016 General Session

**26-55-107 Opiate Overdose Outreach Pilot Program -- Grants -- Annual reporting by grantees -- Rulemaking -- Annual reporting by department.**

(1) As used in this section:

- (a) "Persons that are in a position to assist an individual who is at increased risk of experiencing an opiate-related drug overdose event":

- (i) means the following organizations:

- (A) a law enforcement agency;
    - (B) the department or a local health department, as defined in Section 26A-1-102;
    - (C) an organization that provides drug or alcohol treatment services;
    - (D) an organization that provides services to the homeless;
    - (E) an organization that provides training on the proper administration of an opiate antagonist in response to an opiate-related drug overdose event;
    - (F) a school; or
    - (G) except as provided in Subsection (1)(a)(ii), any other organization, as defined by department rule made under Subsection (7)(e), that is in a position to assist an individual who is at increased risk of experiencing an opiate-related drug overdose event; and

- (ii) does not mean:

- (A) a person licensed under Title 58, Chapter 17b, Pharmacy Practice Act;
    - (B) a health care facility; or
    - (C) an individual.

- (b) "School" means:

- (i) a public school:

- (A) for elementary or secondary education, including a charter school; or
    - (B) for other purposes;

- (ii) a private school:

- (A) for elementary or secondary education; or
    - (B) accredited for other purposes, including higher education or specialty training; or
  - (iii) an institution within the state system of higher education, as described in Section 53B-1-102.

(2) There is created within the department the "Opiate Overdose Outreach Pilot Program."

(3) The department may use funds appropriated for the program to:

- (a) provide grants under Subsection (4);
- (b) promote public awareness of the signs, symptoms, and risks of opioid misuse and overdose;
- (c) increase the availability of educational materials and other resources designed to assist individuals at increased risk of opioid overdose, their families, and others in a position to help prevent or respond to an overdose event;
- (d) increase public awareness of, access to, and use of opiate antagonist;
- (e) update the department's Utah Clinical Guidelines on Prescribing Opioids and promote its use by prescribers and dispensers of opioids;
- (f) develop a directory of substance misuse treatment programs and promote its dissemination to and use by opioid prescribers, dispensers, and others in a position to assist individuals at increased risk of opioid overdose;

- (g) coordinate a multi-agency coalition to address opioid misuse and overdose; and
  - (h) maintain department data collection efforts designed to guide the development of opioid overdose interventions and track their effectiveness.
- (4) No later than September 1, 2016, and with available funding, the department shall grant funds through the program to persons that are in a position to assist an individual who is at increased risk of experiencing an opiate-related drug overdose event.
- (5) Funds granted by the program:
- (a) may be used by a grantee to:
    - (i) pay for the purchase by the grantee of an opiate antagonist; or
    - (ii) pay for the grantee's cost of providing training on the proper administration of an opiate antagonist in response to an opiate-related drug overdose event; and
  - (b) may not be used:
    - (i) to pay for costs associated with the storage or dispensing of an opiate antagonist; or
    - (ii) for any other purposes.
- (6) Grantees shall report annually to the department on the use of granted funds in accordance with department rules made under Subsection (7)(d).
- (7) No later than July 1, 2016, the department shall, in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, make rules specifying:
- (a) how to apply for a grant from the program;
  - (b) the criteria used by the department to determine whether a grant request is approved, including criteria providing that:
    - (i) grants are awarded to areas of the state, including rural areas, that would benefit most from the grant; and
    - (ii) no more than 15% of the total amount granted by the program is used to pay for grantees' costs of providing training on the proper administration of an opiate antagonist in response to an opiate-related drug overdose event;
  - (c) the criteria used by the department to determine the amount of a grant;
  - (d) the information a grantee shall report annually to the department under Subsection (6), including:
    - (i) the amount of opiate antagonist purchased and dispensed by the grantee during the reporting period;
    - (ii) the number of individuals to whom the opiate antagonist was dispensed by the grantee;
    - (iii) the number of lives known to have been saved during the reporting period as a result of opiate antagonist dispensed by the grantee; and
    - (iv) the manner in which the grantee shall record, preserve, and make available for audit by the department the information described in Subsections (7)(d)(i) through (7)(d)(iii); and
  - (e) as required by Subsection (1)(a)(i)(G), any other organization that is in a position to assist an individual who is at increased risk of experiencing an opiate-related drug overdose event.
- (8) The department shall report to the Legislature's Social Services Appropriations Subcommittee no later than September 1 of each year on the outcomes of the Opiate Overdose Outreach Pilot Program.

Enacted by Chapter 202, 2016 General Session  
Amended by Chapter 207, 2016 General Session, (Coordination Clause)



# Vision Screening

# **State of Utah**

# **School Vision Screening**

# **Guidelines**

Utah Department of Health

Utah Division of Services for the Blind and Visually Impaired

2013

## Contact Information

Vision Screening Specialist at the Division of Services for the Blind and Visually Impaired (DSBVI), 801-323-4343

State School Nurse Consultant at State of Utah Department of Health, 801-538-6814

Online version of Vision Screening Guidelines can be found at:

<http://choosehealth.utah.gov/providers/school-nurse/screenings.php>

<http://www.utahschoolnurses.org/>

Effective August 2013

# A Message from the State Superintendent of Public Education

The Utah State Office of Education (USOE) applaud and support the efforts of the Utah Department of Health (UDOH) and the Utah State Division of Services for the Blind and Visually Impaired (DSBVI) for their collaboration in the development of Guidelines for Vision Screening in Utah schools.

It is well documented that a child's ability to see greatly impacts his or her ability to learn. A vision screening program plays a vital role in the early identification of visual problems that may negatively affect a child's academic success. Vision screening is an important component of school health services and a cost-effective means to identify students who may have a vision disturbance.

Our school nurses administer Vision Screening programs at the district level. Having state guidelines will promote consistency and standardization of school vision screenings. When a student is identified as having a possible visual disturbance, the student is properly referred to an eye care specialist for diagnosis and treatment. In addition, school nurses assist low-income children in obtaining free vision care.

In preparing these guidelines, many knowledgeable professionals with experience implementing vision screening programs assisted, I wish to thank them for their tremendous efforts.



Martell Menlove, Ph.D.  
State Superintendent of Public Instruction

# Acknowledgments

The Utah Department of Health and the Division of Services for the Blind and Visually Impaired acknowledge the following people for their contributions to these guidelines:

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# Introduction

Utah State Law recommends vision screening as a necessary and worthwhile undertaking in helping to identify children who may require further evaluation of their eyesight. Utah schools have a responsibility to identify health issues that may impact a student's academic success. A child's ability to see greatly impacts her or his ability to learn. A school vision screening program is a cost effective approach that plays a vital role in the early identification of serious vision problems that might negatively affect the physical, intellectual, social, and emotional development of the individual student.

The Utah Department of Health (UDOH) and the Division of Services for the Blind and Visually Impaired (DSBVI) have an interest in ensuring that vision screening of children is accomplished in a reliable, valid, and consistent manner. These guidelines were developed with the advice and contributions of the UDOH Vision Screening Guidelines Task Force to assist school nurses in implementing a successful and evidence based vision screening program.

Vision screening, when overseen by a school nurse and performed by properly trained individuals, leads to early identification and appropriate medical referral for diagnosis and treatment of visual disturbances. The child's eye is continually developing and is most susceptible to vision correction during the first 7 to 8 years of life (Eliot, 2007). Children often do not identify a vision deficiency themselves; therefore, school vision screening may become the first identifier of a potential vision problem that without correction may lead to permanent vision loss or impairment.

Although vision screening is crucial in identifying children with visual problems, it is important for parents to understand that it is not a substitute for a complete eye exam and vision evaluation by an eye care professional.

# Utah Vision Screening Law

## **53A-11-203. Vision screening.**

(1) As used in this section, "division" means the Division of Services for the Blind and Visually Impaired, State Office of Education.

(2) A child under eight years of age entering school for the first time in this state must present the following to the school:

(a) a certificate signed by a licensed physician, optometrist, or other licensed health professional approved by the Division, stating that the child has received vision screening to determine the presence of amblyopia or other visual defects; or

(b) a written statement signed by at least one parent or legal guardian of the child that the screening violates the personal beliefs of the parent or legal guardian.

(3) (a) The Division:

(i) shall provide vision screening report forms to a person approved by the division to conduct a free vision screening for children aged 3-1/2 to eight; and

(ii) may work with health care professionals, teachers, and vision screeners to develop protocols that may be used by a parent, teacher, or vision screener to help identify a child who may have conditions that are not detected in a vision screening, such as problems with eye focusing, eye tracking, visual perceptual skills, visual motor integration, and convergence insufficiency; and

(iii) shall, once protocols are established under Subsection (3)(a)(ii), develop language regarding the vision problems identified in Subsection (3)(a)(ii) to be included in the notice required by Subsection (3)(b).

(b) The report forms shall include the following information for a parent or guardian: "Vision screening is not a substitute for a complete eye exam and vision evaluation by an eye doctor."

(4) A school district may conduct free vision screening clinics for children aged 3-1/2 to eight.

(5) (a) The division shall maintain a central register of children, aged 3-1/2 to eight, who fail vision screening and who are referred for follow-up treatment.

(b) The register described in Subsection (5)(a) shall include the name of the child, age or birthdate, address, cause for referral, and follow-up results.

(c) A school district shall report referral follow-up results for children aged 3-1/2 to eight to the division.

(6) (a) The division shall coordinate and supervise the training of a person who serves as a vision screener for a free vision screening clinic for children aged 3-1/2 to eight.

(b) A volunteer vision screener providing services under Subsection (6)(a) is not liable for any civil damages as a result of acts or omissions related to the vision screening unless the acts or omissions were willful or grossly negligent.

(7) (a) Except as provided in Subsection (7)(b), a licensed health professional providing vision care to private patients may not participate as a screener in a free vision screening program provided by a school district.

(b) A school district may:

(i) allow a licensed health professional who provides vision care to private patients to participate as a screener in a free vision screening program for a child nine

years of age or older;

(ii) establish guidelines to administer a free vision screening program described in Subsection (7)(b)(i); and

(iii) establish penalties for a violation of the requirements of Subsection (7)(c).

(c) A licensed health professional or other person who participates as a screener in a free vision screening program described in Subsection (7)(b):

(i) may not market, advertise, or promote the licensed health professional's business in connection with providing the free screening at the school; and

(ii) shall provide the child's results of the free vision screening on a form produced by the school or school district, which:

(A) may not include contact information other than the name of the licensed health professional; and

(B) shall include a statement: "Vision screening is not a substitute for a complete eye exam and vision evaluation by an eye doctor."

(d) A school district may provide information to a parent or guardian of the availability of follow-up vision services for a student.

(8) The Department of Health shall:

(a) by rule, set standards and procedures for vision screening required by this chapter, which shall include a process for notifying the parent or guardian of a child who fails a vision screening or is identified as needing follow-up care; and

(b) provide the division with copies of rules, standards, instructions, and test charts necessary for conducting vision screening.

(9) The division shall supervise screening, referral, and follow-up required by this chapter.

Amended by Chapter 132, 2011 General Session



# Utah Vision Screening Rule

## **R384. Health, Disease Control and Prevention, Health Promotion.**

### **R384-201. School-Based Vision Screening for Students in Public Schools.**

#### **R384-201-1. Authority.**

(1) This rule is authorized by section 53A-11-203.

(2) The Department of Health is authorized under the rule to set standards and procedures for vision screening required by this chapter, which shall include a process for notifying the parent or guardian of a child who fails a vision screening or is identified as needing follow-up care; and provide the Division with copies of rules, standards, instructions, and recommendation for test charts necessary for conducting vision screening.

#### **R384-201-2. Definitions.**

(1) Division -- Division of Services for the Blind and Visually Impaired, State Office of Education.

(2) Eye care professional -- Ophthalmologist or optometrist

(3) LEA -- Local education agency

(4) Photoscreening -- Automated screening technique that facilitates vision screening in children, especially those who are difficult to screen (infants, toddlers, and children with developmental delays). It screens for a range of eye problems including most refractive errors, alignment errors, opacities (such as cataracts), and other visible eye abnormalities.

(5) Screening certificate -- Written documentation of vision screening or comprehensive eye examination by a licensed physician, or eye care professional that have been given within one year of entering a public school are acceptable.

(6) Sure Sight -- A vision screening auto-refractor that identifies nearsightedness, farsightedness, astigmatism and the difference between eyes.

(7) Significant visual impairment -- A visual impairment severe enough to interfere with learning. The term is the designation required for a child to receive services from district vision specialist or Utah Schools for the Deaf and Blind (USDB).

(8) Screener -- Pediatricians, family practitioners, nurses, or trained medical staff can perform vision screening at regular well child office visits. In addition, school

volunteers and groups are trained to support vision screening programs for children. A licensed health professional providing vision care to private patients may participate as a screener in a school vision screening program for a child nine years of age or older.

(9) USDB -- Utah Schools for the Deaf and Blind

(10) UDOH -- Utah Department of Health

(11) Vision Screening: School Vision Screening programs are an efficient and cost-effective method for identifying children with significant visual impairment so that a referral can be made to an appropriate eye care professional for further evaluation and treatment. School Vision Screenings must use devices and procedures approved by the Division and UDOH. The procedures for conducting screening may include age or grade levels to be screened, tests to be used, criteria for referral, and documentation of findings.

**R384-201-3. Purpose.**

The purpose of school based vision screening is to set standards and procedures for vision screening for students in public schools. This is necessary to detect vision difficulties in school-age children in public schools so that follow-up for potential concerns may be done by the child's parent or guardian. Vision screening is not a substitute for a complete eye exam and vision evaluation by an eye care professional.

**R384-201-4. Students Eligible for Free Screening.**

The following students in an LEA may receive free vision screenings to include: distance visual acuity and other age appropriate tests that may detect visual problems upon request.

(1) Students entering pre-kindergarten, kindergarten and any student age eight and under entering school for the first time in Utah;

(2) Vision screening may be conducted for all school-age children in grades pre-kindergarten through 12. The UDOH and the Division recommend screening students every other year after pre-kindergarten and kindergarten screenings, to include grades 1, 3, 5, 7, and 9 or 10 and annually for students with hearing impairment and any student referred by school personnel, parent or self to rule out vision as a reason for learning problems;

(3) Tenth grade students may be screened as part of their driver's education class; and

(4) Students who are currently receiving services from the Utah Schools for the Deaf and Blind (USDB) or LEA vision staff who have a diagnosed significant visual impairment will be exempt from screening.

#### **R384-201-5. Required Screening.**

Required screening for students identified with disabilities in an LEA are as follows:

(1) Vision issues have to be ruled out as reasons for learning problems before Specific Learning Disability can be used as eligibility criteria; and

(2) Every three years, a student must be reevaluated for eligibility for special education in all areas of suspected disability, including vision.

#### **R384-201-6. Proof of Screening.**

A certificate or health form from a licensed physician, nurse practitioner, or eye care professional documenting a visual screening or examination given within one year of entering a public school is acceptable for school entry. All children age eight and under entering a public school for the first time without proof of screening mentioned above may be screened during that school year by a trained vision screener.

#### **R384-201-7. Training of Screeners.**

(1) A training session shall be provided by the LEA to all volunteer vision screeners prior to the start of annual vision screenings.

(2) Trainings in compliance with Division materials should be provided by the LEA.

(3) The Department of Health, in collaboration with the Division, shall provide Train the Trainer vision screening training materials.

(4) Training vision screening materials will be shared with groups that provide free vision screening services in Utah schools.

#### **R384-201-8. Screening.**

(1) Screenings are to be performed following criteria developed by the UDOH in collaboration with the Division.

(2) It is recommended that vision screenings are done early in the school session to provide time in that school year for adequate referral and follow-up to be done.

(3) Parents/legal guardian of a child have the right not to participate in vision screening due to personal beliefs. All parents must be notified of scheduled vision screenings by the public school to provide an opportunity to opt out of screening for their child utilizing the vision screening exemption form, available at the public school, to document a personally held belief.

(4) A public school staff member should be present at all times during vision screenings performed by any volunteer(s), including those done by an eye care professional. If the school nurse is not present, the school nurse should be available for consultation and re-screening.

(5) Screenings are to be done using material and procedures approved by the UDOH in collaboration with the Division. Standards and procedures are based on guidance of the American Academy of Pediatrics, the American Academy of Ophthalmology and the National School Nurse Association.

(6) An eye care professional providing vision care to private patients may participate as a screener in a free vision screening program for students nine years of age or older.

(a) An eye care professional screener may not market, advertise, or promote their business in conjunction with the free screening at a public school.

(b) The eye care professional will provide results of the vision screening to the public school in a format (paper or electronic) as required by the Division.

(7) Any group that provides free vision screening services in the LEA will provide results of the vision screening to the public school on forms required by the Division.

#### **R384-201-9. Documentation and Follow-up.**

All vision screening findings are to be documented in the student's permanent school record. Screening failures and follow-up results for students age eight and under, who are entering school for the first time in this state, are to also be reported to the Division by the LEA

Reported information to the Division shall include:

(1) The LEA shall report to the division the names of students who the fail vision screening and referral follow-up results for children age 8 and under, who are entering school for the first time in this state.

(2) Follow-up information from an eye examination referral, if available, may be included with written permission obtained by the public school from the parent or guardian;

(3) Follow-up results and screening findings are to be documented in a format approved by the UDOH in collaboration with the Division;

(4) Screening results and follow-up information shall be sent to the Division on or before June 15 for all screenings performed during that school year;

(5) The Division is responsible for maintaining a state database/registry, accessible only by authorized Division staff, of students who fail vision screening and who are referred for follow-up.

(6) In the interest of family privacy, the Division shall not contact a parent or guardian for information related to follow-up referral for professional eye examination unless assistance is requested in writing by the LEA.

#### **R384-201-10. Requirements for Referral.**

(1) Children who fail initial age-appropriate school vision screening may be re-screened by a school nurse to confirm results before notification of a student's parent or guardian of any impairment disclosed by the vision screening recommending further evaluation by an eye care professional. If the screening of a child age 9 or older was administered in the public school by an eye care professional, the school nurse does not have to rescreen.

(2) The public school shall notify in writing within 30 days from vision screening, a student's parent or guardian of any impairment disclosed by the vision screening recommending further evaluation by an eye care professional.

(3) An LEA may provide information to a parent or guardian of availability of follow-up vision services for students.

(4) A student diagnosed by an eye care professional with a significant visual impairment shall be referred to the LEA vision consultant or teacher of the visually impaired prior to referral to the Division.

#### **R384-201-11. Photoscreening.**

Preschool, kindergarten, and special education students who are not candidates for regular vision screening may be screened by a school nurse using a photoscreening device or another device approved by the Division or by Division staff. The Division is

available for assistance and consultation for photo screening. Prior to photo screening by the Division or other outside agencies approved by the Division, the public school shall obtain written permission from the parent or guardian.

References:

National Association of School Nurses (2006) Vision Screening, schools.

S. Proctor (2005) To See or Not to See: Screening the Vision of Children in School. National Association of School Nurses.

Pediatrics Vol. 111 No.4 April 2003, pp. 902-907, 2003 American Academy of Pediatrics ICPC-2 Category F.Eye.

**KEY: eye exams, school vision, vision evaluations**

**Date of Enactment or Last Substantive Amendment: July 1, 2013**

**Authorizing, and Implemented or Interpreted Law: 53A-11-203**

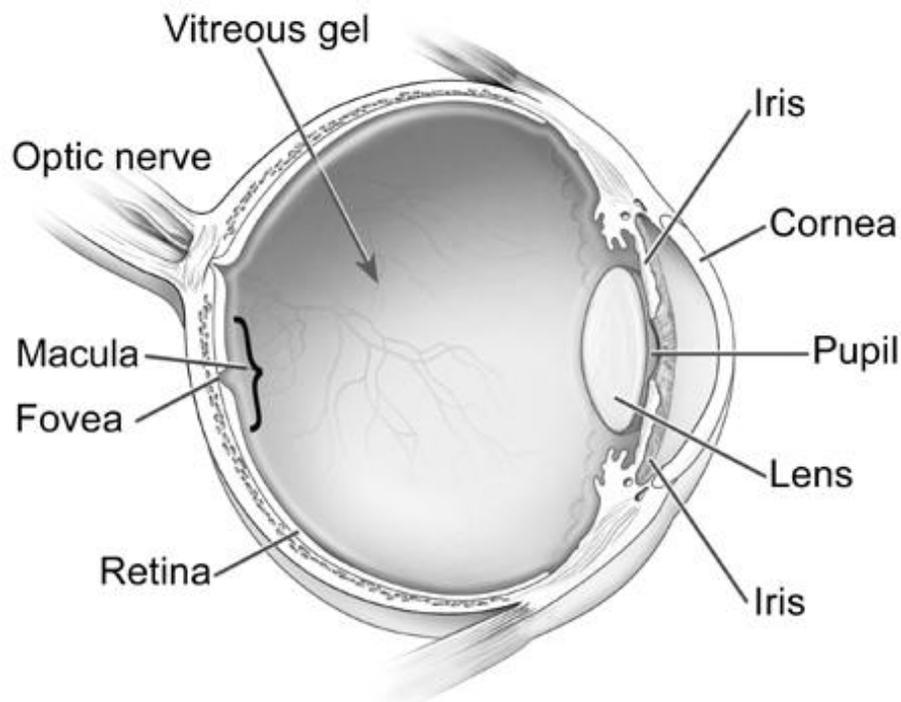
# Vision Basics

Our eyes receive messages from the outside world and transmit them to our brain. All images we see are the result of reflected or emitted light from the surfaces of objects that we view.

The vision process begins when light rays enter the eye through the transparent, curved **cornea**. The cornea directs the light through the **pupil**. The pupil is an opening that can be expanded or constricted by the **iris** to control light entering the eye. The light is then focused toward the **retina** by a transparent lens. An upside-down image is formed on the retina in the back of the eye.

Cells on the retina called rods and cones can sense light and color. Rods detect black and white, while cones detect colors. The cells on the retina turn the picture into electrical signals (nerve impulses) that travel along the **optic nerve** to the brain. The images from both eyes are combined and are “seen” by the brain as right-side up.

Some parts of the eye are protective. The eyelids, cornea, and sclera all protect the eye from injury. The sclera is the outer “white part” of the eye. The outer wall is tough and gives protection to the delicate inner structures. Below is an illustration of the major eye structures. Defects in any part of the eye may cause visual deficits.



Illustrations Courtesy: National Eye Institute, National Institutes of Health (NEI/NIH).

# Common Vision Problems

The goal of screening is to detect commonplace or possible visual anomalies and refer for examination and treatment. This section outlines and describes some of these anomalies.

## Refractive Errors

In a normal eye the image is focused on the retina. Refractive errors are caused by a defect in the shape of the cornea or the shape of the eye that causes the image to focus in front of or behind the retina. All refractive errors may occur in one eye and not in the other or in both eyes equally or in differing degrees in each eye. The result is blurred vision for near and/or distant objects. The following are common refractive errors:

### Myopia - Nearsightedness

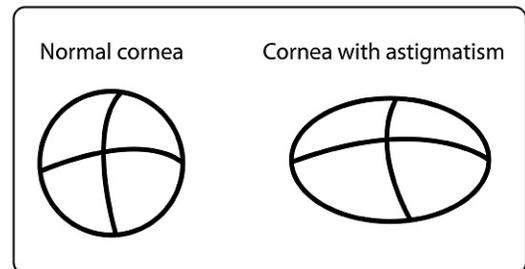
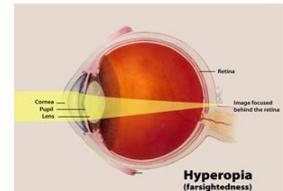
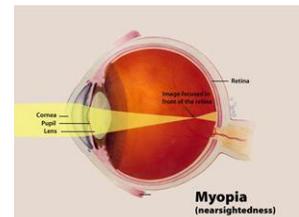
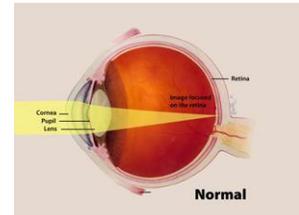
Myopia is the most common vision problem seen in children. Myopic eyes are too long from the front to the back. The images of distant objects are focused in the front of the retina and appear blurred. This is commonly known as nearsightedness because near things are seen more clearly than distant objects.

### Hyperopia - Farsightedness

Hyperopia is the result of an eyeball that is shorter than normal from the front to the back. The image of near objects is focused behind the retina resulting in blurred near vision. It is commonly called farsightedness because distant images are seen more clearly.

### Astigmatism

Astigmatism is caused by an uneven surface of the eye that prevents light rays from falling on a single point on the retina. The normal cornea is round like a basketball while the astigmatic cornea is irregular and elliptical, like a football.



## Strabismus - Crossed Eyes

Strabismus is a misalignment of the eyes that prevents them from looking at the same object together. One eye may be directed inward, outward, or rarely, up or down in relation to the other eye. The condition can be alternating or intermittent in either or both eyes. Strabismus usually occurs in early childhood because of improper development of the muscles that align the eyes. When one eye turns while the other sees straight, a double image is sent to the brain. Strabismus is one of the primary causes of amblyopia. Loss of vision in the affected eye may be avoided if it is treated early.



Esotropia



Exotropia



Hypertropia

## Amblyopia - Lazy Eye

Amblyopia occurs when the eyes are not working together and the brain cannot fuse the images from each eye into one clear image. If the images from each eye are very different, vision in one eye will be suppressed to avoid double vision. Normal vision will not develop in that eye. Screening for amblyopia should be done preferably by age 8, but the earlier, the better. If amblyopia is not detected before the age of 9, the child may have permanent vision loss in the affected eye. Treatment can be very successful if started before the age of 6. Therefore early detection and compliance with treatment is critical in preventing permanent vision loss.



Amblyopia may be caused by several conditions. Most often it is the result of unequal refractive error or strabismus. Differences between the information received in each eye and sent to the brain occur if there is:

- A large visual acuity difference or a marked difference in the refractive error between the right and left eyes
- A muscle imbalance (strabismus)
- A combination of the above

Illustrations Courtesy: National Eye Institute, National Institutes of Health (NEI/NIH).

Health issues of the eyes such as cataracts and drooping eyelids may also cause amblyopia. This is due to the difference in image quality between the eyes that these conditions present. In these cases, the brain suppresses the image of poorer quality, causing a permanent vision loss in the affected eye unless detected and treated early in childhood while the vision system is still developing. Rarely does amblyopia fully respond to treatment after age 9, but for some disorders (dense cataracts) the period of visual plasticity is much shorter and treatment needs to be instituted at a much earlier age (sometimes even infancy).

### **Color Deficiency**

Children with color deficiency have difficulty identifying certain colors. Color deficiencies are a result of a defect in special cells on the retina called cones. This defect is more common in boys than girls. There is no correction for color deficiency defects. A child who is colorblind can be reasonably accommodated under section 504 of the Americans with Disabilities Act.



# Observation of Visual Problems

Most symptoms of vision problems are behavioral in nature and may be confused with symptoms of ADD/ADHD or Autism. The following symptoms are most likely to be observed in the classroom by the teacher or teacher's aide. Vision problems should be addressed quickly so the student can perform at his/her best. Early intervention is of utmost importance.

## Behaviors

- Head turns as student reads across page
- Uses finger as marker to keep place
- Omits small words, letters, or numbers
- Writes up- or down-hill
- Rereads or skips lines unknowingly
- Blinks to read blackboard or clear eyes after close work
- Rubs eyes or blinks during or after reading
- Squints, closes, or covers one eye
- Writes crookedly, poorly spaced, or cannot stay on lines
- No interest in activities revolving critical seeing
- Mistakes/confuses similar words or letters
- Short attention span, especially while reading
- Thrusts head forward or backward while looking at blackboard
- Avoids reading
- Excessive stumbling, awkwardness, or daydreaming
- Holds printed materials close or in odd position
- Difficulty changing focus from distance to near and back
- Restless while working at the desk
- Reverses words or letters
- Frequent signs of frustration or tension during close work
- Unusual fatigue after completing a visual task
- Can respond orally, but not in writing

## Academic Performance

- Slow reading or word by word reading
- Slow writing
- Omits or repeats words, letters or phrases
- Fatigue with reading
- Poor comprehension or comprehension drops with time
- Reads words aloud or lip reads
- Writes slowly
- Skips lines
- Loses place or uses finger for orientation
- Difficulty copying from blackboard or book
- Poor recall of visually presented material



### Appearance of eyes

- Eyes turn in or out
- Crusty or red eyelids
- Different size pupils or eye
- Swelling of eyelids
- Watering or bloodshot eyes
- Drooping lids



### Posture

- Holds head too close to desk or book
- Turns head to use one eye
- Tilts head or moves head frequently while reading
- Poor sitting posture & position while reading



### Complaints/Questions

- Eyes hurt or headache when reading
- Blurred vision – can you clear it?
- Letters and lines run together
- Words move or jump about while reading
- Double vision
- Eyes feel hot and itchy
- Can't see the blackboard
- Eyes get tired after reading for a few minutes



# The Screening Process

Although Utah law does not mandate vision screening, the UDOH Vision Screening Guidelines Task Force highly recommends districts develop a distance vision screening program. This section provides guidelines for the recommended charts, recommended grades to be screened, procedure for distance screening, and the referral criteria. In addition, this section provides guidance for notification, referral and follow-up for any vision screening performed.

## Recommended Charts for Distance and Near Vision Acuity Testing

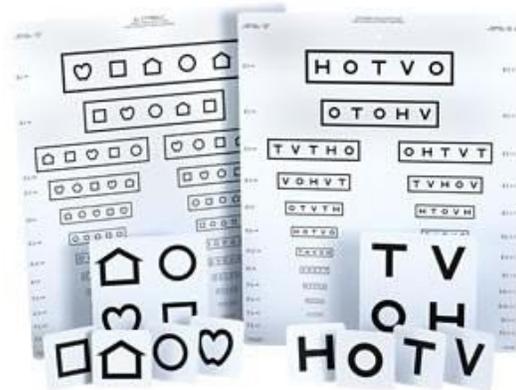
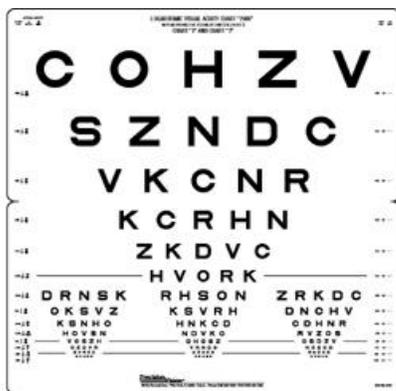
The following charts **ARE** recommended due to their standardized and culturally unbiased optotypes:

- LEA Symbols or HOTV for younger children or preliterate students.
- HOTV, Sloan Letter or Number Charts for older students.

The following charts are **NOT** recommended due to their non-standardized and culturally biased optotypes:

- Allen figures
- Hand
- Light House
- Blackbird
- Tumbling E
- Snellen

Note: The 10 foot chart is preferred since it reduces the potential for distraction between the examiner and the student.



## **Recommended Grades**

The UDOH and the DSBVI recommend screening students for distance visual acuity for pre-kindergarten, kindergarten, and grades 1,3,5,7, and 9 or 10. Tenth grade students may be screened as part of their driver's education class. Students referred by a parent or school personnel should also be screened. In addition students with hearing impairment should be screened annually. It is also suggested that new students be screened if they fall within the recommended grades above.

## **Planning for Vision Screening**

### **Scheduling**

At the beginning of the school year or during the previous year when the new school year calendar is available, meet with a school administrator to discuss vision screening planning. Include the following discussion points:

1. Determine grade levels and number of students to be screened.
2. Schedule dates on the school calendar for vision screening, volunteer training, classroom visits for student orientation, and follow-up screening for absentees (within 30 days of initial screening). It is recommended that vision screenings be done early in the school session to provide time in that school year for adequate referral and follow-up to be done.
3. Reserve an appropriate room for vision screening. Consider equipment to be used, number of desired vision lanes, lighting, and potential distractions.
4. Reserve an appropriate room for vision screener training; consider using reserved vision screening room, 1-2 hours prior to actual vision screening.
5. Discuss teacher notification, class lists, and concerns about privacy and confidentiality related to the Family Educational Rights and Privacy Act (FERPA) and/ the Health Insurance Portability and Accountability Act (HIPAA).
6. Review your school and district policies regarding these regulations and plan to set up your screening room accordingly.
7. Discuss parent/legal guardian notification of vision screening, in writing, following school/district policies.
8. Discuss working through the PTA to recruit volunteers and provide host services to volunteers on screening day.

### **Parent/Guardian Notification**

All parents must be notified of scheduled vision screenings by the public school to provide an opportunity to opt out of screening for their child utilizing the vision screening exemption form, available at the public school, to document a personally held belief.

Notification of scheduled vision screenings and rescreening dates may be disseminated to parents/legal guardians through parent handbooks, school newsletters, computer generated messages, and other means of communication as per your school or district policy. Include in your message: types of screening tools that may be used; use of trained volunteers; and rescheduling capability if the student has difficulty or is absent during the first screening. Explain that if a child has difficulty meeting the criteria during a second screening, parent/legal guardians will be notified with a referral to an eye care professional. Opt out instruction should be included in the notification of screening. (See sample of parent notification and opt out form in appendix.)

### **Student Orientation**

Younger students and those being screened for the first time may benefit greatly when given an explanation of the purpose of screening and a demonstration of screening procedures. Arrange with the classroom teacher to perform an orientation or go in person to address toes on line, covering each eye (no peeking), and identifying optotypes. Explain to the students that a vision screening is not a test and that they may not be able to see everything. They must tell the examiner when they cannot see the letters or symbols and to avoid guessing. Provide an opportunity for practice. This can be done as a class group or individually. Establishing rapport with students can help lead to a successful screening event.

### **Training Screening Volunteers**

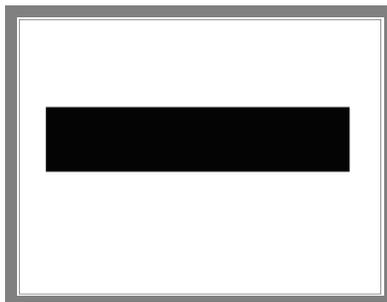
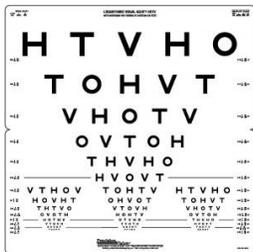
As required by Utah law R384-201-7, vision screeners will be trained by LEA prior to the start of annual screenings. Trainings shall be provided in compliance with training materials developed by the Division in collaboration with the UDOH.

## Procedure for Distance Vision Acuity Testing

All schools are encouraged to screen for distance acuity. Screening for distance acuity in schools is done primarily to identify myopia. Myopia is the most common of the refractive errors in which light rays from an incoming visual image converge before they reach the retina. Generally, myopia begins in middle childhood and tends to steadily increase until it levels off in the mid-teen years. For this reason it is important to screen for distance acuity in elementary and middle school.

### Equipment

1. Charts: Lea Symbols or HOTV for younger children or preliterate students. HOTV, Sloan Letter or Number Charts for older students.
2. Masking tape, blue tape or footprints.
3. Occluders (paper patch or small paper cup)
4. Pencils for recording
5. Pointer
6. Window card (optional)
7. Wastepaper basket
8. Tape measure



## Vision Screening Procedure (cont.)

1. Select a room for testing that is well lit and does not have a glare on the chart.
2. Place the chart on the wall with masking tape. Hang the chart so the 20/30 line is at the child's eye level.
3. Measure 10 or 20 feet, whichever is appropriate for your chart, from the mounted chart and place footprints or tape to mark the spot for the student to stand. If using footprints, make sure that the toes of the footprints are at 10 (or 20) feet.
4. Provide a clean occluder for each child. This is to be discarded in a wastepaper basket after use.
5. Ask the child to position toes on the line.
6. Have the child cover the left eye with an occluder. Screen the right eye, then reverse the process and screen the left eye and document results. Be consistent in testing the right eye first to avoid recording errors.
  - a. Child should keep both eyes open and not press the cover card against the eye, but rest it against the nose.
  - b. No part of the eye that is being covered should show behind the cover.
  - c. Do not allow the child to lean the head or torso forward.
  - d. Do not allow the child to turn face or tilt head during testing, (peeking may easily occur).
7. If a child wears glasses, screen with the glasses on. Place the occluder over the glasses, not underneath them.
8. Mass screening
  - a. On the chart, expose the critical passing line for the specific age group (see explanation next section). The child must identify more than half of the optotypes to pass this line. If the child can read this line easily, he/she passes the test. Record the pass or fail results.
  - b. If the child is unable to read the critical line, refer to the school nurse for rescreening.
  - c. In a mass screening, if the child does not pass the critical line there may be no need to continue screening if a rescreening will be conducted by the school nurse. The rescreening will determine the line the child passes. This will allow the mass screenings to flow faster and more smoothly.
9. School nurse rescreening
  - a. On the chart, expose the critical passing line for the specific age group the child must identify more than half of the optotypes to pass a line. If the child cannot read the critical line, continue moving up the chart until the child can pass a line.
  - b. Record the results. Vision acuity is recorded as a fraction. The numerator is always 20. If using the 10-foot chart, convert to the 20-foot equivalent. The denominator represents the line the child passes. Therefore, if the child read the symbols on the 30-foot line, record the vision as 20/30.

## Tips

- It may be helpful to have the child read the largest line with both eyes before proceeding to the critical line. This allows the child to experience success and provides for practice.
- Eye charts should be appropriate to the age and skill of the child.
- Window cards may be used to isolate one line, however do not isolate only one optotype.
- When testing distance visual acuity, have the student wear his/her glasses or contacts unless the glasses are for reading or near work only.
- Offer encouragement and praise to build confidence.
- To enhance performance of young or cognitively impaired children, point to optotypes on the chart. You may also allow children to match the optotypes on a chart to a handheld card.

## **Recommended Referral Criteria for Distance Vision Acuity**

### Critical lines

- Pre-Kindergarten and Kindergarten – 20/40 line
- Grades 1 and above – 20/30 line

Grades pre-kindergarten and kindergarten	Refer if the child does not pass the <b>20/40</b> line.
Grades 1 through 12	Refer if the child does not pass the <b>20/30</b> line.

- A child passes a line if he/she can correctly identify more than half of the optotypes on the line.
- Ideally, students should be rescreened within one month of the original screening date.
- When using technology, such as a photoscreener, or computer-based screening methods the correct pass/fail criteria will be set by the machine and there is no need to rescreen the student.

## **Notification, Referral and Follow-Up**

### Notification

Parents and guardians should be notified in writing of abnormal screening results within 30 days of vision screening or rescreening if one is performed. It is also recommended that the classroom teacher be notified if a student fails the vision screening. (See appendix for sample referral form.)

## Referral

Referrals should be made if the child's screening results indicate a need for a professional eye exam. Failure of vision screening is not the only reason a student may need to be referred (see under Observation of Visual Problems). When screening findings are inconclusive and your professional judgment indicates that the student would benefit from seeing an eye care professional the student should be referred. In addition, if a parent or teacher has a legitimate concern based on observation of behaviors suggesting a visual problem, even with a normal vision screening the student should be referred for further evaluation. All children who are unable to perform a vision test and are currently not under the care of an eye care specialist should also be referred.

## Follow-up

The ultimate goal of screening is to identify children with visual problems and to assist the families in obtaining further evaluation. Whatever can be done to achieve the goal of a professional eye examination should be done. One way to promote success in achieving this goal is to make a follow-up phone call to the parent or guardian after the notification/referral letter is sent. Further follow-up with parents may be necessary to assure the student is seen by an eye care professional.

# Alternative Screenings

This section provides information on alternative screenings that may be warranted in special circumstances. These screenings are not recommended for mass screenings but may be beneficial on an individual basis.

## **Near Vision Acuity Testing**

Near vision is an important function of the human eye. Adequate near vision depends on both accommodation and convergence, which combine to produce a clear image, typically 12 to 24 inches from the eye. Testing near vision in schools is directed toward the identification of hyperopia, particularly severe, or “high” hyperopia.

Testing with a plus lens with strength of at least plus 2.00 diopter is recommended for testing near vision acuity. Plus lenses refract light when placed in front of the eye. Plus lenses may be mounted (1) in a holder or frame which is held before the eye, (2) in a frame that is a common pair of glasses, or (3) in a frame that may be inserted in a stereoscope or vision-testing machine. In the absence of plus lenses, near vision may be tested using near vision cards.

Grades: As requested by parent or school personnel

## **Procedure for Testing Near Vision with a Plus Lens**

Equipment: Sloan distance chart, occlude, and plus 2.00 diopter lens

Near vision may be assessed using plus lenses with a wall-mounted or portable illuminated distance acuity chart. It may seem counterintuitive to assess near vision using a distance chart, but this is the way it is done, in part, because some accommodation is also needed for good distance vision.

1. Place distance vision acuity chart at eye level. If using a wall chart, place in a well-lit area, avoiding places where the chart will be in shadows.
2. Measure the exact distance from the wall where the chart is mounted or placed. Typically the distance will be 10 or 20 feet, depending on the chart used. Mark the floor so the child will know where to stand.
3. Direct the child’s attention to the age appropriate critical line of the chart. Have the child cover the eye not being tested. Ask the child to read the optotypes on the critical line while looking through the plus lens. If the child is unable to discern the optotypes, he or she may hesitate or indicate the images are blurry. The inability to read the optotypes on the critical line while viewing through a plus lens is a PASS.

4. If a child is able to read some, most, or all of the optotypes on the critical line on the chart with one or the other eye while looking through the plus lens, this is a FAIL. A retest is recommended in two weeks. Failure in one eye or both in the retest constitutes a referral.

**Tips:**

If a child wears glasses or contact lenses to correct for a distance vision problem, testing the child with the glasses/contacts on will produce a better result.

**Procedure for Testing Near Vision with Cards**

Equipment: Near vision cards with LEA symbols or Sloan letters and occluder

1. Mount the card on a wall or other flat vertical surface at eye level. Make sure that the card is well lit, and that it is free from shadows.
2. Measure the exact distance from the acuity card to where the student will be positioned. A distance of 13-16 inches is recommended. Mark the floor so the child will know where to stand.
3. Don't allow the child to lean the torso forward or tilt the head forward. Have the child occlude the eye not being tested.
4. Direct the child's eye to the 20/70 line on the card/chart and move down the card to successively smaller optotypes. The card may be noted as a distance chart with 20/20, or it may be noted in inches or centimeters. If noted in inches, begin with the 14/27 line of the card or the equivalent of 20/70. Proceed to the other eye and repeat the process.
5. Ask the child to read or name the letter or symbol on each line as directed. Pass/Fail criteria are manufacturer specific so follow the manufacturer's instructions.
6. A retest is recommended in two weeks. Failure in one eye or both constitutes a referral.

**Tips:**

If a child is already wearing glasses or contact lenses, attempt to determine the reason for the correction. If the glasses are for reading, test the child with and without glasses in order to obtain a baseline. If the glasses are to correct for a distance vision problem, testing the child with his/her glasses on will produce a better result.

## Recommended Referral Criteria for Near Vision Acuity:

Plus Lenses	A referral is made when a child successfully reads most or all of the optotypes on the 20/30 line of the chart with one or the other eye, while looking at the chart through the plus lens.
Near Acuity Cards	Near acuity cards differ as to what constitutes a <b>PASS</b> . Follow manufacturer's instructions. If in doubt retest using a plus lens prior to referral.

### **Testing for Accommodation**

The Near Point of Convergence (NPC) test examines the convergence reflex and is nearly always combined with the Pupil Size Test. The Pupil Size Test observes the size of the pupils when the child gazes at distant and near focal objects, respectively.

Grades: As requested by parent or school personnel.

Equipment: No special equipment required.

### **Procedure for Testing Accommodation Using the NPC Test**

1. Direct the child's attention to your finger or a near object placed about 18 inches in front of the child's eyes.
2. Move the focal object, or your finger, in toward the child's face to a distance about 3 inches from the child's eyes, or to the tip of the child's nose, and observe the eye movement. It is recommended that you perform the NPC five times in a row to test stamina.
3. A normal response is a movement of both eyes, nasally, with convergence of the two axes of the eyes. An inability of the eyes to converge may be related to limited accommodation, a problem with the extra ocular muscles, or a frank neurological ocular or systemic condition. Referral to an ophthalmologist is recommended. No retesting is required.
4. If the child is wearing glasses for near vision, test the child with and without his/her glasses. If the child wears glasses for distance vision, remove the glasses during testing.

### **Procedure for Testing Accommodation Using Pupil Size Test**

1. Choose a near focal object, like the examiner's finger, and a distance focal object.
2. Have the child sit or stand in front of you. A very young child may sit on a parent's lap. The child should be about 2 feet or less from the examiner.
3. Direct the child's eyes to the distance focal object and observe the pupil size.
4. Direct the child's attention to your finger or a near object placed about 18 inches in front of the child's eyes. Move the focal object, or your finger, in toward the child's face to a distance about 3 inches from the child's eyes and once again, observe the pupil size.
5. A normal response is a change in the pupil size from dilated to constricted as the accommodative reflex is engaged. No pupillary constriction connotes poor accommodation, and a referral is made, accompanied by results of a screening with a plus lens.
6. If the child is wearing glasses for near vision, test the child with and without glasses. If the child wears glasses for distance vision, remove the glasses during testing.

### **Color Vision Testing**

Color vision is the perception of the full spectrum of white light and is a function of the cones in the fovea and macula. The fovea and the macula are responsible for clarity of an image, perception of detail, and capturing form. The cones are responsible for color sensitivity and allow the perception of color. A color disorder is a condition of the eye in which there is a deficiency, absence, or unresponsiveness of photochemical receptors in the cones, or an alteration in the structure or function of the cones unrelated to color receptors.

Identification of a childhood color disorder is important information to share with teachers and parents, especially in the child's early years. So much of preschool and primary grades' curricula are color-driven. Reading readiness develops and builds on a variety of cognitive skills from matching to recognition and recall, much of which is presented or enhanced through the use of color.

#### **Grades**

As requested by parent or school personnel. Color vision screening once in a child's school life is sufficient and need not be repeated unless special circumstances indicate otherwise.

#### **Equipment**

Pseudoisochromatic plates and a cotton-tipped applicator.

For younger children you may prefer to use "*Color Vision Testing Made Easy*"; pseudoisochromatic plates especially designed for younger age groups.

### **Procedure for Testing Using Standard Pseudoisochromatic Plates**

1. Place the plates on a table with the book closed. Seat the child comfortably at the table and sit down next to the child. Provide the child a clean, cotton-tipped applicator and instruct the child not to touch the cotton.
2. Direct the child's attention to the practice plate(s) and explain and demonstrate what you would like the child to do.
3. Begin with the first plate and ask the child to trace the shape, form, or object, using the cotton-tipped applicator. Instruct the child not to touch or trace the image with his/her fingers. If numbers are part of the test, the child may call out the number. There is no timing with this test, so a bit more time with a given plate is not a concern.
4. A Pass is the ability to discern the images presented within a reasonable length of time.
5. Note the plates that the child is able or unable to see, and make an interpretation of the nature of the color disorder, if possible, based on the manufacturer's directions.
6. Notify the teacher and family of the results.

### **Procedure for Testing Using “Color Vision Testing Made Easy” Plates**

1. Place the plates on a table with the book closed. Seat the child comfortably at the table, and sit down across the table opposite from the child.
2. The test begins with a practice plate. Explain that you will be showing him/her various pictures and that you want him/her to name the pictures on each plate. Be sure the child knows the words necessary to respond.
3. Flash each plate to the child from a distance of about 30 inches and keep each plate up for no more than three seconds. Position the plates so they are comfortable to see and at eye level.
4. Using the manufacturer's guidelines, make an assessment of the presence or absence of a color problem and the nature of the disorder, if the plates facilitate this.

#### **Tips**

- Color disorders are overwhelmingly a male problem. The prevalence of color disorders among females is very low.
- Be alert to the possibility of misdiagnosing a color problem in a very young child, or a child who is an ESL (English as a second language) student.

# Screening Students with Special Needs

Some groups of students may not be able to complete a vision screening using the recommended charts due to age, immaturity, or physical/cognitive challenges. These students will need the use of alternative vision screening methods. Photo vision screening is the predominant vision screening method used for these populations of students.

Photo vision screeners are available for loan from the Division for pre-Kindergarten, Kindergarten, Head Start and Special Needs students. Newer technology may be used as it becomes available and approved by the Division.

School districts may choose to use other vision screening instruments at their discretion and expense. These instruments include chart software, other photo vision screeners, and the McDowell Vision Screening Kit (a behavioral/observation based tool).

The Division is available to assist with screening special needs students. If the Division or other outside agencies approved by the Division assist with photoscreening students, the public school should obtain written permission from the parent or guardian, unless the school nurse is available during the screening.

## Screening Tips

1. If you screen children with LEA Symbols, familiarize children with the symbols prior to vision screening day. For example, introduce the LEA Symbols 3-D Puzzle in circle time or for play at the manipulatives table.
2. Say you are going to play a game. Do not say, "I am going to *test* your eyes." This could frighten the child.
3. Naming optotypes is a fast way of testing but requires a linguistic ability that we are not measuring. If you use naming, let the child choose the names for the optotypes. Accept the name the child suggests. It is in error to suggest abstract names such as circle and square because they are not concepts familiar to young children and may frighten the child so that answering stops. Matching is the best way of measuring recognition. If you are screening children with disabilities or very young children and the child has a difficulty with pointing or eye movements, see information on "Special Use of the Puzzle Board" at <http://lea-test.fi/en/vistests/instruct/lea3dpuz/lea3dpuz.html>.
4. If a child will not name the optotypes and your eye chart includes response panels and individual flash cards, ask the child to play a matching game by pointing to the symbol on the response panel that matches the symbol on your chart. Another option is to place the individual flash cards on the floor in front of the child and ask the child to step on the symbol that matches the symbol on your eye chart.
5. Refrain from giving young children responsibility for their own occlusion. Children are likely to peek, especially if one eye has amblyopia or blurred vision. Occluder

glasses will increase testability in children who do not want to participate in vision screening.

6. If a child strongly resists occluding one eye and does NOT resist occluding the other eye, the first eye may be preferred for vision and the second eye *may* have amblyopia. Try screening first with the second eye and then return to the first eye. If the child still resists, refer for a comprehensive, confirmatory eye exam.
7. If you must direct a child's attention to optotypes, briefly use your finger or a pen to point above or below each symbol, but not directly on the symbol. Refrain from displaying one optotype at a time. Both can interfere with screening and result in an overestimation or underestimation of visual acuity.
8. For untestable children, rescreen or refer for a comprehensive eye exam. Research from the Vision in Preschoolers Study suggests that untestable children are more likely to have vision disorders than children who passed vision screening. If you rescreen, the American Academy of Pediatrics suggests 4 to 6 months for children aged 3. Rescreen in 1 month for children aged 4 and older.

# State Reports

In addition to filing a vision screening report in each student's individual record, Utah state law requires schools to report vision screening referrals (failures) for all children ages 8 and under each school year, regardless if they were entered in a prior year. These reports must be completed on-line by April 30 of each year using the on line reporting tool Q90. This tool will help collect annual data for funding that provides instruments for future vision screenings. This database is simple to use and allows the school nurse or representative to report findings in a quick and easy manner. Initial referral information may be added immediately after rescreening. Provider findings on individual students may be entered at a later date by using the edit button for the identified student. Student information may also be entered in its entirety prior to April 30 after receiving provider reports. The Division will provide training on data entry so that the reporting data are entered correctly. Contact the Division at 801-323-4343 to access the training and to receive a username and passcode.

Be prepared to provide the following information:

Your name: Last, First

Your Title: (school nurse/administrator/other)

Your work e-mail contact information

Your Phone number + AREA CODE

Your Fax number + AREA CODE

List of each District and Name of the school for which you will be entering vision referral data for students aged 8 and under.

## Step-by-step directions on how to use Q90:

<p>Access website  <a href="https://www.olderblind.com/">https://www.olderblind.com/</a>.          Enter username          passcode</p>	

Click on  

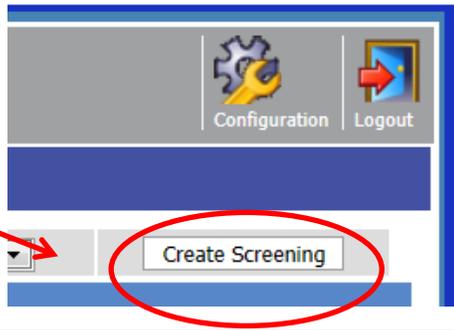



To add new information click on

[Create Screening](#)

To revise or update entry, click on title with appropriate date

Title	District	sr
<a href="#">ALTA VIEW 2009-10</a>	CANYONS	
<a href="#">ALTA VIEW 2008-09</a>	CANYONS	
<a href="#">ALTA VIEW 2007-08</a>	CANYONS	



Enter Information

Title: School Name plus current school year  
 i.e. Alta 2012-13  
 Student Enrollment and Number screened  
 per grade level:

(The primary purpose of the online Q90 is to provide a variety of data points for statistical information on the percentage of eye problems in Utah students per grade level under the age of 9.)

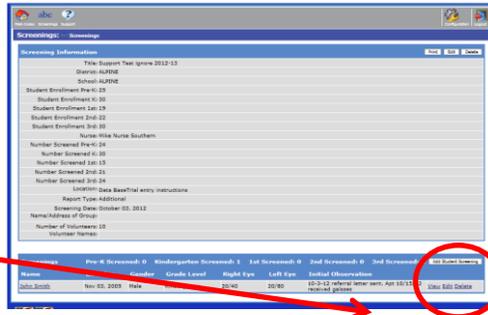
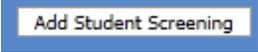
Clarification

Location: School Address  
 Number of volunteers: please report total number of volunteers and staff providing vision screenings including yourself  
 Names of Volunteers: not required. Please assure that volunteers are trained according to guidelines.  
 Official Thank You cards are available through the Division.

Click: [Save Screening](#)

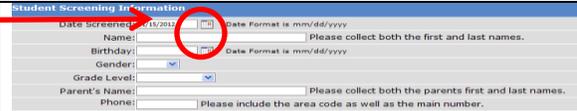
Enter information only for students that are referred (failed) after rescreening vision, No need to rescreen failures if using a photo screener.

To add student information click on



It is best to use the calendar to enter dates correctly

Enter student's name, birthday, gender, grade level, parents name, address, city, state, and ZIP.



Visual Acuity: enter Pass (P) or fail (F) for each eye.

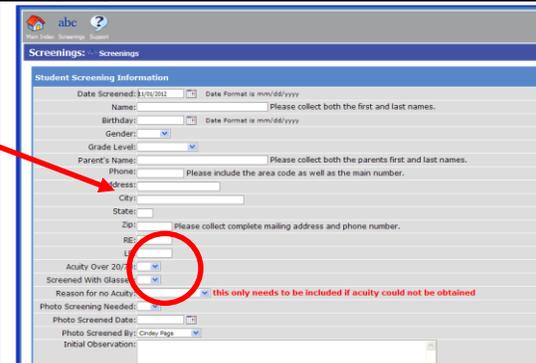
R (or O.D.) indicates the right eye, and L (or O.S.) indicates the left eye.

Provide yes or no in the "Acuity Over 20/70" drop down box, if known.

Provide yes or no for screened with glasses.

Select from drop down the reason for no acuity if unable to obtain.

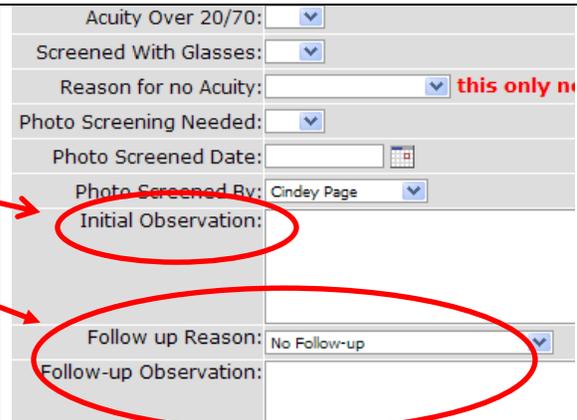
Provide yes or no if photo screening is needed (If photo screening is used, provide photo screening information: photo screened date and by whom).



Use initial observation to record date of rescreening and findings; struggling, squinting, peaking

Provide follow up information from the eye care professional or parent

If adding follow-up information at a later date: click edit next to the students name and fill out the follow up reason and follow up observation



Be sure to click on save  
For questions call the Division at 801-323-4343.



## Vision Resources

**EyeCare America Children's EyeCare Program** is a public service foundation of the American Academy of Ophthalmology (AAO). They provide comprehensive eye exams and care for children. They also provide education for parents and primary care providers about the importance of early childhood (newborn through 36 months) eye care. Telephone: 1-877-887-6327.

<http://eyecareamerica.org>.

**Eye Care For Kids** is a non-profit organization that helps provide eye exams and eyeglasses for low income children who meet eligibility criteria.

[www.eyecare4kids.org](http://www.eyecare4kids.org)

**Friends for Sight** is a non-profit agency that provides eye exams and glasses for low income children who meet eligibility criteria.

[www.friendsforsight.org](http://www.friendsforsight.org)

**InfantSEE®** is a public health program designed to ensure early detection of eye conditions in babies. Member optometrists provide a comprehensive eye and vision assessment for infants within the first year of life regardless of a family's income or access to insurance coverage. Telephone: 1-888-396-3937.

<http://www.infantsee.org>.

**Lion's Club** is a non-profit organization that provides financial assistance for eye care for children who meet eligibility criteria.

[www.lionsclubs.org](http://www.lionsclubs.org)

**Moran Eye Center** provides eye exams for patients who qualify based on income status through the University of Utah Billing office.

Telephone: 801-587-6303 or 1-800-862-4937;

email: [billing@healthcare.utah.edu](mailto:billing@healthcare.utah.edu)

**New Eyes for the Needy** provides vouchers for the purchase of new prescription eyeglasses.

<http://www.new-eyesfortheneedy.org>

**Sight for Students** is a Vision Service Plan (VSP) program that provides free eye exams and glasses to low income and uninsured children 18 years and younger who meet eligibility criteria. **School nurses, who are members of National Association of School Nurses (NASN), can receive free vision vouchers for students in need.**

Telephone: 1-888-290-4964.

<http://www.sightforstudents.org>.

**Utah Division of Services for the Blind and Visually Impaired** can provide school nurses with a list of State-approved outside agencies that can assist with vision screening.

Telephone: 801-323-4343

**Vision Utah** is a foundation created for Utah School Nurses by the Utah Optometric Association. Individual doctors may participate by providing vouchers for a free eye exam and eyeglasses to students who meet eligibility criteria. To locate doctors in your area visit <http://www.utaheyedoc.org> then call to see if they participate in Vision Utah.

**Zenni Optical** an economical way for parents to order glasses on line with Rx and PD (pupil distance) information.

<http://www.zennioptical.com>

***Local businesses** such as Walmart, Target, Shopko, LensCrafters, and private practices often donate services for eye exams and eyeglasses. It is best to check with the local vendors in your area for needed services.*

# Glossary

## A

**Accommodation** -- The ability of the eye to allow an individual to focus clearly on objects at near range.

**Amblyopia or Lazy eye** -- The loss or lack of development of central vision. It is not related to any eye health problem, and it usually cannot be corrected with eyeglasses or contact lenses. It can be the result of a failure to use both eyes together. Lazy eye is often associated with cross-eyes, or a large difference in the degree of near or farsightedness between two eyes. It generally develops before age 6.

**Astigmatism** -- A condition which causes blurred vision. It is caused by either the irregular shape of the cornea, which is the clear front cover of the eye, or sometimes the curvature of the lens inside the eye.

**Auto refractor** -- A small, portable, light weight vision assessment system capable of detecting refractive errors. This portable auto refractor is a miniature version of refractors used at the eye care professionals' offices.

## B

**Blepharitis** -- An inflammation, that can be acute or chronic, of the eyelash follicles and the meibomian eyelid glands.

## C

**Cataract** -- A cloudy or opaque area in the lens of the eye that is normally clear. It can interfere with normal vision, depending on the size and location. Cataracts develop primarily in people over 55 years of age, but they can occasionally occur in infants and young children. Cataracts usually develop in both eyes, but one may be worse than the other.

**Color vision** -- A perception of all specters of white light from the responsiveness of the cones in the fovea and macula, which contain photochemical receptors which are sensitive to red, green, or light blue.

**Color vision deficiency (color blindness)** -- The inability to distinguish certain shades of color. In rare cases, it can be more severe and they cannot see colors at all.

**Conjunctivitis** -- An inflammation of the conjunctiva which is a thin, transparent layer that lines the inner eyelid and covers the white part of the eye. There are three main

types of conjunctivitis: infectious, allergic, and chemical. The infectious type is commonly called, "pink-eye" which is caused by a contagious virus or bacteria.

**Convergence/convergence reflex** -- The movement of both eyes goes inward toward each other, usually to focus on an object near at hand.

**Convergent strabismus (also called esotropia)** -- A type of strabismus in which the movements of one or both eyes go inward or nasally.

**Cornea** -- The front part of the eye that is transparent and covers the iris, pupil, and anterior chamber and provides most of an eye's optical power.

**Corneal abrasion** -- When the cornea has been scraped or has a tear and visual acuity is temporarily reduced, may cause photophobia, and result in considerable pain.

**Critical line** -- The line age appropriate at which a student passes vision screening recommended vision screening

## D

**Diopter** -- A unit of measure to designate the refractive power of the lens, which is given a plus or minus value on the refractive error.

**Distance vision** -- The ability of the eye to see images clearly at a distance (usually a great distance).

**Divergent strabismus** -- A type of strabismus, in which one or both eyes will deviate outward, or away from the nose.

**Double vision** -- The perception of two images, one by each fovea, when the eyes are intentionally crossed or may be from misalignment from an imbalance of the extra ocular muscles.

## E

**Eye Care Professional** -- Refers to a professional eye doctor such as an Optometrist or an Ophthalmologist who specializes in treating vision abnormalities.

## F

**Farsightedness** -- (See hyperopia).

## **G**

**Glaucoma** -- A group of eye diseases that damage the optic nerve as seen by elevated intraocular pressure. The optic nerve carries information from the eye to the brain, when damaged can cause loss of vision.

## **H**

**Hyperopia (farsightedness)** -- The inability of the eye to focus on objects close up. This happens because the eye is too short or the cornea is too flat, so the image focuses at a point behind the retina.

## **L**

**Lazy eye (see Amblyopia)**

**Legal blindness** – Best corrected visual acuity of 20/200 or less in the better eye; or a peripheral field in the better eye of 20 degrees or less.

## **M**

**Myopia (see Nearsightedness)** -- A vision condition in which the cornea has too much curvature so the light entering your eye does not focus correctly. When near objects are seen clearly, but distant objects do not come focus properly.

## **N**

**Nearsightedness (see Myopia)**

**Nystagmus** -- A condition where the eyes make uncontrolled, repetitive movements, which often results in reduced vision. These movements can occur up and down, side to side, or in circular motion patterns. Therefore, both eyes are unable make a steady hold on the objects in view.

## **O**

**Ophthalmologist** -- One who specializes in medical and surgical diagnosis, whom treats defects and diseases of the eye, prescribes drugs, eyeglasses, contact lenses and optical aids.

**Optic nerve** -- The largest sensory nerve of the eye, which carries visual impulses for sight from the retina to the brain.

**Optician** -- A professional who makes and adjusts lenses, fits them into frames and adjusts the frames to the wearer.

**Optometrist** -- A Doctor of Optometry (OD) who specializes in the diagnosis and treatment of functional vision problems, prescribes corrective lenses or visual therapy and examines eyes for disease.

**Optotypes** -- Letters or symbols on a vision screening chart which are placed before the examinee's eyes and used to discern visual functioning.

**Orthoptics** -- A type of exercise that is a non-medical, non-surgical treatment of lazy eye to strengthen extra ocular muscles of the eye. This method of treatment is to correct faulty coordination affecting ocular alignment.

## **P**

**Patching** -- A type of treatment for amblyopia in which the patient's preferred eye would be covered, to improve vision in the other eye.

**Peripheral vision** -- The ability to perceive presence, motion or color of objects to the side.

**Photorefractive imager** -- Type of new technology in school vision screening that uses a camera to take a photograph of the corneal light reflex, bilaterally. Also, termed refractometer or photorefractor.

**Photophobia** -- A discomfort or abnormal sensitivity to light. Excessive tearing may be a symptom, which could be caused by inflammation of the iris and cornea.

**Phoria** -- A latent alignment disorder of one eye to deviate up, down, left or right.

**Pink eye (see Conjunctivitis)**

**Ptosis** -- A condition in which there is a drooping of the upper eyelid.

## **R**

**Refraction** -- A test to determine an eye's refractive error and correction of lenses to be prescribed.

**Rescreening** -- A follow-up or second screen performed before referral when findings are suspicious or inconclusive.

## **S**

**Screening** -- A simple and quick testing procedures used identify children with visual impairment or eye conditions that are likely to lead to visual impairment so that a referral can be made to an appropriate eye care professional for further evaluation and treatment.

**Stereopsis** -- Binocular depth perception or three-dimensional when both eyes are in alignment and perceive the same image clearly.

**Strabismus** -- An eye misalignment caused by extraocular muscle imbalance.

**Sty** -- Eye infection, which involves the gland in the margin of the eyelid.

**Suppression** -- A condition in which the image from one eye is ignored by the brain and the two eyes see disparate images. This can lead to amblyopia.

## **V**

**Visual acuity** -- Assessment of the eye's ability to distinguish detail, as an object is placed farther away or as it becomes smaller in size.

**Visual impairment** -- A term used by eye care professionals when a child or adult whose best-corrected central vision is less than 20/40 but better than 20/200.

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*Guidelines for School Vision Screening Programs*. St. Louis, Mo.: American Optometric Association, 1992

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Proctor, S.E. (2005). *To see or not to see: Screening the vision of children in school*. Castle Rock, CO

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# Appendix

SAMPLE NOTIFICATION OF VISION SCREENING LETTER

School or District Letterhead  
or insert in Student handbook

Date

Dear Parent(s) or Guardian:

Your child, if in grades pre-K, K, 1,3,5,7,9 or 10, may be given a vision screening during this school year. Before screening is conducted, state law requires parents be informed that **vision screening is *not a substitute* for an eye examination by an eye care specialist.**

Vision screening may take place at any point during the school year. Every attempt is made to have student vision screening completed within 60 days from the start of the school year. Several methods for vision screening are state approved and available for student screening. Any of the following methods may be used to screen your child: Distance vision charts, photo screening, or computerized programs. School screenings are coordinated by the school nurse who may use trained parent volunteers and school staff to assist, or may request state-approved vision screening assistance from the Lions Sight Foundation, Friends for Sight, or the Utah Division of Services for the Blind and Visually Impaired.

You will receive a referral letter if your child fails the screening. However, even if your child passed, it is important that your child see an eye care specialist once a year. School vision screening does not evaluate eye health and cannot uncover important vision problems or prescribe treatment. Vision referral information, on children age 8 and under, will be reported to the Utah State Division for the Blind and Visually Impaired as stated in Utah Law 53A-11-203.

Because academic learning is 80% visual, and visual problems are best detected and treated early, a comprehensive eye and vision examination is recommended. Healthy eyes and good vision are essential for success in school.

Please provide the school with written notification if you do not want your child to participate in the screening program.

If you have questions or would like to volunteer to assist with vision screenings, please contact (school nurse or volunteer coordinator) at (contact information).

Sincerely,

Principal

SAMPLE VISION SCREENING OPT-OUT FORM  
VISION SCREENING EXEMPTION FORM

To: School Nurse

Due to a personally held belief, I do not wish for my child to have a vision screening during this school year until further notice. I understand that I may change my mind at any time and will do so in writing.

My child's name is: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_

Signature: \_\_\_\_\_ Date \_\_\_\_\_

Printed name: \_\_\_\_\_

I am the child's \_\_\_\_\_parent \_\_\_\_\_ guardian

**SAMPLE 1 CLASSROOM LIST FOR VISION SCREENING**  
 Fill in student's names alphabetically or by hand or electronically in advance

School or Organization \_\_\_\_\_  
 Teacher \_\_\_\_\_

District \_\_\_\_\_  
 Grade \_\_\_\_\_

County \_\_\_\_\_  
 Date \_\_\_\_\_

Student's Name		Right	Left	✓if With	Comments	Right	Left
	Do not need to rescreen if using a photo screener	Pass(P) Referred (R) - send to school nurse for rescreen		Glasses or contacts	wears glasses, peeks, squints, struggles, uncooperative	Re-screen Information by <b>school nurse</b>	
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							

## SAMPLE 2 CLASSROOM LIST FOR VISION SCREENING

\_\_\_\_\_ School District

### VISION SCREENING REPORT

School: \_\_\_\_\_ Teacher: \_\_\_\_\_ Date: \_\_\_\_\_

Name	Observations, Glasses, etc.	Vision		Vision		Comments
		R	L	R	L	
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
14.						
15.						
16.						
17.						

**SAMPLE VISION REFERRAL FORM  
(Enter Name) SCHOOL DISTRICT**

Student: \_\_\_\_\_ Date: \_\_\_\_\_  
School: \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_

Dear Parent or Guardian:

Our school district routinely performs vision screenings identify students who have vision problems or might be at risk for vision problems. A student's ability to see well is vital for learning, so it's important to identify any barriers to learning that can be corrected.

Your child's vision screening indicated some visual difficulties. These results suggest that your child should have a complete professional eye exam.

Date of Initial Screening _____ Results Right Eye: _____ Left Eye: _____	Date of Rescreening _____ Results Right Eye: _____ Left Eye: _____
---	---

Comments: \_\_\_\_\_  
\_\_\_\_\_

Please take this form to the eye specialist and **return it to the school** when completed. If you do not have insurance and need financial assistance in obtaining an eye exam and/or glasses for your child, please contact your school nurse to see if you qualify for our eye care program.

School Nurse: \_\_\_\_\_ Phone: \_\_\_\_\_

<b>EYE SPECIALIST REPORT</b>	
Date: _____	
<b>ACUITY RESULTSS:</b> Right Eye: _____ Left Eye: _____	Were glasses prescribed? YES <input type="checkbox"/> NO <input type="checkbox"/>
Summary of vision problems and/or diagnosis: _____ _____ _____	
Eye Care Specialist Name: _____ Eye Care Specialist Phone: _____	
Eye Care Specialist Signature: _____ Date: _____	

DIVISION OF SERVICES FOR THE BLIND & VISUALLY IMPAIRED  
 VISION SCREENING REPORTING TOOL FOR REFERRED PK, K, KINDERGARTEN, 1st, 2nd & 3<sup>rd</sup> Grades  
 Save for your records. If unable to enter data into the Q-90, please send this report to

Division of Services for the Blind & Visually Impaired, Attention: Q-90 report, 250 N 1950 W #B, SLC, UT 84116

District: \_\_\_\_\_ School Name: \_\_\_\_\_ Address: \_\_\_\_\_

Reporting Person: \_\_\_\_\_ Title: \_\_\_\_\_ Page \_\_\_\_\_ of \_\_\_\_\_  initial report  additional report

# of trained volunteers used during screening process \_\_\_\_\_

Total # of students enrolled per grade	Pre-K	Kindergarten	1 <sup>st</sup> grade	#2 <sup>nd</sup> grade	3 <sup>rd</sup> grade
Total # of students screened per grade					

Referred Student's Name	DOB	Sex	Grade	Date of rescreening or photo screening	RE	LE	Acuity over 20/70 <input type="checkbox"/> yes <input type="checkbox"/> no
					With glasses or contacts <input type="checkbox"/> yes <input type="checkbox"/> no		
					Photo screening needed <input type="checkbox"/> yes <input type="checkbox"/> no		
Photo Screened by: _____							

Parent's Name	Mailing Address (City/ZIP)	Initial Observation:
---------------	----------------------------	----------------------

Information from referral report or parent comment:	(Amblyopia, Astigmatism, Cross-eyed, Glasses Prescribed, Moved, No Follow-up, Other, Over Referred, Parent Refused, Pathology, Strabismus, Treatment Pending, Within Normal Limits)
---	---

Referred Student's Name	DOB	Sex	Grade	Date of rescreening or photo screening	RE	LE	Acuity over 20/70 <input type="checkbox"/> yes <input type="checkbox"/> no
					With glasses or contacts <input type="checkbox"/> yes <input type="checkbox"/> no		
					Photo screening needed <input type="checkbox"/> yes <input type="checkbox"/> no		
Photo Screened by: _____							

Parent's Name	Mailing Address (City/ZIP)	Initial Observation:
---------------	----------------------------	----------------------

Information from referral report or parent comment:	(Amblyopia, Astigmatism, Cross-eyed, Glasses Prescribed, Moved, No Follow-up, Other, Over Referred, Parent Refused, Pathology, Strabismus, Treatment Pending, Within Normal Limits)
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VISION SCREENING REPORTING TOOL FOR REFERRED PK, K, KINDERGARTEN, 1st, 2nd & 3<sup>rd</sup> Grades

District: \_\_\_\_\_ School Name: \_\_\_\_\_ Page \_\_\_\_\_ of \_\_\_\_\_

Referred Student's Name	DOB	Sex	Grade	Date of rescreening or photo screening	RE	LE	Acuity over 20/70 <input type="checkbox"/> yes <input type="checkbox"/> no
							With glasses or contacts <input type="checkbox"/> yes <input type="checkbox"/> no
							Photo screening needed <input type="checkbox"/> yes <input type="checkbox"/> no
Photo Screened by: _____							

Parent's Name	Mailing Address (City/ZIP)	Initial Observation:
---------------	----------------------------	----------------------

Information from referral report or parent comment:	(Amblyopia, Astigmatism, Cross-eyed, Glasses Prescribed, Moved, No Follow-up, Other, Over Referred, Parent Refused, Pathology, Strabismus, Treatment Pending, Within Normal Limits)
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VISION SCREENING REPORTING TOOL FOR REFERRED PK, K, KINDERGARTEN, 1st, 2nd & 3<sup>rd</sup> Grades

Referred Student's Name	DOB	Sex	Grade	Date of rescreening or photo screening	RE	LE	Acuity over 20/70 <input type="checkbox"/> yes <input type="checkbox"/> no
							With glasses or contacts <input type="checkbox"/> yes <input type="checkbox"/> no
							Photo screening needed <input type="checkbox"/> yes <input type="checkbox"/> no
Photo Screened by: _____							

Parent's Name	Mailing Address (City/ZIP)	Initial Observation:
---------------	----------------------------	----------------------

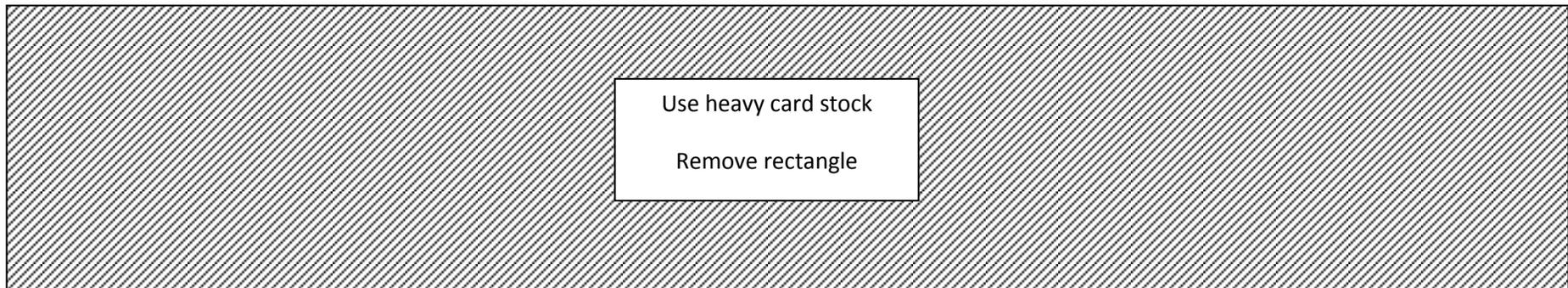
Information from referral report or parent comment:	(Amblyopia, Astigmatism, Cross-eyed, Glasses Prescribed, Moved, No Follow-up, Other, Over Referred, Parent Refused, Pathology, Strabismus, Treatment Pending, Within Normal Limits)
---	---

VISION SCREENING REPORTING TOOL FOR REFERRED PK, K, KINDERGARTEN, 1st, 2nd & 3<sup>rd</sup> Grades

Referred Student's Name	DOB	Sex	Grade	Date of rescreening or photo screening	RE	LE	Acuity over 20/70 <input type="checkbox"/> yes <input type="checkbox"/> no
							With glasses or contacts <input type="checkbox"/> yes <input type="checkbox"/> no
							Photo screening needed <input type="checkbox"/> yes <input type="checkbox"/> no
Photo Screened by: _____							

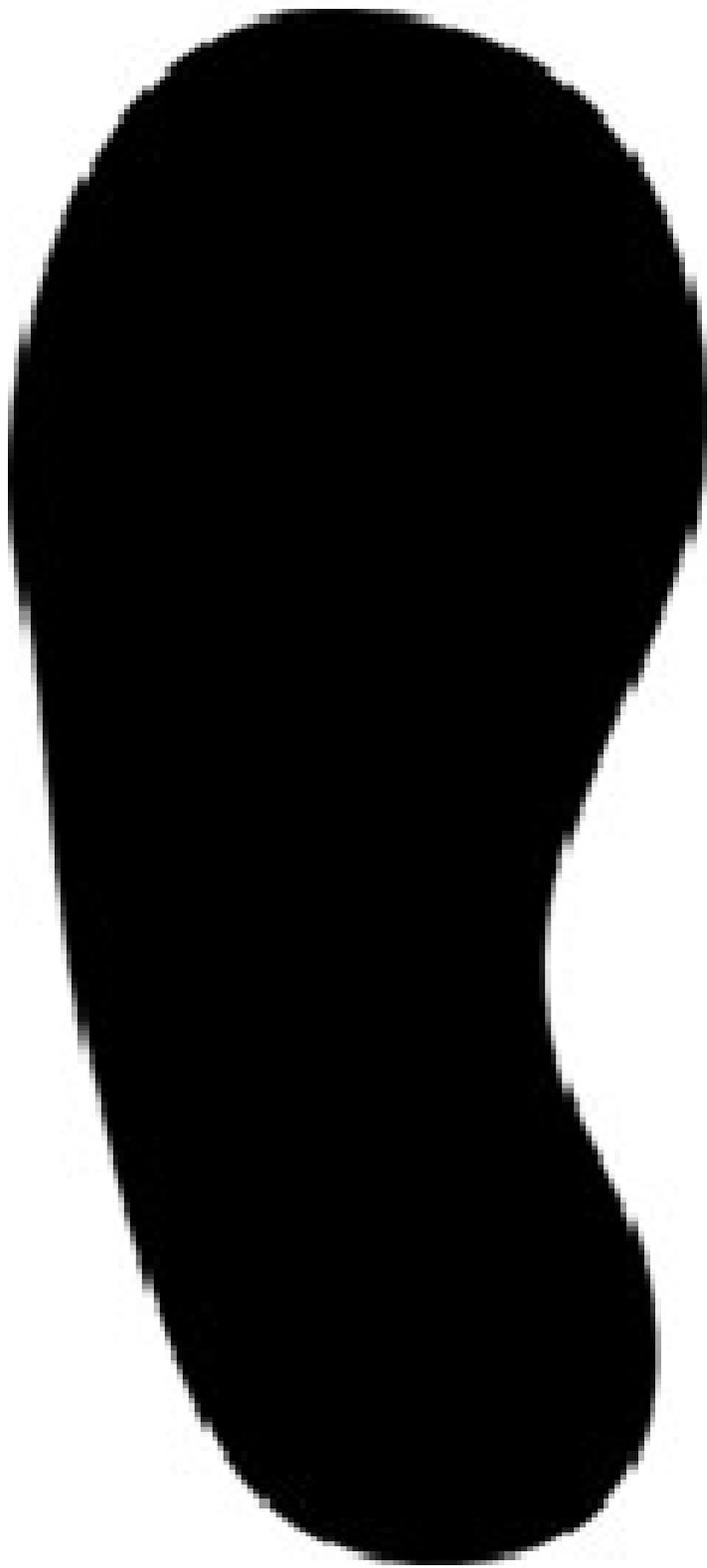
Parent's Name	Mailing Address (City/ZIP)	Initial Observation:
---------------	----------------------------	----------------------

Information from referral report or parent comment:	(Amblyopia, Astigmatism, Cross-eyed, Glasses Prescribed, Moved, No Follow-up, Other, Over Referred, Parent Refused, Pathology, Strabismus, Treatment Pending, Within Normal Limits)
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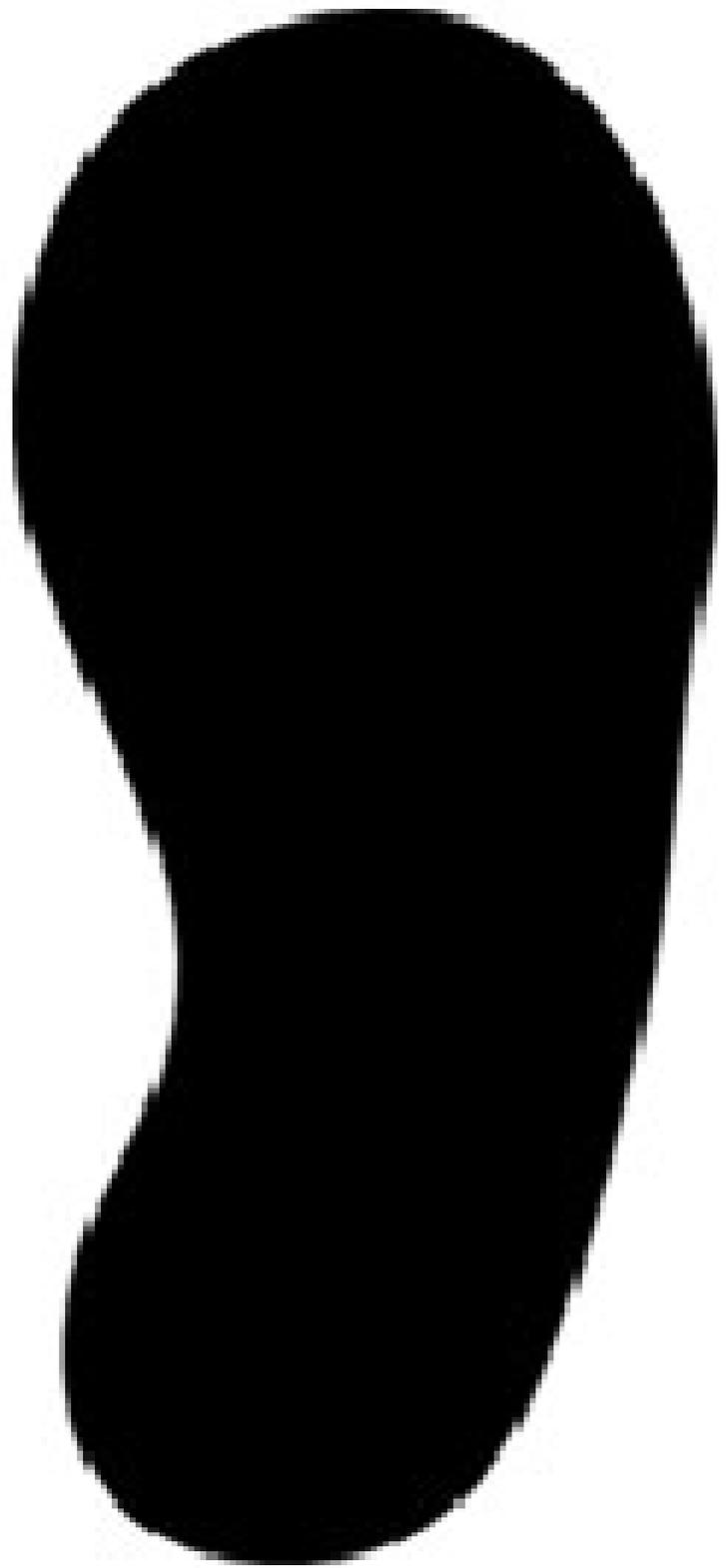


Use heavy card stock

Remove rectangle



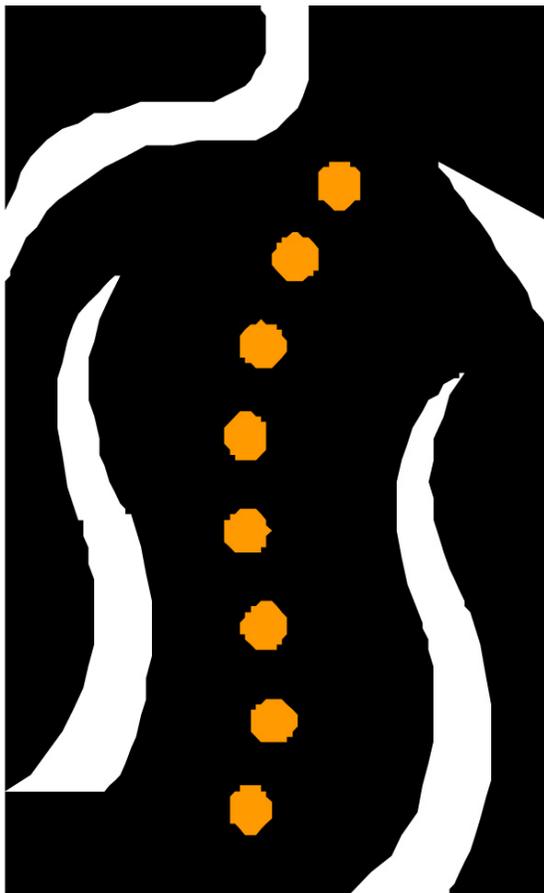
Toes on line



## Scoliosis Guidelines

2017

# Utah School Spinal (Scoliosis) Screening Guidelines



Utah Department of Health  
Healthy Living Through Environment, Policy,  
and Improved Clinical Practice

1/9/2017

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## **School Spinal (Scoliosis) Screening Guidelines**

### **INTRODUCTION**

School spinal (scoliosis) screening was developed to identify adolescents with small spinal curves and refer them for treatment before these curves become too severe. Many states do some form of spinal screening to assure students needing evaluation and/or treatment get early attention. The State of Utah does not mandate spinal screening, but does require each local school board to implement rules developed by the Department of Health (UCA 53A-11-201).

If the school has one nurse assigned full-time, screening may be considered worth the expense; however, most schools share a nurse with up to 15 other schools. For this reason, along with the high amount of false-positives from screening tests, the time and cost involved, and the minimal need for significant intervention, the Utah Department of Health recommends against routine school scoliosis screening in Utah.

Scoliosis is an abnormal curvature of the spine. The purpose of screening is to detect scoliosis at an early state when it is believed treatment can be most effective in preventing the progression of the disease.

Routine school scoliosis screening began in the late 1950's (Karachalios, Theofilos, Nikolaos, Papageloupoulos, & Karachalios, 2000), but has recently come under fire. In 2004, the U.S. Preventive Services Task Force recommended against routinely screening asymptomatic patients, stating the screening was ineffective finding a number of false-negatives and false-positives (U.S. Preventive Services Task Force (USPSTF), 2004). These false-positives resulted in avoidable expense and anxiety, and has not decreased the likelihood of those students screened needing surgery, with the majority of students identified needing minimal or no follow-up (Jakubowski & Alexy, 2014). Many believe that the routine school scoliosis screening to be based more on tradition than evidence.

Another study found there was insufficient evidence to support school scoliosis screening stating that most cases do not progress enough to require treatment, cases needing treatment are likely to be detected without school screening, and false-positives often result in unnecessary X-rays and medical appointments (Honeyman, C. 2014), as well as painful and unnecessary brace wear (Linker, 2012).

### **SCHOOL SPINAL (SCOLIOSIS) SCREENING**

If school scoliosis screening is to be done, personnel should be educated on the correct way to screen to minimize unnecessary referrals. Currently, the Adams Forward Bend Test with use of a scoliometer is thought to be an effective way to measure abnormalities. The Scoliosis Research Society (SRS) recommends that students found to have a five to seven degree deformity be the threshold for a positive screening (2015). Karachalios, et al. (2000) recommend that eight degrees or more be the criteria for referral, but also don't believe school screenings are the best way to detect scoliosis because over-referral is common, and progressive curves are rare.

The SRS recommends that girls be screened twice at ages 10 and 12 (5<sup>th</sup> and 7<sup>th</sup> grade), and boys be screened once at age 13 or 14 (8<sup>th</sup> or 9<sup>th</sup> grade) (Hresko, Talwalkar & Schwend, 2015), although methods and locations of screenings vary. Screenings can be done in schools by school nurses, PE teachers, or other qualified healthcare professionals; or is often done during a routine physical examination by the student's healthcare provider. Parents can also be made aware of signs to watch for that may indicate a spinal deformity.

Most all cases have no known cause and are referred to as idiopathic scoliosis. It commonly affects young people between the ages of 10 and 16 years of age. Idiopathic scoliosis can go unnoticed in a young person because it is rarely painful in the formative years.

### **SPINAL (SCOLIOSIS) SCREENING PROCESS**

The screening process identifies students that may have some physical findings that suggest a spinal curve. The screening process does not diagnose a spinal deformity. The student showing these findings is referred to a healthcare provider who completes an extensive examination and then will likely take x-rays to confirm whether or not the student has an abnormal spinal curve. At that point, the healthcare provider can provide recommendations for treatment.

Parents must be notified before students can be screened, and have the right to deny screening. This can be done through active or passive permission slips. Students already under treatment should not be screened

The room in which the screening is done should have sufficient lighting and the floor should be level. Boys and girls must be screened separately in an area that accommodates the need for privacy. It is recommended that students wear gym clothes, ideally wearing shorts to allow better visualization of the waist, hips, and legs. Boys should remove their shirts, and girls should be wearing a bra, bathing suit, or camisole. If the girl is wearing a camisole, it should be rolled up so the examiner can visualize the upper back. Girls should keep their shirt on until in a private area, and then can be instructed to either take the shirt off, or pull it up around their neck with their arms out of the sleeves, with the shirt hanging in front of them. Girls not wearing a bra, bathing suit, or camisole should not remove their shirt. There should always be a minimum of two adults present for security/liability concerns. The most common area to conduct the screening is in a middle school or junior high locker room.

1. The student begins by standing erect (shoulders back, head up, gaze ahead, arms hanging loosely at their sides, knees straight, and facing away with their back to the screener). The student should not look backward since this can cause a change in the findings. Long hair should be moved forward to allow full view of the student's back. The screener should check for the following:
  - One shoulder higher than the other
  - One shoulder blade higher or more prominent than the other
  - One hip higher than the other

- Space between arms and body greater on one side
  - Waist creases uneven
  - Obvious lateral curvature of the spine
  - Observe from either left or right side for kyphosis (increased curve of thoracic spine) or lordosis (increased curve in lumbar area)
2. The next position is the Adams Forward Bend Test. With palms together, chin to the chest, the student bends forward until the back is horizontal. Screeners should check for:
    - Asymmetry of two sides of the back
    - Rib prominence
  3. The final portion is using a scoliometer. This is considered best practice and should be used if at all possible. It is similar to a carpenter's level and designed to measure the degree of spinal rotation.
    - Hold the scoliometer with the number "0" directly over the top ridge of the spine
    - Do not press down as this will distort the reading
    - A reading should be taken at both the thoracic and lumbar spine

### **CRITERIA FOR REFERRAL**

To minimize unnecessary referrals, the school nurse should screen those with positive findings a second time. This can be done the same time as the original screening by having the student stand up and reposition, or can be done another day. Criteria for referral include:

- Eight degrees or more on scoliometer
- A combined reading (thoracic and lumbar) of 10 degrees or more
- Obvious curvature of the spine (or kyphosis or lordosis)
- Two or more of the following:
  - Shoulder or scapula asymmetry
  - Space between arms and body greater on one side
  - One hip higher than the other
  - Waist creases uneven

### **DOCUMENTATION**

All results should be documented either electronically or on paper. Those with positive findings (above) should have a referral sent to parent or guardian. Referral should be to a medical physician (MD or DO), and not to a chiropractor. The school nurse should maintain a record of students who were referred for a professional examination, and those that were excluded from screening (for any reason). Sample referral letters are included in the appendix.

Lists of students referred to a medical physician do not need to be sent to the Utah Department of Health.

## **MANAGEMENT**

Management of spinal deformities will typically consist of either observation, bracing, or surgical intervention. The majority of students with scoliosis require no treatment other than observation (Jakubowski & Alexy, 2014). Alternative treatments have not been successful in preventing curves from progressing. These include electrical muscle stimulation, exercise programs, manipulation, massage, and magnets.

### **SHOULD THE SCHOOL PROVIDE THE SCREENING?**

The current Utah law states that the decision for schools to provide the screening should be determined at the local school board level. These guidelines have been established by the Utah Department of Health to help local school boards that choose to implement school scoliosis screening. The local school board, with input from their school nurses, should review the most current research to make the decision whether to screen or not.

The USPSTF (2004) states that most cases of scoliosis are obvious and would be found in the student's regular visits with their healthcare provider. If the school has one nurse assigned full-time, routine school scoliosis screening may be considered worth the expense; however, most schools share a nurse with up to 15 other schools. For this reason, along with the high amount of false-positives, the time and cost involved, and the minimal need for significant intervention, the Utah Department of Health recommends against routine school scoliosis screening in Utah.

If the local school board decides to implement screening, the above guidelines should be followed. If the decision is made to not provide school scoliosis screening, a letter or flyer should be sent home with students in 5<sup>th</sup> or 6<sup>th</sup> grade containing more information on scoliosis (sample in appendix).

APPENDIX

**SAMPLE ACTIVE PERMISSION LETTER**

**SCOLIOSIS SCREENING PERMISSION LETTER**

XXXX School

PRINT Student Name: \_\_\_\_\_ Grade \_\_\_\_\_

Scoliosis screening will be conducted in the \_\_\_\_\_ grade P.E. classes under the direction of the District's School Nurses.

The purpose of scoliosis, or postural screening, is to detect signs of spinal curvature at the earliest stages so that the need for treatment can be determined. Scoliosis is a side-to-side curve of the spine and is the most common spinal abnormality. It is usually detected in childhood or early adolescence by the student's primary care provider. Some schools may choose to have the school nurses also screen for spinal abnormalities. Most cases of spinal curvatures are mild and require only ongoing observation by a physician after the diagnosis has been made. Mild curvatures are often noticeable only to those trained in the detection spinal abnormalities. Others may become progressively more severe as the child continues to grow. Early treatment can prevent the development of a severe deformity which can later affect the health and appearance of the child.

The procedure for screening is simple. Screeners who have been specially trained will look at your child's back while he/she stands and then bends forward. **For this screening, *boys and girls will be seen separately and individually in a private area.***

**Boys must remove their shirt. Girls must also remove their shirt and must wear a bra (or camisole, or bathing suit top) or they cannot be screened. It is necessary for the entire back to be visible during the screening process. Shoes must also be removed.**

**You will be notified ONLY if medical follow-up is necessary.** This screening does not replace your child's need for regular health care and check-ups.

Please have your student return this form to his/her P.E. teacher before the screening day. If a student does not have a permission form, he/she will not be screened.

\_\_\_\_\_ I **DO** WANT MY STUDENT SCREENED FOR SCOLIOSIS

\_\_\_\_\_ I **DO NOT** WANT MY STUDENT SCREENED FOR SCOLIOSIS

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

\*\*\*\*\*

**For School Use:**

Scoliosis Screening Findings: \_\_\_ Within normal limits \_\_\_ Possible problem noted (indicate findings below)

L	R		L	R	
		Shoulder blade more prominent than other			High shoulder blade
		Obvious curve of spine in lower back			Rib hump
		Obvious curve of spine in area of rib cage			Hip higher than other side
		Obvious curve of spine in upper back			High shoulder
		Waist to arm space greater			Other:

\_\_\_\_\_ Rounded back (K=kyphosis, L=lordosis) \_\_\_\_\_ Uneven on bend test by \_\_\_\_\_ degrees  
 \_\_\_\_\_ upper back \_\_\_\_\_ middle back \_\_\_\_\_ lower back

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

Nurse \_\_\_\_\_ Date \_\_\_\_\_

## SAMPLE INFORMATION LETTER

### Scoliosis Information

What is Scoliosis? Scoliosis is a side-to-side curving of the spine. It is a developmental defect and not the result of poor posture habits. 80% of scoliosis cases are idiopathic (no known cause) but it is known to be more common in some families, suggesting hereditary factors.

Idiopathic scoliosis starts as a slight bend in a growing child's spine. It may remain slight and non-progressive, or it may progress over time, sometimes rapidly during the adolescent growth years, ages 10 to 15. About 10% of people have a very mild form of scoliosis that will need no treatment and many times is unnoticeable to anyone not trained to examine for it. About 1% will have a progressive condition and need some medical treatment. In the developing stage the spine stays flexible and there is no pain to indicate progression.

Significant curves that are unstable will continue to advance in adulthood. Left untreated, scoliosis can cause obvious physical deformity, pain, arthritic symptoms, and heart and lung complications and can also limit physical activity.

If detected early, scoliosis can be treated before it becomes a physical or emotional disability. Frequent signs of scoliosis are: a prominent shoulder blade, uneven hip and shoulder levels, unequal distance between arms and body, uneven hemlines, and clothes that do not hang right.

Home screening tests can be done with the child having no shirt on. For girls, a bra or a swimsuit that is low enough in back to show the lumbar spine (lower back) will be OK.

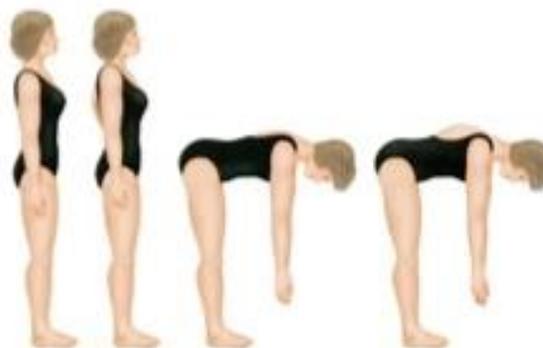
While your child is standing facing away from you look at the child's back and answer these questions:

1. Is one shoulder higher than the other, or is one shoulder blade more prominent?
2. When his/her arms hang loosely at her sides, does one arm swing away from the body more than the other?
3. Is one hip higher or more prominent than the other?
4. Does the child seem to tilt to one side?
5. Do you see an obvious curve?

THEN: ask your child to bend forward, with arms hanging down and palms together at knee level. Can you see a hump on the back at the ribs or near the waist?

If your answer to any of these questions is "yes", you should contact your doctor to verify your findings.

Screenings are routinely done by your healthcare provider at a well-child exams, and are recommended twice for girls at age 10 and 12, boys once at age 13-14.



**SAMPLE PARENT REFERRAL LETTER**

Spinal Screening Program  
Parent Notification and Referral

Parent or Guardian of: \_\_\_\_\_ Grade: \_\_\_\_\_ Date: \_\_\_\_\_

Students in our schools were recently screened for a curve of the spine that can appear during the years of rapid growth between ages 10 and 16 years. Your child has signs of a possible curve listed below.

This does not mean your student has scoliosis. Only a physician can make that diagnosis. It is recommended that your child have a complete evaluation by your pediatrician or family physician. After the doctor has examined your child and completed this form, please return it to school. If you cannot afford a doctor or have questions, contact the school for information.

Thank you for your cooperation,

School Screening Findings:

L	R		L	R	
		Shoulder blade more prominent than other			High shoulder blade
		Obvious curve of spine in upper back			Rib hump
		Obvious curve of spine in lower back			High shoulder
		Obvious curve of spine in area of rib cage			Hip higher than other side
		Waist to arm space greater			Other:

\_\_\_\_\_ Rounded back                      \_\_\_\_\_ Uneven on bend test by \_\_\_\_\_ degrees

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

<p><b>Physical Examination Report</b></p> <p>Diagnosis: _____</p> <p>Recommendation:</p> <p>___ No treatment</p> <p>___ Observation only                      Follow-up appointment scheduled (date): _____</p> <p><u>Treatment</u></p> <p>Describe: _____</p> <p>Activity limitations: _____</p> <p>Additional</p> <p>Comments: _____</p> <p>Doctor's Signature/stamp: _____ Date: _____</p> <p>Doctor's Mailing Address/Phone: _____</p>	
<p><b>For School Use:</b></p> <p>Form completed and returned (name/date): _____</p> <p>Form not returned (reason): _____</p>	

## **UTAH LAW**

53A-11-201. Rules for examinations prescribed by Department of Health -- Notification of impairment.

- (1) (a) Each local school board shall implement rules as prescribed by the Department of Health for vision, dental, abnormal spinal curvature, and hearing examinations of students attending the district's schools.
  - (b) Under guidelines of the Department of Health, qualified health professionals shall provide instructions, equipment, and materials for conducting the examinations.
  - (c) The rules shall include exemption provisions for students whose parents or guardians contend the examinations violate their personal beliefs.
- (2) The school shall notify, in writing, a student's parent or guardian of any impairment disclosed by the examinations.

53A-11-202. Personnel to perform health examination.

A local school board may use teachers or licensed registered nurses to conduct examinations required under this chapter and licensed physicians as needed for medical consultation related to those examinations.

## DEFINITIONS

**Abnormal spinal curvature:** an anatomic, structural deviation from the normal spine curve, such as scoliosis, kyphosis, or lordosis.

**Cervical spine:** neck portion of the spine

**Forward Bend Test:** procedure used to assess the possible presence of abnormal spinal curvature (also known as the Adams Forward Bend Test).

**Idiopathic:** a condition with no known cause.

**Kyphosis:** abnormally increased roundness in the spine of the upper back as viewed from the side; also known as round back, hunchback, or humpback.

**Lordosis:** abnormally increased curvature in the spine of the lower back as viewed from the side; also known as sway back.

**Lumbar spine:** portion of the spine in the small of the back, or lower back.

**Scoliometer:** an apparatus for measuring the clinical deformity of patients with scoliosis.

**Screening:** a test or procedure to determine the need for a professional diagnostic examination.

**Thoracic spine:** the chest area or upper part of the spine.

## **RESOURCES**

Scoliometers can be obtained from most school supply companies.

Shriners Hospitals for Children – Salt Lake City

<http://www.shrinershospitalsforchildren.org/en/Locations/saltlakecity>

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These guidelines were written in conjunction with UCA 53A-11-201 and replace previous guidelines from 2009.



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Revised  
2017

# Utah Guidelines for Administration of Seizure Rescue Medication

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UTAH GUIDELINES FOR ADMINISTRATION OF  
SEIZURE RESCUE MEDICATION

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## General Guidelines for Administration of Seizure Rescue Medication

### INTRODUCTION

The purpose of this Guide is to assist school personnel in ensuring a safe learning environment for students with epilepsy. This Guide will assist school personnel with the management, response and administration of seizure rescue medication under certain conditions to students with epileptic seizures. Epilepsy can be a life-threatening condition. Some people with epilepsy are at special risk for abnormally prolonged seizures called status epilepticus.

Senate Bill (SB) 232 (2016 General Session) pertains to the administration of seizure rescue medication by trained volunteer nonmedical school personnel, codified in Utah Code section UCA 53A-11-603.5, which authorizes public school employee volunteers to be trained to administer a seizure rescue medication under certain conditions, upon request of a parent or guardian.

Disclaimer: the Utah Department of Health (UDOH) has developed this training in conjunction with input from the Utah State Board of Education, Primary Children's Hospital, and several other stakeholders. If the trainer or volunteer modifies the training program or application in any way they may not be protected from legal action.

Pursuant to UCA 53A-11-603.5, a student's parent or legal guardian can request that the public school identify and train school employees who are willing to volunteer to receive training to administer a seizure rescue medication. If the school receives a qualified request from a parent or guardian, meaning one that meets the conditions set forth in Senate Bill 232, the school must attempt to recruit for and subsequently provide the school employee volunteer with medical training from a licensed health care professional such as a physician, physician assistant, school nurse, registered nurse, or certificated public health nurse, who has been approved to do the training set up per UCA 53A-11-603.5. It is imperative that this solicitation not be a factor in any employee's condition of employment. This is strictly on a volunteer basis and must be presented as such. Until the school finds an employee to function in this trained volunteer capacity or if for any reason the trained person is unavailable, and the need for seizure rescue medication arises, the school will follow the health care plan, excepting the administration of the medication, and call 911 and school first responders.

#### Points from the law:

- The student's parent or guardian must have previously administered the student's seizure rescue medication in a non-medically supervised setting without a complication.
- The student must have previously ceased having a full body prolonged convulsive seizure.
- Trained school employee volunteer must be 18 years or older, complete this training program, demonstrate competency, and complete refresher training.
- The student's parent or guardian and 911 must be called if medication is administered at school.

- The school cannot compel a school employee to become a trained school employee volunteer

School districts must have a plan to:

- Identify existing staff within the district or region who could be trained in the administration of a seizure rescue medication and would be available to respond to an emergency need to administer the seizure rescue medication.
- Identify students whose parent or guardian have requested seizure rescue medication be available at school.
- Maintain a Seizure Medication Management Order (SMMO) and an Individualized Healthcare Plan (IHP) from the student's health care practitioner authorizing the administration of the seizure rescue medication. A Section 504 Accommodation Plan or Individualized Education Plan (IEP) may also be necessary.
- Require a parent or guardian to notify the school if the student has had any seizure rescue medication administered within the past four hours on a school day.
- Notify the parent or guardian that a seizure rescue medication has been administered at school.

## **STANDARD PROCEDURES**

The school nurse must always be notified if any seizure rescue medication is brought to the school. Before any seizure rescue medication can be administered or stored at school, there must be a current IHP and Seizure Medication Management Order signed by physician and parent submitted to the school (as per district or school policy). A Section 504 Accommodation Plan or IEP may also be necessary. The school nurse should review these forms to ensure they are complete.

- It is the responsibility of the parent/guardian to ensure that the proper forms (as required by district/school policy) are submitted to the school, and that the forms have the required signatures from the prescriber and parent or guardian.
- All seizure rescue medication must be locked up, but easily accessible for use during a seizure. The exact location of the locked medication can be determined by the school, after evaluating the student-specific situation (i.e. office or classroom).
- General protocol for seizure rescue medication is that it be given if seizure lasts 5 minutes or longer. Trained school employee volunteers may only give seizure rescue medication for generalized tonic-clonic type seizures (full body prolonged or full body convulsive seizures). For any other type of seizure, rescue medication can only be given by a registered nurse, parent, or Emergency Medical Services (EMS). See IHP for information on student specific instructions.
- Seizure rescue medication cannot be administered as a first dose at school, and it cannot be given if it is the first dose after a dosage change (will be treated as a first dose).
- A change in medication will be handled the same way and may not be administered if the new dose has not already been given as described above.

- In the case of a dosage change, new paperwork reflecting the change must be filled out and signed appropriately and reviewed by the school nurse. The school employee volunteer will be trained regarding the change in dosage and any paperwork with old dosage information must be removed and replaced with new paperwork. Parent or guardian must bring the updated medication with appropriate dose and label to the school.
- Seizure rescue medication must come fully assembled and labeled with the student's name and dosage. Any medication not received as described above must be returned to the parent or guardian. Parent or guardian must transport the medication to and from school. Medication cannot be carried by the student.
- The student's parent or legal guardian must have previously administered the student's seizure rescue medication in a non-medically supervised setting without a complication.
- The student must have previously ceased having full body prolonged or full body convulsive seizure activity as a result of receiving the seizure rescue medication.
- Parent or guardian, school nurse, and 911 must ALWAYS be called if seizure rescue medication is administered at school. The school administrator must also be notified.
- If a school employee volunteer has not or cannot be identified at a school with an order for seizure rescue medication, it cannot be given except by parent or guardian, registered nurse if available, or EMS.
- If oxygen is ordered by the physician, the parent or guardian must provide all the equipment necessary, including a medication authorization signed by parent or guardian and physician, along with a safe storage mechanism. Parent or guardian is responsible for maintaining oxygen. The school does not provide oxygen, nor are they required to provide oxygen. .
- Students given seizure rescue medication may not remain at school after the seizure unless the student's parent or guardian can be present to monitor the student for adverse reactions. Trained school employee volunteers can only monitor until parent or guardian, EMS arrive. If parent or guardian want the student to remain in school after receiving seizure rescue medication, the parent or guardian will have to stay with the student at school.
- The student cannot be excluded from attending a field trip, or before or after school activity because of the need for seizure rescue medication.
- Each school should develop protocols on contacting the trained school employee volunteer immediately if the student with the seizure rescue medication has a seizure at school. The trained school employee volunteer must be allowed to leave their current location immediately to attend to the needs of the student having a seizure. If no trained employee is available to give the medication, it will not be given and the school will call 911 and the school's first responders.

Solicitation for trained school employee volunteers:

Schools that receive a qualified request for a school employee volunteer to administer a seizure rescue medication to a student shall solicit volunteers. It is imperative that this solicitation not be a factor in an existing employee's condition of employment. This is strictly on a volunteer basis and must be presented as such. If the school is unable to find an employee to function in

this trained school employee volunteer capacity or the trained school employee volunteer is unavailable, and the need for seizure rescue medication arises, the school will follow the health care plan, excepting the administration of the medication, and call 911, school first responders, and parents.

- Each school should develop protocols on how to find a school employee volunteer, such as an email to all staff, or a general announcement at a staff meeting. No potential school employee volunteer should be coerced.
- The school and parent or guardian cannot solicit trained school employee volunteers other than as described above.
- The request for a trained school employee volunteer should include the expected time required to complete the training, and information regarding the need for the trained school employee volunteer to attend field trips with the student.
- Each school should provide a description of the training the school employee volunteer will receive.
- Each school should provide a description of the voluntary nature of the trained school employee volunteer program.
- No person (school staff, parent or guardian, etc.) may coerce, intimidate, or threaten staff regarding their decision to take or not to take this trained school employee volunteer position.
- Each school that has an order for seizure rescue medication should attempt to find at least three school employee volunteers in the event of staff absence.

#### Training for school employee volunteers

School employee volunteer must be informed of the following:

- Trained school employee volunteers should be first aid/CPR trained, including giving rescue breaths if the student stops breathing.
- The school cannot force someone to be a trained school employee volunteer.
- Training must be documented with training date and signature of both the trainer and school employee volunteer.
- The agreement to administer a seizure rescue medication is voluntary
- The school employee volunteer will not administer a seizure rescue medication until they have completed the required training and documentation of completion is recorded.
- Trained school employee volunteer may withdraw from the agreement at any time.
- The trained school employee volunteer should be paid at least their hourly rate for any training related to the seizure rescue medication. If a trained school employee volunteer is required to work beyond their normally scheduled hours in this capacity, they should also be paid at least their hourly rate.
- The trained school employee volunteer must review administration procedures with the school nurse at least quarterly.
- All required training materials should be maintained at the school where there is an order for seizure rescue medication.
- If a trained school employee volunteer gives the rescue seizure medication it must be reported to the school administrator.

- Schools should make every effort for a trained school employee volunteer to go on field trips if there is a need for them to serve in their capacity on the field trip. If a parent or guardian chooses to go instead, that parent or guardian should not be charged a participation fee.
- If the parent or guardian cannot attend a school sponsored overnight trip, the school should make every effort to have a trained school employee volunteer accompany the student.
- A trained school employee volunteer who administers a seizure rescue medication in accordance with UCA 52A-11-603.5 in good faith is not liable in a civil or criminal action for an act taken or not taken.

Training content:

The training provided by an authorized licensed healthcare professional must be provided in accordance with the seizure rescue medication manufacturer's instructions, the student's healthcare provider, and in accordance with UCA 52A-11-603.5. The training shall include, but not be limited to, *all* of the following:

- Recognition and treatment of different types of seizures, including techniques to recognize symptoms that warrant the administration of a seizure rescue medication.
- Procedures for the administration of commonly prescribed seizure rescue medication.
- Basic emergency follow-up procedures, including a requirement for the school administrator or another school staff member to call 911 and the school nurse (if available), and to contact the student's parent or guardian.
- Calling 911 shall not require a student to be transported to an emergency room unless the parent or guardian is not available.
- Techniques and procedures to ensure student privacy.
- Standards and procedures for the storage of a seizure rescue medication.
- An assessment to determine if the trained school employee volunteer is competent to administer a seizure rescue medication.
- Record-keeping and record retention, including documenting each time a seizure rescue medication is administered, the student's name, the name of the medication administered, the dose given, the date and time of administration, the length of the seizure, and observation and action taken after the seizure.
- A refresher component - school nurse should follow up with the trained school employee volunteer at least quarterly to determine if additional training is needed.

## FIRST AID FOR SEIZURES

### General care for all types of seizures

There are many types of seizures, and most seizures end in a few minutes. These are general steps to help someone who is having any type of seizure.

- Stay with the person until the seizure ends and he or she is fully awake.
- When the seizure ends, help the person sit in a safe place.
- Once they are alert and able to communicate, tell them what happened in very simple terms.
- Comfort the person and speak calmly.
- Check to see if the person is wearing a medical bracelet or other emergency information.
- Keep yourself and other people calm.
- If this is a student, check to see if there is a health care plan for more information.

### Seizures Requiring First Aid

The types of seizures that might require first aid are: tonic clonic, complex partial, which may generalize, status epilepticus or prolonged seizures, and clusters of seizures. Seizures that do not generally need first aid but should be monitored and reported are: absence, infantile spasms, atonic, or myoclonic. Call 911 if a seizure lasts more than 5 minutes or if the person gets injured during the seizure.

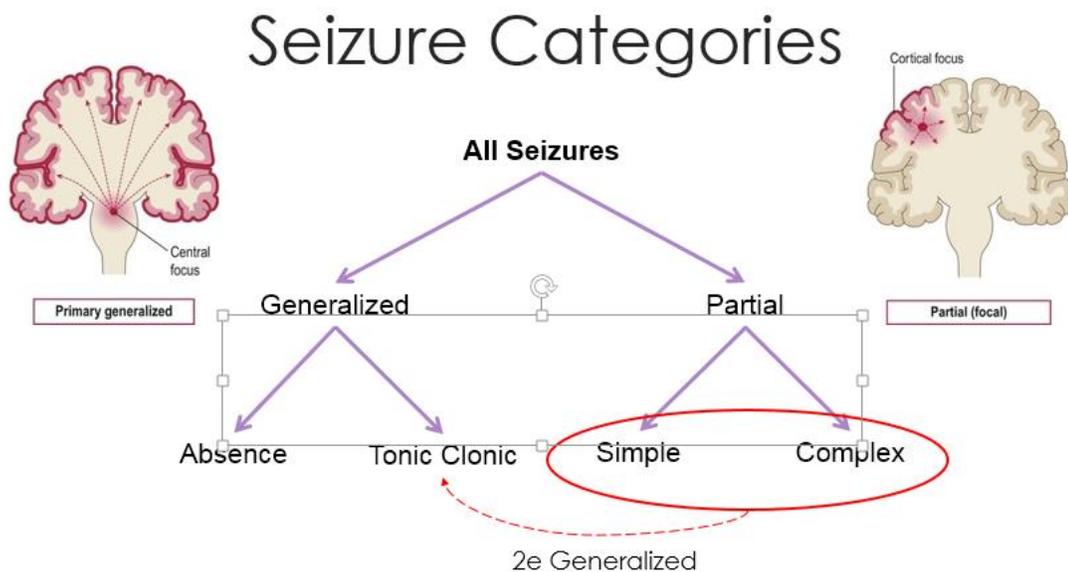


Figure 1. Seizure categories. This figure illustrates the differing categories of seizures. Reprinted from “Seizure 101”, by K. Orton, 2016.

Here are things you can do to help someone who is having a generalized tonic-clonic seizure:

- Ease the person to the floor.
- Turn the person gently onto their side, this will help the person breathe and prevent aspiration if they vomit -- which is common.
- Ensure the child's airway is not obstructed.
- Clear the area around the person of anything hard or sharp to help prevent injury.
- Put something soft and flat, like a folded jacket, under the head.
- Remove eyeglasses.
- Loosen ties or anything around the neck that may make it hard to breathe.
- Time the seizure.
- Have someone call 911, and then parents if the seizure lasts longer than 5 minutes.
- Administer seizure rescue medication if authorized and trained school employee volunteer is available.

Call 911 if

- The person has never had a seizure before.
- The person has difficulty breathing or waking after the seizure.
- The seizure lasts longer than 5 minutes.
- The person has another seizure soon after the first one.
- The person is seriously hurt during the seizure.
- The seizure happens in water.
- The person has a health condition like diabetes, heart disease, or is pregnant.

First aid for seizures involves keeping the person safe until the seizure stops and observing them afterwards.

STARR

**S – SAFETY:** Make the area safe, clear hazardous objects and minimize the number of people in the area. Put something soft under the person's head if possible.

**T -- TIME:** Time how long the seizure lasts (at 5 minutes administer the seizure rescue medication if ordered, or follow IHP/SMMO for student specific time), 98% of seizures end before 5 minutes.

**A -- ACT CALMLY:** You set the tone of the emergency, keep your cool so you can help the person who is having the seizure.

**R – RECOVERY POSITION:** Once the seizure has stopped, place the person in the recovery position. Stay with the person until they are conscious, breathing, and recovered.

**R -- RECORD and REPORT:** record in the seizure log what took place, and report to the school nurse and 911 all observations.



What NOT to do during a seizure

Knowing what **NOT** to do is important for keeping a person safe during and after a seizure.

**NEVER DO** any of the following things:

- Do **not** hold the person down or try to stop his or her movements.
- Do **not** put anything in the person's mouth, this can injure teeth or the jaw; a person having a seizure cannot swallow his or her tongue.
- CPR is not necessary **during a seizure**. **If breathing does not resume** or stops after a seizure, follow the protocol for CPR/AED for the person's age, including calling 911.
- Do **not** offer the person water or food until fully alert.

Medication Guidelines

Medication Route	Specifics	Supplies
<b>Intranasal Medication Guidelines:</b>	<ul style="list-style-type: none"> <li>• Midazolam can be stored at room temperature in a light sensitive bag (dark in color), expiration in about 6 months from when it was dispensed by pharmacist.</li> </ul>	Seizure emergency action plan Documentation log Atomizer Prescribed medication Gloves
<b>Rectal Medication Guidelines:</b>	<ul style="list-style-type: none"> <li>• The correct dose of rectal diazepam ordered by the health care provider must be locked into place on the device by the dispensing pharmacist. This is evident when the green READY is visible.</li> <li>• Be sure to check expiration date on the medication package.</li> </ul>	Seizure emergency action plan Documentation log Rectal diazepam medication kit (Diastat®) Gloves Lubricant Blanket or pillowcase as barrier
<b>Other types/routes of medication:</b>	<ul style="list-style-type: none"> <li>• For any medication other than those listed above, call Primary Children's Hospital Neuro Nurse Specialist (801-213-3599) for more information.</li> </ul>	

## DEFINITIONS

Atomizer: a device for reducing liquids to a fine spray.

Emergency Care Plan (ECP): a written document which guides actions during an emergency. For our purposes, this document gives guidance for actions to be taken for a specific student having a seizure at school. An IHP may also be necessary.

Full body prolonged convulsive seizure: this terminology is used in UCA 53A-11-603.5 as those seizures where seizure rescue medication can be administered. For purposes of this training these are defined as generalized tonic-clonic seizures.

Generalized tonic-clonic seizure: a seizure where the person loses consciousness, muscles stiffen, and jerking movements are seen. These types of seizures usually last one to three minutes, if they last more than five minutes, is a medical emergency.

Individualized Education Plan (IEP): a plan or program developed to ensure that a child who has a disability identified under the law attending school receives specialized instruction and related services.

Individual Healthcare Plan (IHP): a plan developed by the registered school nurse for a student with a medical condition that may interfere with their ability to learn. These are done for students who require complex health services on a daily basis or have a medical condition that could result in a health crisis. An EAP may also be necessary.

Non-medically supervised setting: this refers to any setting outside a hospital or clinic where there are no medical professional available to respond in the event of an emergency, such as a home or school.

Section 504 Plan: a federal law that protects students with disabilities from being discriminated against at school. It requires the school to make “reasonable” accommodations for all students, even those without and IEP.

Seizure Medication Management Order (SMMO): this is the form created by the team that developed this training, that is taken to the prescribing provider to authorize the use of a seizure rescue medication at school in the event of a full-body prolonged convulsive seizure during school hours. This form specifies the student to be given the medication, and under what circumstances the medication can be given. This form must be signed by the prescribing provider and parent to be valid, and must be re-signed and re-submitted to the school each year.

Status Epilepticus: this occurs when a seizure lasts too long or when seizures occur close together and the person doesn’t recover between seizures. Status epilepticus is dangerous and can lead to brain injury or even death. Seizure rescue medication can often decrease the chance of a student progressing into status epilepticus.



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**APPENDIX A – Seizure Medication Management Order (SMMO)**

<b>SEIZURE Medication/Management Orders (SMMO)</b> Utah Department of Health/Utah State Board of Education In Accordance with UCA 53A-11-603.5		<b>PCH Pediatric          Neurology Clinic</b> 801-213-3599 Fax: 801-587-7539	<b>Other provider:</b>
<b>STUDENT INFORMATION</b>			
<b>Student:</b>	<b>DOB:</b>	<b>Grade:</b>	<b>School:</b>
<b>Parent:</b>	<b>Phone:</b>		<b>Email:</b>
<b>Physician:</b>	<b>Phone:</b>		<b>Fax:</b>
<b>School Nurse:</b>	<b>School Phone:</b>		<b>Fax:</b>
<b>SEIZURE INFORMATION</b>			
<b>Seizure Type/Description</b>		<b>Length</b>	<b>Frequency</b>
<input checked="" type="radio"/> If Seizures are full body tonic-clonic, rescue medication may be administered by a trained volunteer. <b>Seizures other than tonic-clonic, rescue medication can only be given by an RN, Parent or EMS.</b>			
<input type="checkbox"/> Yes <input type="checkbox"/> No Student has received a first dose of this medication in a non-medically-supervised setting without a complication. <b>If No, medication cannot be given by a trained volunteer. Can only be given by an RN, parent, or EMS.</b>			
<input type="checkbox"/> Yes <input type="checkbox"/> No Student has previously ceased having a full body prolonged or convulsive seizure as a result of receiving this medication. <b>If No, medication cannot be given by a trained volunteer. Can only be given by an RN, parent, or EMS.</b>			
<b>Parent: complete the above section, read and sign below, obtain signature from Health Care Provider, and return to school nurse.</b>			
As parent/guardian of the above named student, I give permission for my child's healthcare provider to share information with the school nurse for the completion of this order. I understand the information contained in this order will be shared with school staff on a need-to-know basis. It is the responsibility of the parent/guardian to notify the School Nurse of any change in the student's health status, care or medication order. If medication is ordered I authorize school staff to administer medication described below to my child. If prescription is changed a new SMMO must be completed before the school staff can administer the medication. Parents/Guardian are responsible for maintaining necessary supplies, medications and equipment.			
<b>Parent Signature:</b> _____		<b>Date:</b> _____	

Student Name:		DOB:		
<b>EMERGENCY SEIZURE RESCUE MEDICATION</b>				
To Be Completed by Prescriber - In accordance with these orders, an Individualized Health Care Plan (IHP) must be developed by the School Nurse and parent to be shared with appropriate school personnel, and cannot be shared with any individual outside of those public education employees without parental consent. As the student's LIP I confirm that the student has a diagnosis of seizures.				
Give Emergency Medication IF:	Medication	Dose	Route	Call
<ul style="list-style-type: none"> <li>If seizure lasts ___ minutes or greater</li> <li>If ___ or more consecutive seizures with or without a period of consciousness (in ___ minutes)</li> <li>Other _____</li> </ul>	<input type="checkbox"/> Midazolam (Versed) (Dose must be provided in 2 syringes)  <input type="checkbox"/> Diazepam (Diastat)  <input type="checkbox"/> Other _____	_____ mg  _____ ml	<input type="checkbox"/> Nasal <input type="checkbox"/> Rectal <input type="checkbox"/> Other	<b>ALWAYS call 911, parent and School Nurse</b>
<input type="checkbox"/> This medication is necessary during the school day. Trained personnel should and will be allowed to administer this medication.				
Common potential side effects: respiratory depression, nasal irritation, memory loss, drowsiness, other:				
Additional instructions for administration:				
<b>VAGUS NERVE STIMULATOR</b>				
<input type="checkbox"/> This student has a Vagus Nerve Stimulator. Trained personnel should and will be trained on magnet use. Describe magnet use:				
<b>PRESCRIBER SIGNATURE</b>				
This order can only be signed by an MD/DO; Nurse Practitioner, Certified Physician's Assistant or a provider with prescriptive practice.				
Prescriber Name: _____		Phone: _____		
Prescriber Signature: _____		Date: _____		
School Nurse Signature: _____		Date: _____		

**APPENDIX B – Seizure Individualized Healthcare Plan (IHP)**

<b>SEIZURE Individualized Healthcare Plan (IHP) Emergency Care Plan (ECP)</b>			School Year:	Picture
			<b>SMMO</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>STUDENT INFORMATION</b>				
Student:	DOB:	Grade:	School:	
Parent:	Phone:		Email:	
Physician:	Phone:		Fax:	
School Nurse:	School Phone:		Fax:	
History:				
<b>SEIZURE INFORMATION</b>				
<b>Seizure Type/Description</b>		<b>Length</b>	<b>Frequency</b>	
Seizure triggers or warning signs:				
Student's reaction to seizure:				
<b>SPECIAL CONSIDERATIONS</b>				
Special considerations and precautions (regarding school activities, field trips, sports, etc):				
<b>EMERGENCY SEIZURE RESCUE MEDICATION (See SMMO)</b>				
Person to give seizure rescue medication: <input type="checkbox"/> School Nurse <input type="checkbox"/> Parent <input type="checkbox"/> EMS <input type="checkbox"/> Volunteer(s) Specify:				
Attach volunteer(s) training documentation			<input type="checkbox"/> Other:	
Location of seizure rescue medication (must be locked):				
<b>VAGUS NERVE STIMULATOR (VNS) (See SMMO)</b>				
This student has a Vagus Nerve Stimulator: <input type="checkbox"/> Yes <input type="checkbox"/> No				
Location of magnet:				
Person(s) trained on magnet use: <input type="checkbox"/> School Nurse <input type="checkbox"/> Teacher <input type="checkbox"/> Aide <input type="checkbox"/> Volunteer(s) Specify:				
Attach volunteer(s) training documentation			<input type="checkbox"/> Other:	
Describe magnet use:				

Student Name: _____		DOB: _____	
<b>SEIZURE ACTION PLAN – Mark all behaviors that apply to student</b>			
<b>If you see this:</b>		<b>Do this:</b>	
<input type="checkbox"/> Sudden cry or squeal <input type="checkbox"/> Falling down <input type="checkbox"/> Rigidity/Stiffness <input type="checkbox"/> Thrashing/Jerking <input type="checkbox"/> Loss of bowel/bladder control <input type="checkbox"/> Shallow breathing <input type="checkbox"/> Stops breathing <input type="checkbox"/> Blue color to lips <input type="checkbox"/> Froth from mouth <input type="checkbox"/> Gurgling or grunting noises <input type="checkbox"/> Loss of consciousness <input type="checkbox"/> Staring <input type="checkbox"/> Lip smacking <input type="checkbox"/> Eye movement <input type="checkbox"/> Other: _____		<b>BASIC SEIZURE FIRST AID</b> <input type="checkbox"/> Stay calm & track time <input type="checkbox"/> Keep child safe <input type="checkbox"/> Do not restrain <input type="checkbox"/> Do not put anything in mouth <input type="checkbox"/> Stay with child until fully conscious <input type="checkbox"/> Protect head <input type="checkbox"/> Keep airway open/watch breathing <input type="checkbox"/> Turn child on side <input type="checkbox"/> Do not give fluids or food during or immediately after seizure	
<b>EMERGENCY SEIZURE PROTOCOL</b>		<b>Expected Behavior after Seizure</b>	
<input type="checkbox"/> Call 911 at _____ minutes for transport to: _____ <input type="checkbox"/> Call parent or emergency contact <input type="checkbox"/> Administer emergency medications as indicated on SMMO <input type="checkbox"/> Oxygen <input type="checkbox"/> Other _____  <b>A seizure is generally considered an emergency when:</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> Convulsive (tonic-clonic) seizure lasts longer than 5 minutes</li> <li><input type="checkbox"/> Student has repeated seizures with or without regaining consciousness</li> <li><input type="checkbox"/> Student is injured, pregnant or has diabetes</li> <li><input type="checkbox"/> Student has a first-time seizure</li> <li><input type="checkbox"/> Student has breathing difficulties</li> <li><input type="checkbox"/> Student has a seizure in water</li> </ul>		<input type="checkbox"/> Tiredness <input type="checkbox"/> Weakness <input type="checkbox"/> Sleeping, difficult to arouse <input type="checkbox"/> Somewhat confused <input type="checkbox"/> Regular breathing <input type="checkbox"/> Other: _____	
		<b>Follow-Up</b>	
		<input type="checkbox"/> Notify School Nurse <input type="checkbox"/> Document!	
<b>SIGNATURES</b>			
<p>As parent/guardian of the above named student, I give permission for my child's healthcare provider to share information with the school nurse for the completion of this plan of care. I understand the information contained in this plan will be shared with school staff on a need-to-know basis. It is the responsibility of the parent/guardian to notify the School Nurse of any change in the student's health status, care or medication order. If medication is ordered, I authorize school staff to administer medication described below to my child. If prescription is changed, a new SMMO must be completed before the school staff can administer the medication. Parents/Guardian are responsible for maintaining necessary supplies, medications and equipment.</p>			
Parent Signature: _____		Date: _____	
School Nurse Signature: _____		Date: _____	

**APPENDIX C – Medication Administration/Adverse Event Report**

 <p>UTAH DEPARTMENT OF <b>HEALTH</b> <small>The Healthiest Through Evidence-Based Policy and Improved Clinical Care. UDHHC</small></p>	<p><b>SEIZURE RESCUE MEDICATION</b> Administration/Adverse Event (AE) Report Form</p>	
<p>Please report any administration of seizure rescue medication in the schools. Data collected will be used for evaluation only, not for any punitive purposes. Please do not submit any personally identifying information on the student.</p> <p>Please report within 5 business days from the date the reporter became aware of administration, and report any Adverse Events which are determined to be possibly, probably, and definitely related to the administration of seizure rescue medication at school.</p>		
Location (School/District):		Date of administration:
Name and title of person making report:		
Phone of person making report:		
Email address of person making report:		
Description of student: <input type="checkbox"/> Male <input type="checkbox"/> Female Age:            Grade:		
<b>Medication</b>	<b>Route</b>	<b>Dose</b>
<input type="checkbox"/> Midazolam <input type="checkbox"/> Diazepam <input type="checkbox"/> Lorazepam <input type="checkbox"/> Other:	<input type="checkbox"/> Intranasal <input type="checkbox"/> Rectal <input type="checkbox"/> Oral <input type="checkbox"/> Feeding Tube <input type="checkbox"/> Other:	_____ ml _____ mg
Description of the medication administration:		
<p>Was there a staff member available certified in CPR and rescue breathing when medication was administered?</p> <input type="checkbox"/> Yes, person administering medication is CPR certified. <input type="checkbox"/> Yes, another person in the school is CPR certified and was available. <input type="checkbox"/> No (if No, please explain):		
<b>Outcome (check all that apply)</b>	<b>Adverse Event (AE)?</b>	<b>Action Taken for AE</b>
<input type="checkbox"/> 911 called <input type="checkbox"/> Seizure resolved <input type="checkbox"/> Ongoing/continuing treatment <input type="checkbox"/> Condition worsening (AE) <input type="checkbox"/> Respiratory depression (AE) <input type="checkbox"/> Death (AE) <input type="checkbox"/> Unknown <input type="checkbox"/> Other:	<input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please describe:	<input type="checkbox"/> None/Not applicable <input type="checkbox"/> CPR (with rescue breathing) <input type="checkbox"/> Dose modification <input type="checkbox"/> Medical intervention <input type="checkbox"/> Hospitalization <input type="checkbox"/> Medication discontinued <input type="checkbox"/> Medication changed <input type="checkbox"/> Other:
<p>Seizure Rescue Medication was administered by:</p> <input type="checkbox"/> School Employee Volunteer <input type="checkbox"/> Health Clerk <input type="checkbox"/> Aide <input type="checkbox"/> Licensed Practical Nurse (LPN) <input type="checkbox"/> School Nurse (RN) <input type="checkbox"/> Other (specify):		
<p>Had the person who administered the medication been trained by an authorized trainer?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No (if No, please explain):		
<p>What steps were taken to resolve any adverse event?</p>		

Please email completed report to [bhinkson@utah.gov](mailto:bhinkson@utah.gov). Call (801) 419-1078 with any questions.  
 Report can also be done online at: [https://healthutah.co1.qualtrics.com/ife/form/SV\\_0HVmXVHPtWkYaDr](https://healthutah.co1.qualtrics.com/ife/form/SV_0HVmXVHPtWkYaDr)



APPENDIX D – Volunteer Training & Competency Checklist

**School Employee Volunteer Competency Check List**  
Emergency Seizure Rescue Medication

VOLUNTEER TRAINING INFORMATION						
Name of Volunteer Trainee:			Position:			
Volunteer Phone:			Email:			
School Year:			School:			
Student:		Grade / Teacher:		Medication / Route:		
School Nurse or Licensed Trainer:		Phone:		E-mail:		
Volunteer Training						
CPR (with rescue breathing) and First Aid Certification - not required (but <b>HIGHLY recommended</b> ) if two or more other employees are trained as first responders at the school						
Seizure Recognition and First Aid Training Date:		Seizure Rescue Medication PPT Completion Date:	Seizure Rescue Medication Training Completion Date:		Seizure Rescue Medication Training Expiration Date:	
Seizure recognition / First-Aid Skills-Seizure Rescue Medication Administration				Supervision Follow-up and Evaluation		
				Date	Date	Date
1. Review the student's IHP and Section 504 or IEP plan (if applicable. Not all students will have a 504/IEP.)						
2. View/review training PPT and videos						
3. View/review Utah Guide for Administration of Seizure Rescue Medication						
4. View/review district/school medication policy						
5. Verbalization and demonstration of administration of Medication						
6. Passed Skills Competency <input type="checkbox"/> Intranasal <input type="checkbox"/> Rectal <input type="checkbox"/> Other:						
7. Discussion of potential problems and expected outcomes						
8. Identify symptoms of a prolonged seizure described in the student's Individualized Healthcare Plan (IHP), the type of emergency seizure rescue medication, and the time it is ordered to be given in the IHP <ul style="list-style-type: none"> <li>▪ When to call EMS (911)</li> <li>▪ When to administer the medication</li> </ul>						
9. Note time of seizure onset						
10. Confirm that the medication is appropriately labeled with student name, dosage, time to be given, and that it matches the physician orders on the Medication Administration Form						
11. Ensure that the medication has not expired and verbalizes expired medication cannot be given						
12. Verbalizes the Six Rights in medication administration*						
13. Demonstrates asking another school staff person to call EMS, get the AED, seizure rescue medication and notify parent / guardian and school nurse						

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	Date	Date	Date	Date	Date	Date
14. Demonstrates Gathering/Organizing Supplies						
15. Demonstrates Putting on Gloves						
16. DEMONSTRATE/ VERBALIZE HOW TO ADMINISTER MEDICATION AS DETAILED ON ATTACHED INDIVIDUAL MEDICATION INSTRUCTIONS						
17. Note time of medication administration						
18. After seizure is over: <ul style="list-style-type: none"> <li>• Demonstrates how to place student in the rescue position</li> <li>• Explains how to, and why it is important to stay with student, closely monitor breathing until parent / guardian, EMS or school nurse arrives</li> </ul>						
19. If student stops breathing or is only gasping, CALL 911, begin CPR ** (with rescue breathing) and send for the AED, or call staff member certified in CPR.						
20. Once EMS arrives, inform them which medication was administered, including dose and time given.						
21. Dispose of all used equipment and medication containers safely out of the reach of children.						
22. Remove gloves and wash hands.						
23. Document the date, time, dose of medication given on Medication Administration Form.						
24. Document any and all observations on the seizure log.						
25. Follow up with the parent/ guardian and school nurse.						
26. Special Considerations:						
<p>The Trained School Employee Volunteer has:</p> <ul style="list-style-type: none"> <li>• Reviewed the Individualized Healthcare Plan (IHP) and 504/IEP (if applicable) for the student(s) listed above.</li> <li>• Completed the required training program.</li> <li>• Demonstrated competency in the described skills for the student(s) listed above.</li> <li>• Understands the need to maintain skills and will be observed on an ongoing basis by the trainer.</li> <li>• Is willing to complete required refresher training to remain a trained school employee volunteer.</li> <li>• Has had the opportunity to ask questions and received satisfactory answers.</li> </ul>	<p>Medication Training has been completed for the following medication(s):</p> <p><input type="checkbox"/> Intranasal medication administration</p> <p><input type="checkbox"/> Rectal medication administration</p> <p><input type="checkbox"/> Other: _____</p>					
School Nurse/Licensed Trainers Name: _____	Signature: _____			Date: _____		
Volunteer Trainee Name/Position: _____	Signature / Initials: _____			Date: _____		
<b>* Six Rights in Medication Administration</b>	<b>** CPR (with rescue breathing) / AED</b>					
<ul style="list-style-type: none"> <li>• Right Student</li> <li>• Right Medication</li> <li>• Right Dose</li> <li>• Right Time</li> <li>• Right Route</li> <li>• Right Documentation</li> </ul>	<ul style="list-style-type: none"> <li>• If student stops breathing or is only gasping, CALL 911, begin CPR and use the AED.</li> <li>• Demonstrates CPR (with rescue breathing) and using the AED</li> <li>• Turn student onto back and recheck for breathing/responsiveness for no longer than 10 seconds (breathing, moving, gasping)</li> <li>• Performs 30 effective compressions</li> <li>• Opens airway using Head-tilt/Chin-lift, and gives 2 breaths using a mask that makes chest rise</li> <li>• Appropriately used the AED when it arrives</li> </ul>					

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INTRANASAL	SKILLS-Intranasal Medication Administration	Supervision Follow-up and Evaluation					
		Date	Date	Date	Date	Date	Date
	I. Gather medication and put on gloves.						
	II. Attach the atomizer tip to first syringe and twist into place.						
	III. Using your free hand to hold the crown of the head stable, place the tip of the atomizer snugly against the nostril aiming slightly up and outward.						
	IV. Quickly compress the syringe plunger to deliver all of the medication from the first syringe into the nostril.						
	V. Move the atomizer to the second syringe and place into opposite nostril and administer. <i>Must administer both doses even if seizure resolves.</i> a. The child may grimace or appear more restless momentarily after the medication is given.						
	VI. Remove gloves and wash hands						
	VII. Document medication administration on medication log.						

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RECTAL	SKILLS – Rectal Medication Administration	Supervision Follow-up and Evaluation					
		Date	Date	Date	Date	Date	Date
	I. Gather medication and put on gloves						
	II. Make sure the delivery device is in the “Ready” mode.						
	III. Push up on the cap with your thumb and pull to remove the cap from the syringe.						
	IV. Open the package of lubricant. Lubricate the tip by inserting it in the lubricating jelly.						
	V. Move the student to a side-lying position (facing volunteer) with the upper leg forward so the rectum is exposed.						
	VI. Using non-dominant hand, reach over student’s body, separate the buttocks to expose the rectum.						
	VII. Using dominant hand, gently insert the syringe into the rectum until the rim is snug against the rectal opening.						
	• Push the plunger in slowly counting to three until the plunger stops.						
	• Hold the syringe in place after inserting the medication and count to three.						
	• Remove the syringe from rectum.						
	• Immediately hold the buttocks together and count to three again. This helps keep the medication from leaking out.						
	VIII. Keep the student on his or her side.						
	IX. Keep blanket, pillowcase, or other barrier in place to provide privacy for the student.						
	X. Remove gloves and wash hands.						
	XI. Document medication administration on medication log.						

# APPENDIX E – Intranasal Medication Training

8/24/2016

**Training for School Personnel in Administration of Seizure Rescue Medication: Intranasal Administration**

Developed in accordance to UCA 33A-11-403.3 by the Utah Seizure Rescue Medication Task Force. A collaborative effort between:

Utah State Department of Health  
Utah State Board of Education  
PCH Neurology Department  
And other stakeholders

The school nurse, school administration and parent/s must have the following in place before seizure rescue medication can be given in school.

- District/School Policy
- Signed seizure medication management order (SMMO)
- Approved medication
- An Individualized Healthcare Plan (IHP)
- Locked storage for medication
- Volunteer training
- Staff trained in rescue breathing/CPR.

See UDOH "Seizure Rescue Medication Guidelines"

**This training is designed to:**

- Provide consistent, state approved training in the administration of seizure rescue medication in a school setting.
- Assist licensed medical professionals in training unlicensed assistive personnel to administer seizure rescue medication to a student at school for whom it has been prescribed.
- Provide one component of a state approved seizure rescue medication administration training to be used in conjunction with a school nurse lead competency evaluation.

This training describes general guidelines; the Individualized Healthcare Plan (IHP) and the school nurse will describe a student's:

- Type and signs of seizure/s
- Prescribed medication
- Proper dose and route
- When to call 911 and parent
- Protocol for AED/CPR

**Seizure: Electrical disturbance in the brain**

- Most seizures stop without intervention and do not cause any injury.
- Some seizures do not stop on their own and without intervention, can lead to permanent brain damage.
- Treatment may require administration of emergency seizure rescue medication as prescribed by a medical doctor.
- In the case that a student at school needs these medications, certain standards should be followed.

A student at your school has a seizure disorder and has been prescribed **INTRANASAL MEDICATION**

- Intranasal medication is given as an aerosol spray into the nose.
- It comes in 2 (two) prefilled syringes
- Must be accompanied by an atomizer
- Should be stored in light sensitive bag

**FOLLOW HEALTHCARE PLAN**  
*At onset of seizure symptoms:*

**First Aid for Seizures**  
See Management Section and all other IHPs.

- Time length of seizure.
- Follow seizure first aid.
- Act calm.
- Respect student's privacy.
- If seizure ceases before allotted time to give medication, allow student to recover, and notify parent.



**Administration of Intranasal Medication (continued)**

4. Position atomizer snugly into one of the student's nostrils ensuring it occludes the entire nostril.
5. Quickly push plunger to empty entire contents of syringe into student's nostril.
6. Remove atomizer and put it on the other syringe.
7. Empty entire contents of second syringe into other nostril.



**If student meets requirements for administration of seizure rescue medication**

Follow IHP by:

- Retrieving appropriate medication
- Check that it is for the right student
- Check that it is the right time to give medication
- Have someone call 911 and parents




**Administration of Intranasal Medication**

1. Put on gloves.
2. Remove syringes from storage bag.
3. Remove cap from one syringe and put the atomizer on the syringe by twisting it into place.



**After administration of any seizure rescue medication and while waiting for EMS:**

- Follow student's healthcare plan (IHP).
- Assure student is laying on their side (recovery position).
- Monitor student's seizure activity.
- Monitor student's breathing.



***If Breathing Doesn't Resume After Seizure***

Follow healthcare plan and:

- Call for AED (Automatic External Defibrillator).
- Have trained staff perform CPR with rescue breaths.
- Place AED if and when available.



***When EMS arrives***

- If possible, send a copy of healthcare plan including parent contact info with EMS.
- Send any empty syringes or containers of medication with EMS.
- Report events before, during and after seizure medication was administered.
- Document events.



**Thank You for Viewing Seizure Rescue Medication Training PowerPoint and Video**





**Training for School Personnel in Administration of Seizure Rescue Medication: Rectal Administration**

Developed in accordance to UCA 33A-1-403.5 by the Utah Seizure Rescue Medication Task Force. A collaborative effort between:

- Utah State Department of Health
- Utah State Board of Education
- PCN Neurology Department
- And other stakeholders

**This training is designed to:**

- Provide consistent, state approved training in the administration of seizure rescue medication in a school setting.
- Assist licensed medical professionals in training unlicensed assistive personnel to administer seizure rescue medication to a student at school for whom it has been prescribed.
- Provide one component of a state approved seizure rescue medication administration training to be used in conjunction with a school nurse lead competency evaluation.

**Seizure: Electrical disturbance in the brain**

- Most seizures stop without intervention and do not cause any injury.
- Some seizures do not stop on their own and without intervention, can lead to permanent brain damage.
- Treatment may require administration of emergency seizure rescue medication as prescribed by a medical doctor.
- In the case that a student at school needs these medications, certain standards should be followed.

The school nurse, school administration and parent/s must have the following in place before seizure rescue medication can be given in school.

- District/School Policy
- Signed seizure medication management order (SMMO)
- Approved medication
- An Individualized Healthcare Plan (IHP)
- Locked storage for medication
- Volunteer training
- Staff trained in rescue breathing/CPR.

See UDOH "Seizure Rescue Medication Guidelines"

This training describes general guidelines; the Individualized Healthcare Plan (IHP) and the school nurse will describe a student's:

- Type and signs of seizure/s
- Prescribed medication
- Proper dose and route
- When to call 911 and parent
- Protocol for AED/CPR

**A student at your school has a seizure disorder and has been prescribed A RECTAL MEDICATION**

- Some seizure rescue medication is to be given rectally.
- It comes in a prefilled syringe.
- The dose must be dialed and locked by the pharmacist.
- The dose is displayed in a window on the syringe.
- A green "ready" band must be visible.
- Lubricating jelly should accompany the medication.

Green "Ready" Band (Always Green) (Always Locked)

**FOLLOW HEALTHCARE PLAN**  
At onset of seizure symptoms:

- Time length of seizure.
- Follow seizure first aid.
- Act calm.
- Respect student's privacy.
- If seizure ceases before allotted time to give medication, allow student to recover, and notify parent.

**First Aid for Seizures**  
Do not restrain, do not put anything in the mouth, do not give anything to eat or drink.

**If student meets requirements for administration of seizure rescue medication**

Follow IHP by:

- Retrieving appropriate medication
- Check that it is for the right student
- Check that it is the right time to give medication
- Have someone call 911 and parents

**ADMINISTRATION OF RECTAL MEDICATION PROCEDURE**  
**PUT GLOVES ON, then:**

**SLOWLY ... COUNT OUT LOUD TO THREE... 1...2...3**



**After administration of any seizure rescue medication and while waiting for EMS:**

- Follow student's healthcare plan (IHP).
- Assure student is laying on their side (recovery position).
- Monitor student's seizure activity.
- Monitor student's breathing.

**If Breathing Doesn't Resume After Seizure**

Follow healthcare plan and:

- Call for AED (Automatic External Defibrillator).
- Have trained staff perform CPR with rescue breaths.
- Place AED if and when available.



**When EMS arrives**

- If possible, send a copy of healthcare plan including parent contact info with EMS.
- Send any empty syringes or containers of medication with EMS.
- Report events before, during and after seizure medication was administered.
- Document events.



**Thank You for Viewing Seizure Rescue Medication Training PowerPoint and Video**









## FIRST AID FOR SEIZURES AT SCHOOL

### FOR ALL TYPES OF SEIZURES

- Prevent Injury
- Time seizure
- Stay with the person until seizure ends and person fully awake.
- After the seizure tell them what happened in simple terms.
- Calm yourself and others
- Check to see if there is a medical bracelet.
- Follow student's individualized healthcare plan (IHP)

### FOR CONVULSIVE SEIZURES

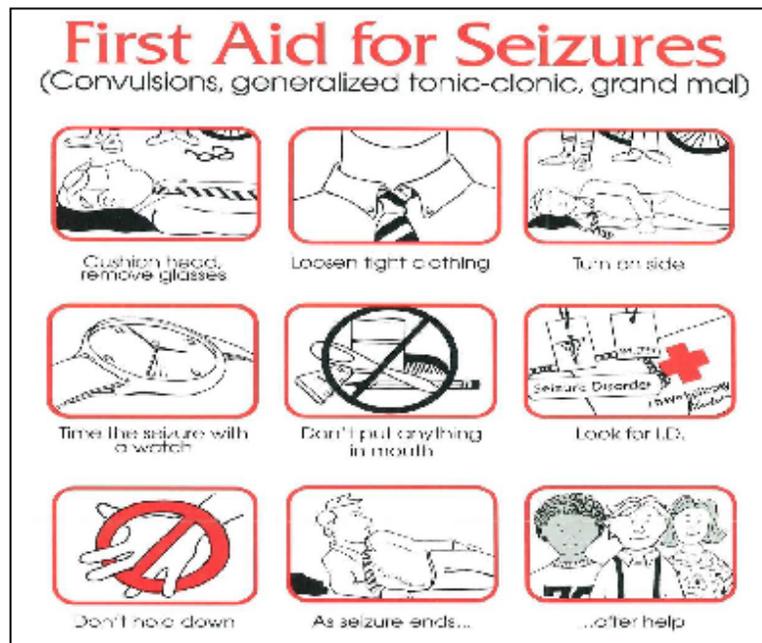
- Follow poster tips and:
- Remove nearby objects that may cause injury
- Remove eyeglasses
- May need to ease the person to the ground
- Time seizure
- Follow health provider's orders for administering emergency rescue medications (usually after 5 minutes). Inform parents and nurse.

### CALL 911 IF

- Rescue medications are given
- Seizures start again soon after ending
- Seizure lasts longer than 5 minutes (or sooner as per student IHP)
- No known history of seizures
- The person has a health condition like diabetes (consider diabetic first aid) or heart disease or pregnancy

### AFTER THE SEIZURE

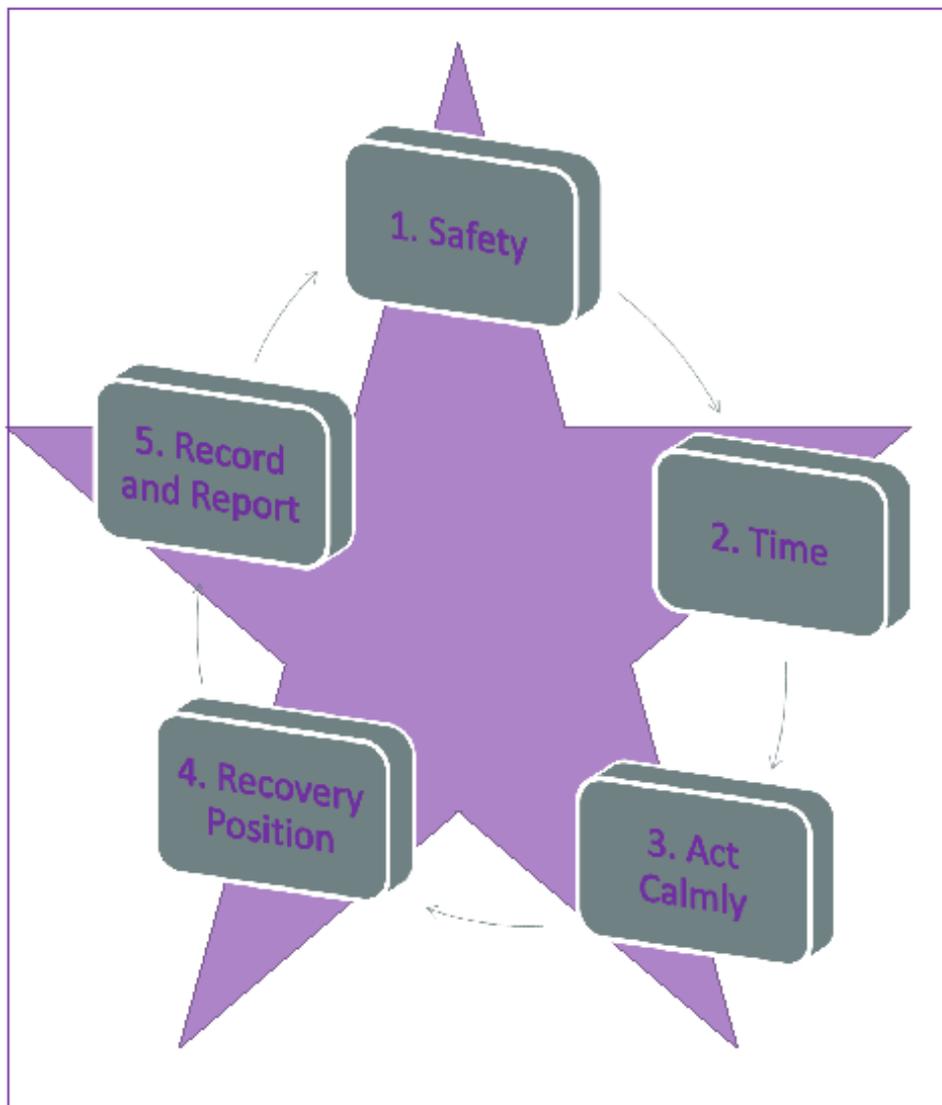
- Place in side-lying recovery position.
- CPR is not necessary during a seizure. If breathing does not resume or stops after a seizure, CALL 911 and follow the protocol for AED/CPR (with rescue breathing) for the person's age



UDOH 7/26/17

## To help during a seizure think STARR

1. **Safety** – Make the area safe. Clear hazards and people, place something soft under the head, call 911 if no history of seizures.
2. **Time** – Time how long the seizure lasts. Take extra steps after 5 minutes (or follow IHP) such as administering rescue medication and calling 911.
3. **Act Calmly** – You set the tone of the emergency!
4. **Recovery Position** – After seizure place the person on their side in the recovery position.
5. **Record and Report** – Record details on seizure log, and report observations to school nurse.





**CERTIFICATE** *Of* **COMPLETION**

---

This recipient has completed the online training for seizure rescue medication. Recipient must meet with the school nurse or other qualified trainer to complete the hands-on portion, the post test, and have certificate signed.

**SEIZURE RESCUE MEDICATION TRAINING**

SIGNED BY  
(TRAINING RN): \_\_\_\_\_

DATE: \_\_\_\_\_



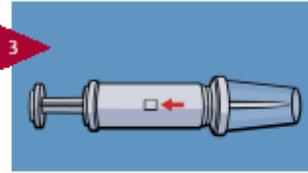
## CHILD ADMINISTRATION INSTRUCTIONS



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.

**SLOWLY... COUNT OUT LOUD TO THREE...1...2...3**



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



11 Slowly count to 3 before removing syringe from rectum.



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

**ONCE DIASTAT® IS GIVEN**



13

Keep person on the side facing you, note time given, and continue to observe.

**DIASTAT® Indication**

DIASTAT® AcuDial™ (diazepam rectal gel) is a gel formulation of diazepam intended for rectal administration in the management of selected, refractory patients with epilepsy, on stable regimens of AEDs, who require intermittent use of diazepam to control bouts of increased seizure activity, for patients 2 years and older.

**Important Safety Information**

In clinical trials with DIASTAT®, the most frequent adverse event was somnolence (23%). Less frequent adverse events reported were dizziness, headache, pain, vasodilation, diarrhea, ataxia, euphoria, incoordination, asthma, rash, abdominal pain, nervousness, and rhinitis (1%–5%).

D955-0308

**CALL FOR HELP IF ANY OF THE FOLLOWING OCCUR**

- Seizure(s) continues 15 minutes after giving DIASTAT® or per the doctor's instructions:

- Seizure behavior is different from other episodes
- You are alarmed by the frequency or severity of the seizure(s)
- You are alarmed by the color or breathing of the person
- The person is having unusual or serious problems

Local emergency number: \_\_\_\_\_ Doctor's number: \_\_\_\_\_  
(Please be sure to note if your area has 911)

Information for emergency squad: Time DIASTAT® given: \_\_\_\_\_ Dose: \_\_\_\_\_

**Diastat**  
(diazepam rectal gel)

**Diastat AcuDial™**  
(diazepam rectal gel)

**DISPOSAL INSTRUCTIONS ON REVERSE SIDE**



## APPENDIX K – UCA 53A-11-603.5

Utah Code

*Effective 5/10/2016*

### **53A-11-603.5 Trained school employee volunteers -- Administration of seizure rescue medication -- Exemptions from liability.**

(1) As used in this section:

(a) "Prescribing health care professional" means:

- (i) a physician and surgeon licensed under Title 58, Chapter 67, Utah Medical Practice Act;
- (ii) an osteopathic physician and surgeon licensed under Title 58, Chapter 68, Utah Osteopathic Medical Practice Act;
- (iii) an advanced practice registered nurse licensed under Title 58, Chapter 31b, Nurse Practice Act; or
- (iv) a physician assistant licensed under Title 58, Chapter 70a, Physician Assistant Act.

(b) "Section 504 accommodation plan" means a plan developed pursuant to Section 504 of the Rehabilitation Act of 1973, as amended, to provide appropriate accommodations to an individual with a disability to ensure access to major life activities.

(c) "Seizure rescue authorization" means a student's Section 504 accommodation plan that:

(i) certifies that:

- (A) a prescribing health care professional has prescribed a seizure rescue medication for the student;
- (B) the student's parent or legal guardian has previously administered the student's seizure rescue medication in a nonmedically-supervised setting without a complication; and
- (C) the student has previously ceased having full body prolonged or convulsive seizure activity as a result of receiving the seizure rescue medication;

(ii) describes the specific seizure rescue medication authorized for the student, including the indicated dose, and instructions for administration;

(iii) requests that the student's public school identify and train school employees who are willing to volunteer to receive training to administer a seizure rescue medication in accordance with this section; and

(iv) authorizes a trained school employee volunteer to administer a seizure rescue medication in accordance with this section.

(d)

(i) "Seizure rescue medication" means a medication, prescribed by a prescribing health care professional, to be administered as described in a student's seizure rescue authorization, while the student experiences seizure activity.

(ii) A seizure rescue medication does not include a medication administered intravenously or intramuscularly.

(e) "Trained school employee volunteer" means an individual who:

(i) is an employee of a public school where at least one student has a seizure rescue authorization;

(ii) is at least 18 years old; and

(iii) as described in this section:

- (A) volunteers to receive training in the administration of a seizure rescue medication;
- (B) completes a training program described in this section;
- (C) demonstrates competency on an assessment; and
- (D) completes annual refresher training each year that the individual intends to remain a trained school employee volunteer.

(2)

- (a) The Department of Health shall, with input from the State Board of Education and a children's hospital, develop a training program for trained school employee volunteers in the administration of seizure rescue medications that includes:
  - (i) techniques to recognize symptoms that warrant the administration of a seizure rescue medication;
  - (ii) standards and procedures for the storage of a seizure rescue medication;
  - (iii) procedures, in addition to administering a seizure rescue medication, in the event that a student requires administration of the seizure rescue medication, including:
    - (A) calling 911; and
    - (B) contacting the student's parent or legal guardian;
  - (iv) an assessment to determine if an individual is competent to administer a seizure rescue medication;
  - (v) an annual refresher training component; and
  - (vi) written materials describing the information required under this Subsection (2)(a).
- (b) A public school shall retain for reference the written materials described in Subsection (2)(a)(vi).
- (c) The following individuals may provide the training described in Subsection (2)(a):
  - (i) a school nurse; or
  - (ii) a licensed health care professional.
- (3)
  - (a) A public school shall, after receiving a seizure rescue authorization:
    - (i) inform school employees of the opportunity to be a school employee volunteer; and
    - (ii) subject to Subsection (3)(b)(ii), provide training, to each school employee who volunteers, using the training program described in Subsection (2)(a).
  - (b) A public school may not:
    - (i) obstruct the identification or training of a trained school employee volunteer; or
    - (ii) compel a school employee to become a trained school employee volunteer.
- (4) A trained school employee volunteer may possess or store a prescribed rescue seizure medication, in accordance with this section.
- (5) A trained school employee volunteer may administer a seizure rescue medication to a student with a seizure rescue authorization if:
  - (a) the student is exhibiting a symptom, described on the student's seizure rescue authorization, that warrants the administration of a seizure rescue medication; and
  - (b) a licensed health care professional is not immediately available to administer the seizure rescue medication.
- (6) A trained school employee volunteer who administers a seizure rescue medication shall direct an individual to call 911 and take other appropriate actions in accordance with the training described in Subsection (2).
- (7) A trained school employee volunteer who administers a seizure rescue medication in accordance with this section in good faith is not liable in a civil or criminal action for an act taken or not taken under this section.
- (8) Section 53A-11-601 does not apply to the administration of a seizure rescue medication.
- (9) Section 53A-11-904 does not apply to the possession of a seizure rescue medication in accordance with this section.
- (10)
  - (a) The unlawful or unprofessional conduct provisions of Title 58, Occupations and Professions, do not apply to a person licensed as a health care professional under Title 58, Occupations and Professions, including a nurse, physician, or pharmacist for, in good faith, training a

Utah Code

nonlicensed school employee who volunteers to administer a seizure rescue medication in accordance with this section.

- (b) Allowing a trained school employee volunteer to administer a seizure rescue medication in accordance with this section does not constitute unlawful or inappropriate delegation under Title 58, Occupations and Professions.

Enacted by Chapter 423, 2016 General Session



## APPENDIX L – Test Question

### Assessment for Intranasal Medication Administration

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

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

Please circle the correct answer and take the completed test to the trainer for scoring.

1. When preparing to give intranasal medications, if time allows, wash your hands and put on gloves.
  - a. True
  - b. False
2. Usually, intranasal medications are given in a divided dose—half placed in each nostril.
  - a. True
  - b. False
3. When giving emergency seizure medications, it is important to be ready to monitor the child for breathing difficulties while waiting for help to arrive.
  - a. True
  - b. False
4. Following a child's emergency plan and knowing when to administer the emergency medication is NOT important.
  - a. True
  - b. False
5. All seizure rescue medications should be securely locked, but accessible.
  - a. True
  - b. False
6. Who designates the person to be trained in the school?
  - a. Principal
  - b. Teacher
  - c. Parent
  - d. The individual must volunteer
7. Seizure rescue medication can be given for the first time at school if necessary.
  - a. True
  - b. False
8. A volunteer may give seizure rescue medication:
  - a. Anytime
  - b. After being trained by the student
  - c. After being trained by the parent
  - d. After completing the required training and demonstrating skills competency.
9. A parent can designate someone to be trained to give seizure rescue medications in the school.
  - a. True
  - b. False
10. When documenting the event, include the following information:
  - a. Date, time of seizure and medication, observations
  - b. Student's last meal eaten
  - c. What the child was wearing
  - d. When the child was last seen at the doctor's office

Number correct: \_\_\_\_ of 10 answers

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## Assessment for Rectal Medication Administration

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

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

Please circle the correct answer and take the completed test to the trainer for scoring.

1. The three "threes" refers to counting to three while performing all of the following activities except:
  - a. Delivery of the medication in the rectum.
  - b. Before removing syringe from rectum.
  - c. Insertion of the syringe in the water soluble lubricant.
  - d. Hold the buttock after withdrawal of the syringe.
2. If alone with student, what immediate action is recommended after the administration of rectal diazepam?
  - a. Encourage the student to become physically active
  - b. Feed the student a snack with carbohydrate and protein foods
  - c. Call emergency medical services or 9-1-1
  - d. Monitoring the student's gait
3. Before administration of rectal diazepam, school personnel should make sure the applicator has the ready collar exposed on the barrel of the syringe.
  - a. True
  - b. False
4. After administering the medication, observe the student for the following:
  - a. Breathing
  - b. Walking
  - c. Eating
  - d. You do not need to monitor the student
5. When documenting the event, include the following information:
  - a. Date, time of seizure and medication, observations
  - b. Student's last meal eaten
  - c. What the child was wearing
  - d. When the child was last seen at the doctor's office
6. Who may designate personnel to be trained to give emergency seizure medication in the school?
  - a. Principal
  - b. Teacher
  - c. Parent
  - d. The individual must volunteer
7. Seizure rescue medication can be given for the first time at school if necessary.
  - a. True
  - b. False
8. A volunteer may give seizure rescue medication:
  - a. Anytime
  - b. After being trained by the student
  - c. After being trained by the parent
  - d. After completing the required training and demonstrating skills competency
9. How do you determine the point at which seizure rescue medication should be given?
  - a. As outlined in IHP
  - b. When the seizure has gone on for awhile
  - c. When the student turns blue
10. A trained volunteer in seizure rescue medication administration can use the medication for any student in the school who exhibits the appropriate seizure symptoms.
  - a. True
  - b. False

Number correct: \_\_\_\_ of 10 answers

UDOH 8/25/16

APPENDIX M – FLOWCHART FOR MEDICATION IN SCHOOLS

Seizure Rescue Medication Administration in Schools



UDOH 9/26/16

## **Seizure Rescue Medication**

### **Checklist for Training School Employee Volunteers**

Before training school employees to administer seizure rescue medication, the following must be in place:

- Has the parent or guardian requested a volunteer be trained to administer the medication?
- Has the parent or guardian administered this medication before in a non-medically supervised setting without a complication?
- Has the student previously ceased having full body prolonged convulsive seizure activity as a result of this medication?
- Is there a current completed seizure medication management order (SMMO) on file with the school?
- Is there a current individualized healthcare plan (IHP) or emergency action plan (EAP) on file with the schools?
- Has the school found school employee(s) who volunteer to be trained to administer the medication?
- Has the parent brought the medication to school fully assembled and labeled with the student's name and dose?
- Has the trainer (either school nurse or other licensed healthcare professional) completed the "Train the Trainer" course?
- Has the school employee volunteer completed the training including:
  - Viewed the applicable presentation and video?
  - Taken the applicable post-test?
  - Completed the hands-on, student-specific training including the competency checklist?
  - Signed the appropriate forms acknowledging they have been trained?
  - Had the chance to ask any questions to the trainer?

*If all of these cannot be checked off, the medication cannot be given except by parent or guardian, registered nurse (if available), or EMS.*

UDOH 9/26/16

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Retrieved on 6-16-2016 from:

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Irvine Unified School District, (2013). Antiseizure medication guide. Retrieved on 6/17/2016 from:

[http://www.iusd.org/education\\_services/health\\_services/index.html](http://www.iusd.org/education_services/health_services/index.html)

Orton, K. (2016). "Seizure 101." Presented at the 2016 School Nurse Summer Institute, June 8, 2016,

Heber, UT.

**This Guide developed as a cooperative effort between:**

**Utah Department of Health**

**Utah State Board of Education**

**University of Utah Health Care, Pediatric Neurology,  
Located at Intermountain Primary Children's Outpatient Services**



# Standardized Forms

<b>ALLERGY &amp; ANAPHYLAXIS - EMERGENCY ACTION PLAN (EAP)</b> <b>Allergy Medication Authorization &amp; Epinephrine Auto-Injector Authorization (EAI)</b> <b>Self-Administration Form</b> Utah Department of Health, In Accordance with UCA 26-41-104	School Year:	Picture
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**STUDENT INFORMATION**

Asthma: <input type="checkbox"/> No <input type="checkbox"/> Yes (if yes, high risk for severe reaction, please also complete Asthma Action Plan)			
Student:	DOB:	Grade:	School:
Parent:	Phone:	Email:	
Physician:	Phone:	Fax or email:	
School Nurse:	School Phone:	Fax or email:	

**EXTREMELY REACTIVE TO THE FOLLOWING:**

**Allergen(s):**

If checked, give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms.  
 If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, even if no symptoms are apparent.

<input type="checkbox"/> peanuts	<input type="checkbox"/> wheat	<input type="checkbox"/> latex	<input type="checkbox"/> other (specify):
<input type="checkbox"/> tree nuts	<input type="checkbox"/> eggs (safe to have in baked goods)	<input type="checkbox"/> animals	
<input type="checkbox"/> soy	<input type="checkbox"/> dairy (safe to have in baked goods)	<input type="checkbox"/> medication	
<input type="checkbox"/> fish	<input type="checkbox"/> dairy (NOT safe to have in baked goods)	<input type="checkbox"/> insect stings (specify):	
<input type="checkbox"/> shellfish	<input type="checkbox"/> eggs (NOT safe to have baked goods)		

**ACTIONS FOR MILD TO MODERATE ALLERGIC REACTION**

<p><i>MILD Symptoms</i></p> <p><b>Nose</b> – itchy/runny nose  <b>Mouth</b>- Itchy mouth  <b>Skin</b> – A few hives, mild itch  <b>Gut</b> – Mild nausea/discomfort, one episode of mild vomiting (not repetitive)</p>	<p>For MILD SYMPTOMS from A SINGLE SYSTEM area, follow the directions below:</p> <ul style="list-style-type: none"> <li>• Antihistamines may be given, if ordered by a healthcare provider.</li> <li>• Stay with the person; alert emergency contacts.</li> <li>• Watch closely for changes. If symptoms worsen, give epinephrine.</li> </ul> <p style="text-align: center;"><b>For MILD SYMPTOMS from MORE THAN ONE system area, GIVE EPINEPHRINE</b></p>
--	--

**ACTION FOR SEVERE ALLERGIC REACTION (ANAPHYLAXIS)**

<p><i>SEVERE Symptoms</i></p> <p><b>Lung</b>-short of breath, wheezing, repetitive cough  <b>Heart</b>-pale, blue, faint, weak pulse, dizzy  <b>Throat</b>-tight, hoarse, trouble breathing or swallowing  <b>Mouth</b>-significant swelling of the tongue and/or lips  <b>Skin</b>-Many hives over body, widespread redness  <b>Gut</b>-Repetitive vomiting, severe diarrhea  <b>Other</b>-Feeling something bad is about to happen, anxiety, confusion</p>	<ol style="list-style-type: none"> <li><b>1. INJECT EPINEPHRINE IMMEDIATELY.</b></li> <li>2. Call 911. Tell them the child is having anaphylaxis and may need epinephrine when they arrive.</li> <li>3. Consider giving additional medications <u>following epinephrine</u> <ul style="list-style-type: none"> <li>• Antihistamine</li> <li>• Inhaler (bronchodilator) if wheezing</li> </ul> </li> <li>4. Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.</li> <li>5. If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.</li> <li>6. Alert emergency contacts.</li> <li>7. Transport them to emergency department even if symptoms resolve. Person should remain in ED for at least 4 hours because symptoms may return.</li> </ol>
--	--

**CONTINUED ON NEXT PAGE**

<b>Student Name:</b>		<b>DOB:</b>
<b>MEDICATION</b>		
Epinephrine (EAI) Brand:	Epinephrine Dose: <input type="checkbox"/> 0.15 mg IM <input type="checkbox"/> 0.3 mg IM	Side Effects:
Antihistamine Name:	Dose:	Side Effects:
Other: (e.g., inhaler-bronchodilator of wheezing)	Other Dose:	Side Effects:
<input type="checkbox"/> Student Carries <input type="checkbox"/> Backpack <input type="checkbox"/> In Classroom <input type="checkbox"/> Health Office <input type="checkbox"/> Front Office <input type="checkbox"/> Other (specify):		
<b>PRESCRIBER TO COMPLETE</b>		
The above named student is under my care. <u>The above reflects my plan of care for the above named student.</u>		
<input type="checkbox"/> <b>It is</b> medically appropriate for the student to self-carry Epinephrine Auto Injector (EAI) medication. The student should be in possession of EAI medication and supplies at all times.		
<input type="checkbox"/> Student can self-carry and self-administer EAI if needed, when able and appropriate.		
<input type="checkbox"/> Student can self-carry, but not self-administer EAI.		
<input type="checkbox"/> <b>It is not</b> medically appropriate to carry and self-administer this EAI medication. Please have the appropriate/designated school personnel maintain this student's medication for use in an emergency.		
Prescriber Name:	Phone:	
Prescriber Signature:	Date:	
<b>PARENT TO COMPLETE</b>		
<b>Parental Responsibilities:</b>		
<ul style="list-style-type: none"> <li>• The parent or guardian is to furnish the Epinephrine Auto Injector (EAI) medication and bring to the school in the current original pharmacy container and pharmacy label with the child's name, medication name, administration time, medication dosage, and healthcare provider's name.</li> <li>• The parent or guardian, or other designated adult will deliver to the school and replace the Epinephrine Auto Injector (EAI) medication within two weeks if the Epinephrine Auto Injector (EAI) single dose medication is given.</li> <li>• If a student has a change in his/her prescription, the parent or guardian is responsible for providing the newly prescribed information and dosing information as described above to the school. The parent or guardian will complete an updated Epinephrine Auto Injector (EAI) Authorization Form/Emergency Action Plan (this form) before the designated staff can administer the updated Epinephrine Auto Injector (EAI) medication prescription.</li> </ul>		
<b>Parent/Guardian Authorization</b>		
<input type="checkbox"/> <b>I authorize</b> my child to carry the prescribed medication described above. My student is responsible for, and capable of, possessing an epinephrine auto-injector per UCA 26-41-104. My child and I understand there are serious consequences for sharing any medication with others.		<input type="checkbox"/> I authorize my student to self-carry and self-administer EAI if needed, when able and appropriate.
<input type="checkbox"/> <b>I do not authorize</b> my child to carry and self-administer this medication. Please have the appropriate/designated school personnel maintain my child's medication for use in an emergency		<input type="checkbox"/> I authorize my student to self-carry, but not self-administer EAI.
Parent Signature:	Date:	
<i>As parent/guardian of the above named student, I give my permission to the school nurse and other designated staff to administer medication and follow protocol as identified in this Emergency Care Plan. I agree to release, indemnify, and hold harmless the above from lawsuits, claim expense, demand or action, etc., against them for helping this student with allergy/anaphylaxis treatment, provided the personnel are following physician instruction as written in the emergency action plan above. Parent/Guardians and students are responsible for maintaining necessary supplies, medication and equipment. I give permission for communication between the prescribing health care provider, the school nurse, the school medical advisor and school-based clinic providers necessary for allergy management and administration of medication. I understand that the information contained in this plan will be shared with school staff on a need-to-know basis and that it is the responsibility of the parent/guardian to notify school staff whenever there is any change in the student's health status or care.</i>		
Parent Name (print):	Signature:	Date:
Emergency Contact Name:	Relationship:	Phone:
<b>SCHOOL NURSE (or principal designee if no school nurse)</b>		
<input type="checkbox"/> Signed by physician and parent <input type="checkbox"/> Medication is appropriately labeled <input type="checkbox"/> Medication Log generated		
EAI is kept: <input type="checkbox"/> Student Carries <input type="checkbox"/> Backpack <input type="checkbox"/> Classroom <input type="checkbox"/> Health Office <input type="checkbox"/> Front Office <input type="checkbox"/> Other (specify):		
Allergy & Anaphylaxis EAP distributed to 'need to know' staff:		
<input type="checkbox"/> Front office/administration <input type="checkbox"/> PE teacher(s) <input type="checkbox"/> Teacher(s) <input type="checkbox"/> Transportation <input type="checkbox"/> Other (specify):		
School Nurse Signature:	Date:	

<b>EPINEPHRINE AUTHORIZATION FORM</b>		School Year:	Picture
<b>Allergy Medication Authorization &amp; Epinephrine Auto-Injector Authorization (EAI) Self-Administration Form</b>			
Utah Department of Health, In Accordance with UCA 26-41-104			
This form <b>REQUIRED</b> for students without State Allergy & Anaphylaxis Emergency Action Plan, and requesting the student possess or possess and self-administer an EAI. Form is not valid without parent and prescriber signatures.			
<b>STUDENT INFORMATION</b>			
Asthma: <input type="checkbox"/> No <input type="checkbox"/> Yes (if yes, high risk for severe reaction, please also complete Asthma Action Plan)			
Student:	DOB:	Grade:	School:
Parent:	Phone:	Email:	
Physician:	Phone:	Fax or email:	
School Nurse:	School Phone:	Fax or email:	
<b>MEDICATION</b>			
Epinephrine (EAI) Brand:	Epinephrine Dose: <input type="checkbox"/> 0.15 mg IM <input type="checkbox"/> 0.3 mg IM	Side Effects:	
Antihistamine Name:	Dose:	Side Effects:	
Other: (e.g., inhaler-bronchodilator of wheezing)	Other Dose:	Side Effects:	
<input type="checkbox"/> Student Carries <input type="checkbox"/> Backpack <input type="checkbox"/> In Classroom <input type="checkbox"/> Health Office <input type="checkbox"/> Front Office <input type="checkbox"/> Other (specify):			
<b>PARENT TO COMPLETE</b>			
<b>Parental Responsibilities:</b>			
<ul style="list-style-type: none"> <li>• The parent or guardian is to furnish the Epinephrine Auto Injector (EAI) medication and bring to the school in the current original pharmacy container and pharmacy label with the child's name, medication name, administration time, medication dosage, and healthcare provider's name.</li> <li>• The parent or guardian, or other designated adult will deliver to the school and replace the Epinephrine Auto Injector (EAI) medication within two weeks if the Epinephrine Auto Injector (EAI) single dose medication is given.</li> <li>• If a student has a change in his/her prescription, the parent or guardian is responsible for providing the newly prescribed information and dosing information as described above to the school. The parent or guardian will complete an updated Epinephrine Auto Injector (EAI) Authorization Form/Emergency Action Plan (this form) before the designated staff can administer the updated Epinephrine Auto Injector (EAI) medication prescription.</li> </ul>			
<b>Parent/Guardian Authorization</b>			
<input type="checkbox"/> I authorize my child to carry the prescribed medication described above. My student is responsible for, and capable of, possessing an epinephrine auto-injector per UCA 26-41-104. My child and I understand there are serious consequences for sharing any medication with others.		<input type="checkbox"/> I authorize my student to self-carry and self-administer EAI if needed, when able and appropriate.	
<input type="checkbox"/> I do not authorize my child to carry and self-administer this medication. Please have the appropriate/designated school personnel maintain my child's medication for use in an emergency			
Parent Signature:		Date:	
<i>As parent/guardian of the above named student, I give my permission to the school nurse and other designated staff to administer medication and follow protocol as identified in this Emergency Care Plan. I agree to release, indemnify, and hold harmless the above from lawsuits, claim expense, demand or action, etc., against them for helping this student with allergy/anaphylaxis treatment, provided the personnel are following physician instruction as written in the emergency action plan above. Parent/Guardians and students are responsible for maintaining necessary supplies, medication and equipment. I give permission for communication between the prescribing health care provider, the school nurse, the school medical advisor and school-based clinic providers necessary for allergy management and administration of medication. I understand that the information contained in this plan will be shared with school staff on a need-to-know basis and that it is the responsibility of the parent/guardian to notify school staff whenever there is any change in the student's health status or care.</i>			
Parent Name (print):		Signature:	Date:
Emergency Contact Name:		Relationship:	Phone:

<b>Student Name:</b>		<b>Student DOB:</b>	
<b>PRESCRIBER TO COMPLETE</b>			
<p>The above named student is under my care. <u>The above reflects my plan of care for the above named student.</u></p> <p><input type="checkbox"/> <b>It is</b> medically appropriate for the student to self-carry Epinephrine Auto Injector (EAI) medication. The student should be in possession of EAI medication and supplies at all times.</p> <p><input type="checkbox"/> Student can self-carry and self-administer EAI if needed, when able and appropriate.</p> <p><input type="checkbox"/> Student can self-carry, but not self-administer EAI.</p> <p><input type="checkbox"/> <b>It is not</b> medically appropriate to carry and self-administer this EAI medication. Please have the appropriate/designated school personnel maintain this student's medication for use in an emergency.</p>			
Prescriber Name:		Phone:	
Prescriber Signature:		Date:	
<b>SCHOOL NURSE (or principal designee if no school nurse)</b>			
<input type="checkbox"/> Signed by physician and parent	<input type="checkbox"/> Medication is appropriately labeled	<input type="checkbox"/> Medication Log generated	
EAI is kept: <input type="checkbox"/> Student Carries <input type="checkbox"/> Backpack <input type="checkbox"/> Classroom <input type="checkbox"/> Health Office <input type="checkbox"/> Front Office <input type="checkbox"/> Other (specify):			
Allergy & Anaphylaxis EAP distributed to 'need to know' staff: <input type="checkbox"/> Front office/administration <input type="checkbox"/> PE teacher(s) <input type="checkbox"/> Teacher(s) <input type="checkbox"/> Transportation <input type="checkbox"/> Other (specify):			
School Nurse Signature:		Date:	

# Asthma Action Plan (AAP)

## Medication Authorization & Self-Administration Form

in accordance with UCA 53G-9-503

Utah Department of Health/Utah State Office of Education

School Year:

Picture

### STUDENT INFORMATION

Student:	DOB:	Grade:	School:
Parent:	Phone:	Email:	
Physician:	Phone:	Fax or email:	
School Nurse:	School Phone:	Fax or email:	

History of anaphylaxis where epinephrine was used?

Yes (please also complete anaphylaxis EAP)--allergy to: \_\_\_\_\_  No

### PHYSICIAN TO COMPLETE



### Green Zone: Doing Great!

Student has ALL of these:

- Breathing is easy
- No cough or wheeze
- Can sleep all night
- Able to work and play normally

Controller (preventive) medications **taken at home**:

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ When: \_\_\_\_\_

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ When: \_\_\_\_\_

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ When: \_\_\_\_\_

Asthma triggers include:  Dust  Pet dander  Colds  Tobacco smoke  Mold  Exercise  Strong odors  Pollen  Inversions

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

Take quick-relief medication (see medication order in Yellow Zone):

Before exercise/exposure to a trigger When: \_\_\_\_\_

Other: \_\_\_\_\_ When: \_\_\_\_\_



### Yellow Zone: Caution!

Student has ANY of these:

- Coughing or wheezing
- Tight chest
- Shortness of breath
- Waking up at night

Quick-relief medication with spacer (if available):

Medication	Dose	Interval
Inhaler:		
Nebulizer:		
Other:		

Possible side effects:

Parent should contact Healthcare Provider below if 1) quick-relief medication is needed more often than every 4 hours, or needed every 4 hours for more than a day or 2) there is no improvement after taking medication.



### Red Zone: Emergency!

Student has ANY of these:

- Can't eat or talk well
- Breathing hard and fast
- Medicine isn't helping
- Rib or neck muscles show when breathing in

**Call 911 for an ambulance or go directly to the emergency department**

Repeat quick-relief medication every 20 minutes until medical help arrives.

Other (specify):

Parent should contact Healthcare Provider below while providing treatment.

**CONTINUED ON NEXT PAGE** →

<b>Student Name:</b>		<b>DOB:</b>
<b>PRESCRIBER TO COMPLETE</b>		
The above named student is under my care. <u>The above reflects my plan of care for the above named student.</u>		
<input type="checkbox"/> <b>It is</b> medically appropriate for the student to carry and self-administer asthma medication, when able and appropriate, and be in possession of asthma medication and supplies at all times. <input type="checkbox"/> <b>It is not</b> medically appropriate for the student to carry and self-administer this asthma medication. Please have the appropriate/designated school personnel maintain this student's medication for use if having symptoms at school.		
Prescriber Name:	Phone:	
Prescriber Signature:	Date:	
<b>PARENT TO COMPLETE</b>		
<b>Parental Responsibilities:</b>		
<ul style="list-style-type: none"> <li>• The parent or guardian is to furnish the asthma medication and bring to the school in the current original pharmacy container and pharmacy label with the child's name, medication name, administration time, medication dosage, and healthcare provider's name.</li> <li>• The parent or guardian, or other designated adult will deliver to the school and replace the asthma medication when empty.</li> <li>• If a student has a change in his/her prescription, the parent or guardian is responsible for providing the newly prescribed information and dose information as described above to the school. The parent or guardian will complete an updated Asthma Action Plan before the designated staff can administer the updated asthma medication prescription.</li> </ul>		
<b>Parent/Guardian Authorization</b>		
<input type="checkbox"/> <b>I authorize</b> my child to carry and self-administer the prescribed medication described above. My student is responsible for, and capable of, possessing or possessing and self-administering an asthma inhaler per UCA 53G-9-503. My child and I understand there are serious consequences for sharing any medication with others. <input type="checkbox"/> <b>I do not authorize</b> my child to carry and self-administer this medication. Please have the appropriate/designated school personnel maintain my child's medication for use in an emergency. <input type="checkbox"/> <b>I authorize</b> the appropriate/designated school personnel maintain my child's medication for use in emergency.		
Parent Signature:	Date:	
<i>As parent/guardian of the above named student, I give my permission to the school nurse and other designated staff to administer medication and follow protocol as identified in the asthma action plan. I agree to release, indemnify, and hold harmless the above from lawsuits, claim expense, demand or action, etc., against them for helping this student with asthma treatment, provided the personnel are following physician instruction as written in the asthma action plan above. Parent/Guardians and students are responsible for maintaining necessary supplies, medication and equipment. I give permission for communication between the prescribing health care provider, the school nurse, the school medical advisor and school-based clinic providers necessary for asthma management and administration of medication. I understand that the information contained in this plan will be shared with school staff on a need-to-know basis and that it is the responsibility of the parent/guardian to notify school staff whenever there is any change in the student's health status or care.</i>		
Parent Name:	Signature:	Date:
Emergency Contact Name:	Relationship:	Phone:
<b>SCHOOL NURSE (or principal designee if no school nurse)</b>		
<input type="checkbox"/> Signed by physician and parent	<input type="checkbox"/> Medication is appropriately labeled	<input type="checkbox"/> Medication log generated
Inhaler is kept: <input type="checkbox"/> Student Carries	<input type="checkbox"/> Backpack	<input type="checkbox"/> In Classroom
<input type="checkbox"/> Other (specify):	<input type="checkbox"/> Health Office	<input type="checkbox"/> Front Office
Asthma Action Plan distributed to 'need to know' staff:		
<input type="checkbox"/> Teacher(s)	<input type="checkbox"/> PE teacher(s)	<input type="checkbox"/> Transportation
<input type="checkbox"/> Front Office/Admin	<input type="checkbox"/> Other (specify):	
School Nurse Signature:	Date:	

<b>ASTHMA MEDICATION AUTHORIZATION FORM</b> <b>Asthma Medication Authorization &amp; Inhaler Authorization</b> <b>Self-Administration Form</b> Utah Department of Health, In Accordance with UCA 26-41-104	School Year:	Picture
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This form REQUIRED for students without State Asthma Action Plan, and requesting the student possess and self-administer asthma medication. Form is not valid without parent and prescriber signatures.

**STUDENT INFORMATION**

Allergy:  No  Yes (if yes, high risk for severe reaction, please also complete Allergy Action Plan)

Student:	DOB:	Grade:	School:
Parent:	Phone:	Email:	
Physician:	Phone:	Fax or email:	
School Nurse:	School Phone:	Fax or email:	

**MEDICATION**

Medication	Dose	Interval
Inhaler:		
Nebulizer:		
Other:		

Student Carries  Backpack  In Classroom  Health Office  Front Office  Other (specify):

**PARENT TO COMPLETE**

**Parental Responsibilities:**

- The parent or guardian is to furnish the asthma medication and bring to the school in the current original pharmacy container and pharmacy label with the child's name, medication name, administration time, medication dosage, and healthcare provider's name.
- The parent or guardian, or other designated adult will deliver to the school and replace the asthma medication when empty.
- If a student has a change in his/her prescription, the parent or guardian is responsible for providing the newly prescribed information and dose information as described above to the school. The parent or guardian will complete an updated Asthma Action Plan before the designated staff can administer the updated asthma medication prescription.

**Parent/Guardian Authorization**

I authorize my child to carry and self-administer the prescribed medication described above. My student is responsible for, and capable of, possessing or possessing and self-administering an asthma inhaler per UCA 53G-9-503. My child and I understand there are serious consequences for sharing any medication with others.

I do not authorize my child to carry and self-administer this medication. Please have the appropriate/designated school personnel maintain my child's medication for use in an emergency.

I authorize the appropriate/designated school personnel maintain my child's medication for use in emergency.

Parent Signature:	Date:
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*As parent/guardian of the above named student, I give my permission to the school nurse and other designated staff to administer medication and follow protocol as identified in the Asthma Action Plan. I agree to release, indemnify, and hold harmless the above from lawsuits, claim expense, demand or action, etc., against them for helping this student with asthma treatment, provided the personnel are following physician instruction as written in the emergency action plan. Parent/Guardians and students are responsible for maintaining necessary supplies, medication and equipment. I give permission for communication between the prescribing health care provider, the school nurse, the school medical advisor and school-based clinic providers necessary for asthma management and administration of medication. I understand that the information contained in this plan will be shared with school staff on a need-to-know basis and that it is the responsibility of the parent/guardian to notify school staff whenever there is any change in the student's health status or care.*

Parent Name (print):	Signature:	Date:
Emergency Contact Name:	Relationship:	Phone:

<b>Student Name:</b>	<b>Student DOB:</b>
<b>PRESCRIBER TO COMPLETE</b>	
<p>The above named student is under my care. <u>The above reflects my plan of care for the above named student.</u></p> <p><input type="checkbox"/> <b>It is</b> medically appropriate for the student to carry and self-administer asthma medication, when able and appropriate, and be in possession of asthma medication and supplies at all times.</p> <p><input type="checkbox"/> <b>It is not</b> medically appropriate for the student to carry and self-administer this asthma medication. Please have the appropriate/designated school personnel maintain this student's medication for use if having symptoms at school.</p>	
Prescriber Name:	Phone:
Prescriber Signature:	Date:
<b>SCHOOL NURSE (or principal designee if no school nurse)</b>	
<input type="checkbox"/> Signed by physician and parent	<input type="checkbox"/> Medication is appropriately labeled
<input type="checkbox"/> Medication Log generated	
Asthma medication is kept: <input type="checkbox"/> Student Carries <input type="checkbox"/> Backpack <input type="checkbox"/> Classroom <input type="checkbox"/> Health Office <input type="checkbox"/> Front Office <input type="checkbox"/> Other (specify):	
Asthma Action Plan distributed to 'need to know' staff: <input type="checkbox"/> Front office/administration <input type="checkbox"/> PE teacher(s) <input type="checkbox"/> Teacher(s) <input type="checkbox"/> Transportation <input type="checkbox"/> Other (specify):	
School Nurse Signature:	Date:

<b>DIABETES - Individualized Healthcare Plan (IHP)</b> Utah Department of Health	School Year:	Picture
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**STUDENT INFORMATION**

<b>Student:</b>	<b>DOB:</b>	<b>Grade:</b>	<b>School:</b>	<b>DMMO</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Parent:</b>	<b>Phone:</b>	<b>Email:</b>		
<b>Physician:</b>	<b>Phone:</b>	<b>Fax or Email:</b>		
<b>School Nurse:</b>	<b>School Phone:</b>	<b>Fax or Email:</b>		
<input type="checkbox"/> <b>Type I</b> <input type="checkbox"/> <b>Type II</b> <b>Age at diagnosis:</b>				

**BLOOD GLUCOSE MONITORING**

Student is independent     Student needs assistance     Student needs supervision  
 Student has a Continuous Glucose Monitoring System (CGMS readings are for trends only, ALWAYS verify with blood glucose before any dosing, unless using Dexcom G5 – must have parent signature on DMMO)

**Always test if student is showing signs/symptoms of high or low blood glucose!**

**INSULIN DELIVERY** (per instructions from PCH, correction doses can be given at mealtime only, unless on a pump)

Method of insulin delivery: <input type="checkbox"/> Pump <input type="checkbox"/> Insulin Pen <input type="checkbox"/> Syringe/vial	<input type="checkbox"/> Student is independent <input type="checkbox"/> Student needs supervision <input type="checkbox"/> Student needs assistance (attach training documentation if applicable)
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High Blood Glucose Correction Dose for **PUMP** only: If BG over \_\_\_\_\_ mg/dl, give correction per pump calculation

**Lunch:** Student will typically eat:     School Lunch (staff can help with carb counts)  
 Home Lunch (parent must provide carb counts)

<b>HYPO</b> glycemia-Low Blood Glucose	<b>HYPER</b> glycemia-High Blood Glucose	<b>ADDITIONAL INFORMATION</b>
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<p><b>Emergency situations may occur with low blood sugar!</b></p> <p><u>Symptoms:</u> shaky, feels low, feels hungry, confused, other (specify):</p> <p><input type="checkbox"/> Student needs treatment when blood glucose is below _____ mg/dl or if symptomatic  <input type="checkbox"/> If treated outside the classroom, a responsible person MUST accompany student to the office  <input type="checkbox"/> If blood glucose is below _____ mg/dl give _____  <input type="checkbox"/> After 15 minutes recheck blood sugar  <input type="checkbox"/> Repeat until blood glucose is over _____ mg/dl  <input type="checkbox"/> Disconnect or suspend pump</p>	<p><u>Symptoms:</u> Increased thirst, increase need for urination, other (specify):</p> <p><input type="checkbox"/> Student needs treatment when blood glucose is over _____ mg/dl  <input type="checkbox"/> If blood sugar is over _____ mg/dl contact parent  <input type="checkbox"/> Allow unrestricted bathroom privileges  <input type="checkbox"/> Encourage student to drink water or sugar-free drinks</p> <p>If vomiting call parent <b>immediately!</b></p>	<ul style="list-style-type: none"> <li>Student must always be allowed access to fast-acting sugar.</li> <li>Student is allowed to carry a water bottle and have unrestricted bathroom privileges.</li> <li>Student is allowed to test his/her blood glucose when/where needed</li> <li>Substitute teachers must be aware of the student’s health situation, but still respecting privacy</li> </ul> <p><b>CALL 911 IF:</b></p> <ul style="list-style-type: none"> <li>Glucagon is administered</li> <li>Student is unable to cooperate to eat or drink anything</li> <li>Decreasing alertness or loss of consciousness</li> <li>Seizure</li> </ul>
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**Notify parent(s)/guardian when blood glucose is below \_\_\_\_\_ mg/dl or above \_\_\_\_\_ mg/dl**

**CONTINUED ON NEXT PAGE**

<b>Student:</b>		<b>DOB:</b>
<b>SPECIAL CONSIDERATIONS</b> (Academic testing, Snacks, PE, School Parties, Field Trips)		
PE: <input type="checkbox"/> Check BG before PE <input type="checkbox"/> Do not exercise if BG is below ____ mg/dl or above ____ mg/dl <input type="checkbox"/> 15 gram carb (free) snack before PE <input type="checkbox"/> Other (specify):		
SPECIAL CONSIDERATIONS AND PRECAUTIONS: <u>School Parties:</u> <input type="checkbox"/> No coverage for parties <input type="checkbox"/> I:C Ratio <input type="checkbox"/> Student to take snack home <input type="checkbox"/> Parent will provide alternate snack <input type="checkbox"/> Other (specify): <u>Field Trips:</u>		
ACADEMIC TESTING: <input type="checkbox"/> Student may reschedule academic testing with teacher, as needed, if blood glucose is below ____ or over ____ Other (specify):		
<b>EMERGENCY MEDICATION</b> (See DMMO)		
Person to give <b>Glucagon:</b> <input type="checkbox"/> School Nurse <input type="checkbox"/> Parent <input type="checkbox"/> EMS <input type="checkbox"/> Volunteer(s) (Specify): Attach volunteer(s) training documentation if applicable.		
Location of Glucagon:		
<b>SIGNATURES</b>		
As parent/guardian of the above named student, I give permission for my child's healthcare provider to share information with the school nurse for the completion of this plan. I understand the information contained in this plan will be shared with school staff on a need-to-know basis. It is the responsibility of the parent/guardian to notify the School Nurse of any change in the student's health status, care or medication order. If medication is ordered I authorize school staff to administer medication described below to my child. If prescription is changed a new prescriber order must be completed before the school staff can administer the medication. Parents/Guardian are responsible for maintaining necessary supplies, medications and equipment.		
Parent:	Signature:	Date:
Emergency Contact:	Relationship:	Phone:
<b>SCHOOL NURSE</b>		
Diabetes medication and supplies are kept: <input type="checkbox"/> Student carries <input type="checkbox"/> Backpack <input type="checkbox"/> Classroom <input type="checkbox"/> Health Office <input type="checkbox"/> Front office <input type="checkbox"/> Other (specify):		
<b>IHP (this form) distributed to 'need to know' staff:</b> <input type="checkbox"/> Teacher(s) <input type="checkbox"/> Lunchroom <input type="checkbox"/> PE teacher(s) <input type="checkbox"/> Transportation <input type="checkbox"/> Front office/admin <input type="checkbox"/> Other (specify):		
School Nurse Signature:		Date:

Addendum:

**STUDENT INFORMATION**

Student:	DOB:	Grade:	School:
Parent:	Phone(s):	Email:	
Physician:	Phone:	Fax or email:	
School Nurse:	School Phone:	Fax or email:	

 **When Blood Glucose is in Target Range (or between \_\_\_\_ and \_\_\_\_)**

Student is fine

**HYPOGLYCEMIA** – When Blood Glucose is Below 80 (or below \_\_\_\_)

Causes: too much insulin; missing or delaying meals or snacks; not eating enough food; intense or unplanned physical activity; being ill.

Onset: sudden, symptoms may progress rapidly

 <b>MILD OR MODERATE HYPOGLYCEMIA</b> Please check previous symptoms	 <b>SEVERE HYPOGLYCEMIA</b> Please check previous symptoms
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<input type="checkbox"/> Anxiety <input type="checkbox"/> Behavior change <input type="checkbox"/> Blurry Vision <input type="checkbox"/> Confusion <input type="checkbox"/> Crying <input type="checkbox"/> Dizziness <input type="checkbox"/> Drowsiness	<input type="checkbox"/> Hunger <input type="checkbox"/> Headache <input type="checkbox"/> Irritability <input type="checkbox"/> Paleness <input type="checkbox"/> Personality change <input type="checkbox"/> Poor concentration <input type="checkbox"/> Poor coordination	<input type="checkbox"/> Shakiness <input type="checkbox"/> Slurred speech <input type="checkbox"/> Sweating <input type="checkbox"/> Weakness <input type="checkbox"/> Other:	<input type="checkbox"/> Combative <input type="checkbox"/> Inability to eat or drink <input type="checkbox"/> Unconscious <input type="checkbox"/> Unresponsive <input type="checkbox"/> Seizures <input type="checkbox"/> Other:
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<b>ACTIONS FOR MILD OR MODERATE HYPOGLYCEMIA</b>	<b>ACTIONS FOR SEVERE HYPOGLYCEMIA</b>
--	--

<ol style="list-style-type: none"> <li>1. Give student fast-acting sugar source</li> <li>2. Wait 15 minutes.</li> <li>3. Recheck blood glucose.</li> <li>4. Repeat fast-acting sugar source if symptoms persist OR blood glucose is less than 80 or ____</li> <li>5. Other:</li> </ol>	<ol style="list-style-type: none"> <li>1. Don't attempt to give anything by mouth.</li> <li>2. Position on side, if possible.</li> <li>3. Contact trained diabetes personnel.</li> <li>4. Administer glucagon, if prescribed.</li> <li>5. <b>Call 911.</b> Stay with student until EMS arrives.</li> <li>6. Contact parents/guardian.</li> <li>7. Stay with student.</li> <li>8. Other:</li> </ol>
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**FAST ACTING SUGAR SOURCES (15 grams carbohydrates): 3-4 glucose tablets OR 4 ounces juice OR 0.9 ounce packet of fruit snacks**

**CONTINUED ON NEXT PAGE** 

<b>Student Name:</b>		<b>DOB:</b>	
<b>HYPERGLYCEMIA</b> - When Blood Glucose is over 250 (or above _____) <u>Causes:</u> too little insulin; too much food; insulin pump or infusion set malfunction; decreased physical activity; illness; infection; injury; severe physical or emotional stress. <u>Onset:</u> over several hours or days.			
 <b>MILD OR MODERATE HYPERGLYCEMIA</b> Please check previous symptoms		 <b>SEVERE HYPERGLYCEMIA</b> Please check previous symptoms	
<input type="checkbox"/> Behavior Change <input type="checkbox"/> Blurry Vision <input type="checkbox"/> Fatigue/sleepiness <input type="checkbox"/> Frequent Urination	<input type="checkbox"/> Headache <input type="checkbox"/> Stomach pains <input type="checkbox"/> Thirst/dry mouth <input type="checkbox"/> Other:	<input type="checkbox"/> Blurred vision <input type="checkbox"/> Breathing changes (Kussmaul breathing) <input type="checkbox"/> Chest pain <input type="checkbox"/> Decreased consciousness <input type="checkbox"/> Increased hunger	<input type="checkbox"/> Nausea/vomiting <input type="checkbox"/> Severe abdominal pain <input type="checkbox"/> Sweet, fruity breath <input type="checkbox"/> Other:
<b>ACTIONS FOR MILD OR MODERATE HYPERGLYCEMIA</b>		<b>ACTIONS FOR SEVERE HYPERGLYCEMIA</b>	
1. Allow liberal bathroom privileges. 2. Encourage student to drink water or sugar-free drinks. 3. Administer correction dose if on a pump. 4. Contact parent if blood sugar is over _____ mg/dl. 5. Other:		<input type="checkbox"/> Administer correction dose of insulin if on a pump <input type="checkbox"/> Call parent/guardian. <input type="checkbox"/> Stay with student <input type="checkbox"/> Call 911 if patient has breathing changes or decreased consciousness. Stay with student until EMS arrives <input type="checkbox"/> Other:	
<b>INSULIN PUMP FAILURE</b> (please indicate plan for insulin pump failure)			
<input type="checkbox"/> NA/not on an insulin pump <input type="checkbox"/> administer insulin via syringe/vial or pen <input type="checkbox"/> parent to come and replace site <input type="checkbox"/> School nurse can replace site (only if previously trained) <input type="checkbox"/> student can replace site alone or with minimal assistance <input type="checkbox"/> Other (specify):			
<b>Never send a child with suspected low blood glucose anywhere alone!!!</b>			
<b>PARENT SIGNATURE</b>			
I have read and approve of the above emergency action plan.			
Parent:		Signature:	Date:
Emergency Contact Name:		Relationship:	Phone:
<b>SCHOOL NURSE</b>			
<u>Diabetes medication and supplies</u> are kept: <input type="checkbox"/> Student carries <input type="checkbox"/> Backpack <input type="checkbox"/> Classroom <input type="checkbox"/> Health Office <input type="checkbox"/> Front office <input type="checkbox"/> Other (specify):			
<u>Glucagon</u> kept: <input type="checkbox"/> Student carries <input type="checkbox"/> Backpack <input type="checkbox"/> Classroom <input type="checkbox"/> Health Office <input type="checkbox"/> Front office <input type="checkbox"/> Other (specify): <input type="checkbox"/> No Glucagon at school			
<b>Copies of EAP (this form) distributed to 'need to know' staff:</b> <input type="checkbox"/> Classroom Teacher(s) <input type="checkbox"/> Lunchroom <input type="checkbox"/> PE Teacher(s) <input type="checkbox"/> Office staff/administration <input type="checkbox"/> Transportation <input type="checkbox"/> Other (specify):			
<b>School Nurse Signature:</b>		<b>Date:</b>	

Addendum:

<b>Diabetes Medication Management Orders (DMMO)</b> In Accordance with UCA 53G-9-504 and 53G-9-506 Utah Department of Health/Utah State Board of Education		PCH Outpatient Diabetes Program (801) 213-3599 Fax (801) 587-7539	Other Provider (LIP)
<b>STUDENT INFORMATION</b>		School Year:	
Student Name:	<input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2	Name of School:	
DOB:	Age at diagnosis:	School Fax:	
<p>In accordance with these orders, an Individualized Healthcare Plan (IHP) must be developed by the School Nurse, Student, and Parent to be shared with appropriate school personnel, <i>and cannot be shared with any individual outside of those public education employees without parental consent.</i> As the student's Licensed Independent Provider (LIP), I confirm the student has a diagnosis of diabetes mellitus and it is 'medically appropriate for the student to possess and self-administer diabetes medication and the student should be in possession of diabetes medications at all times'. Per my assessment, I recommend:</p> <p><input type="checkbox"/> Student is capable to carbohydrate count meals and snacks for insulin adjustment, carry, and self-administer diabetes medication/insulin.</p> <p><input type="checkbox"/> Student requires a trained adult to supervise carbohydrate counting of meals and snacks for insulin adjustment and self-administration of diabetes medication/insulin.</p> <p><input type="checkbox"/> Student requires a trained adult to carbohydrate count meals and snacks, for insulin calculation, and administer diabetes medication/insulin during periods the student is under the control of the school.</p> <p><input type="checkbox"/> This student may participate in ALL school activities, including sports and field trips, without restriction.</p> <p><input type="checkbox"/> This student may participate in school activities with the following restrictions:</p>			
<b>EMERGENCY GLUCAGON ADMINISTRATION</b> Immediately for severe hypoglycemia: unconscious, semiconscious (unable to control airway, or seizing)		Glucagon Dose: 1.0 mg/1.0 ml	Route: IM Possible side effects: Nausea and Vomiting
<b>BLOOD GLUCOSE TESTING</b> Target range for blood glucose (BG): <input type="checkbox"/> 100-200 <input type="checkbox"/> 80-150 <input type="checkbox"/> Other:			
Times to test: <input type="checkbox"/> Before meals <input type="checkbox"/> Before exercise <input type="checkbox"/> After exercise <input type="checkbox"/> Before going home <input type="checkbox"/> If symptomatic (See student's specific symptoms in Individualized Healthcare Plan (IHP). <ul style="list-style-type: none"> <li>• If BG is less than ___ mg/dl, follow management per Diabetes Emergency Action Plan (EAP).</li> <li>• Student should not exercise if BG is below ___ mg/dl or symptomatic of hyperglycemia.</li> </ul>			
<b>SNACKS</b> <input type="checkbox"/> 15 gram carb snack at ___ AM <input type="checkbox"/> 15 gram carb snack at ___ PM <input type="checkbox"/> No routine snacks at school <input type="checkbox"/> 15 gram carb snack before PE/Recess <input type="checkbox"/> 'Free' snacks (no insulin coverage) <input type="checkbox"/> Other:			
<b>INSULIN ADMINISTRATION</b>	<input type="checkbox"/> Humalog <input type="checkbox"/> Novolog <input type="checkbox"/> Apidra <input type="checkbox"/> Other:	<input type="checkbox"/> Insulin vial/syringe <input type="checkbox"/> Insulin pen <input type="checkbox"/> Insulin pump	Route: Subcutaneous Possible side effects: Hypoglycemia
Insulin to Carbohydrate (I:C): ___ units for every ___ grams of carbohydrate before food.		Correction Dose (can only be administered at meal times): ___ unit for every ___ mg/dl for blood glucose above ___ mg/dl.	
<b>SNACKS/PARTIES:</b> <input type="checkbox"/> Snacks/parties (use I:C ratio) <input type="checkbox"/> No coverage for snacks/parties <input type="checkbox"/> Other:			
<b>INSULIN PUMP:</b> If using insulin pump, carbohydrate ratio and correction dose are calculated by pump. Correction doses at times other than meals per PUMP calculation ONLY.			
<b>ADDITIONAL PUMP ORDERS:</b> Student may be disconnected from pump for a maximum of 60 minutes, or per IHP/EAP. If unable to use pump after 60 minutes contact parent/guardian, and if BG is over 250 mg/dl give correction dose via syringe or pen. If able to reconnect pump, administer correction dose as calculated by pump.			
<b>CONTINUED ON NEXT PAGE</b>			

<b>Student Name:</b>	<b>DOB:</b>
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**CONTINUOUS GLUCOSE MONITORING (CGM)**

All students using a CGM at school must have the ability to check a finger stick blood glucose with a meter in the event of a CGM failure or apparent discrepancy.

None

Dexcom G4 is **not** FDA approved for making treatment decisions. When the CGM alarms, treatment should be determined based on a finger stick blood glucose.

Dexcom G5 **is** FDA approved for making treatment decisions. Correction doses of insulin for hyperglycemia, or the intake of carbohydrates for treating hypoglycemia can be determined at school based on the CGM if the sensor glucose value is between 80 mg/dl and 350 mg/dl and there is a directional arrow; unless otherwise directed by the provider. If the symptoms of the student don't match the CGM reading, check a finger stick blood glucose with a meter. In addition, the parent/guardian must sign below verifying they are responsible for calibrating the CGM at home two times daily and approve the school personnel or school nurse to treat hypoglycemia or give insulin doses based on the CGM.

Parent Signature: \_\_\_\_\_

Dexcom G6 **is** FDA approved for making treatment decisions. Correction doses of insulin for hyperglycemia, or the intake of carbohydrates for treating or preventing hypoglycemia can be determined at school based on the CGM if there is a glucose number and a directional arrow visible on the CGM. The "Urgent Low Soon Alert" signifies that a glucose of 55 mg/dl will be reached within 20 minutes. This should be treated based on the student's hypoglycemia treatment plan. If the symptoms of the student don't match the CGM reading, check a finger stick blood glucose with a meter. In addition, the parent/guardian must sign below verifying they approve the school personnel or school nurse to treat hypoglycemia or give insulin doses based on the CGM.

Parent Signature: \_\_\_\_\_

Medtronic 530 G and 630 G with Enlite Sensor, and 670 G with Guardian sensor are **not** FDA approved for making treatment decision. When CGM alarms, treatment should be determined based on a finger stick blood glucose. If the pump requests a calibration, the student can calibrate this on their own. The school nurse and the parent must put a plan in place for calibrating the CGM at school if the pump request a calibration and the student is unable to calibrate the CGM independently. The reading used to calibrate the CGM must come from a finger stick blood glucose using a meter. In addition, the parent/guardian must sign below verifying they approve the school personnel or school nurse to assist with calibrations (if desired).

Parent Signature: \_\_\_\_\_

Frestyle Libre is **not** FDA approved for making treatment decisions in individuals under the age of 18.

**ADDITIONAL ORDERS:**

None

Student to go to office for adult supervision of BG testing and insulin administration

**TO BE COMPLETED BY PARENT OR GUARDIAN**

I understand that a school team, including parent or guardian, may make decisions about implementation and assistance in the school based on consideration of the above recommendation, available resources, and the student's level of self-management. I acknowledge that these orders signed by the LIP will be used by the school nurse, and shared with appropriate school staff, to develop the IHP for my child's diabetes management at school. I understand and accept the risk that in the course of communication between myself, the school, and the provider, protected health information (PHI) sent via unencrypted email or text message may be intercepted and read by third parties.

Parent Name (print):	Signature:	Date:
Emergency Contact Name:	Relationship:	Phone:
Prescriber Name (print):	Phone:	
Prescriber Signature:	Date:	

<b>SEIZURE</b> <b>Individualized Healthcare Plan (IHP)</b> <b>Emergency Care Plan (ECP)</b>	School Year:	Picture
	<b>SMMO</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	

**STUDENT INFORMATION**

<b>Student:</b>	<b>DOB:</b>	<b>Grade:</b>	<b>School:</b>
<b>Parent:</b>	<b>Phone:</b>		<b>Email:</b>
<b>Physician:</b>	<b>Phone:</b>		<b>Fax:</b>
<b>School Nurse:</b>	<b>School Phone:</b>		<b>Fax:</b>

**History:**

**SEIZURE INFORMATION**

Seizure Type/Description	Length	Frequency

Seizure triggers or warning signs:

Student's reaction to seizure:

**SPECIAL CONSIDERATIONS**

Special considerations and precautions (regarding school activities, field trips, sports, etc):

**EMERGENCY SEIZURE RESCUE MEDICATION (See SMMO)**

Person to give seizure rescue medication:  School Nurse    Parent    EMS    Volunteer(s) Specify:  
 Attach volunteer(s) training documentation  Other:

Location of seizure rescue medication (must be locked):

**VAGUS NERVE STIMULATOR (VNS) (See SMMO)**

This student has a Vagus Nerve Stimulator:  Yes    No

Location of magnet:

Person(s) trained on magnet use:  School Nurse    Teacher    Aide    Volunteer(s) Specify:  
 Attach volunteer(s) training documentation  Other:

Describe magnet use:

**CONTINUED ON NEXT PAGE**

<b>Student Name:</b>		<b>DOB:</b>
<b>SEIZURE ACTION PLAN – Mark all behaviors that apply to student</b>		
<b>If you see this:</b>		<b>Do this:</b>
<input type="checkbox"/> Sudden cry or squeal <input type="checkbox"/> Falling down <input type="checkbox"/> Rigidity/Stiffness <input type="checkbox"/> Thrashing/Jerking <input type="checkbox"/> Loss of bowel/bladder control <input type="checkbox"/> Shallow breathing <input type="checkbox"/> Stops breathing <input type="checkbox"/> Blue color to lips <input type="checkbox"/> Froth from mouth <input type="checkbox"/> Gurgling or grunting noises <input type="checkbox"/> Loss of consciousness <input type="checkbox"/> Staring <input type="checkbox"/> Lip smacking <input type="checkbox"/> Eye movement <input type="checkbox"/> Other: _____		<b>BASIC SEIZURE FIRST AID</b> <ul style="list-style-type: none"> <li>▪ Stay calm &amp; track time</li> <li>▪ Keep child safe</li> <li>▪ Do not restrain</li> <li>▪ Do not put anything in mouth</li> <li>▪ Stay with child until fully conscious</li> <li>▪ Protect head</li> <li>▪ Keep airway open/watch breathing</li> <li>▪ Turn child on side</li> <li>▪ Do not give fluids or food during or immediately after seizure</li> </ul>
<b>EMERGENCY SEIZURE PROTOCOL</b>		<b>Expected Behavior after Seizure</b>
<input type="checkbox"/> Call 911 at ____ minutes for transport to: _____ <input type="checkbox"/> Call parent or emergency contact <input type="checkbox"/> Administer emergency medications as indicated on SMMO <input type="checkbox"/> Oxygen <input type="checkbox"/> Other (specify): _____ <b>A seizure is generally considered an emergency when:</b> <ul style="list-style-type: none"> <li>▪ Convulsive (tonic-clonic) seizure lasts longer than 5 minutes</li> <li>▪ Student has repeated seizures with or without regaining consciousness</li> <li>▪ Student is injured, pregnant or has diabetes</li> <li>▪ Student has a first-time seizure</li> <li>▪ Student has breathing difficulties</li> <li>▪ Student has a seizure in water</li> </ul>		<ul style="list-style-type: none"> <li>▪ Tiredness</li> <li>▪ Weakness</li> <li>▪ Sleeping, difficult to arouse</li> <li>▪ Somewhat confused</li> <li>▪ Regular breathing</li> <li>▪ Other: _____</li> </ul>
		<b>Follow-Up</b>
		<ul style="list-style-type: none"> <li>• Notify School Nurse</li> <li>• Document!</li> </ul>
<b>SIGNATURES</b>		
<p>As parent/guardian of the above named student, I give permission for my child’s healthcare provider to share information with the school nurse for the completion of this plan of care. I understand the information contained in this plan will be shared with school staff on a need-to-know basis. It is the responsibility of the parent/guardian to notify the School Nurse of any change in the student’s health status, care or medication order. If medication is ordered, I authorize school staff to administer medication described below to my child. If prescription is changed, a new SMMO must be completed before the school staff can administer the medication. Parents/Guardian are responsible for maintaining necessary supplies, medications and equipment.</p>		
Parent Name (print):	Signature:	Date:
Emergency Contact Name:	Relationship:	Phone:
<b>SCHOOL NURSE</b>		
Seizure Emergency Care Plan (this form) distributed to ‘need to know’ staff:		
<input type="checkbox"/> Front office/admin <input type="checkbox"/> Teacher(s) <input type="checkbox"/> Transportation <input type="checkbox"/> Other (specify): _____		
School Nurse Signature:		Date:

<b>SEIZURE Medication/Management Orders (SMMO)</b> Utah Department of Health/Utah State Board of Education In Accordance with UCA 53A-11-603.5	<b>PCH Pediatric Neurology Clinic</b> 801-213-3599 Fax: 801-587-7539	<b>Other provider:</b>
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<b>STUDENT INFORMATION</b>
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<b>Student:</b>	<b>DOB:</b>	<b>Grade:</b>	<b>School:</b>
<b>Parent:</b>	<b>Phone:</b>		<b>Email:</b>
<b>Physician:</b>	<b>Phone:</b>		<b>Fax:</b>
<b>School Nurse:</b>	<b>School Phone:</b>		<b>Fax:</b>

<b>SEIZURE INFORMATION</b>
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Seizure Type/Description	Length	Frequency

If Seizures are full body tonic-clonic, rescue medication may be administered by a trained volunteer.  
**Seizures other than tonic-clonic, rescue medication can only be given by an RN, Parent or EMS.**

Yes  No Student has received a first dose of this medication in a non-medically-supervised setting without a complication.  
**If No, medication cannot be given by a trained volunteer. Can only be given by an RN, parent, or EMS.**

Yes  No Student has previously ceased having a full body prolonged or convulsive seizure as a result of receiving this medication.  
**If No, medication cannot be given by a trained volunteer. Can only be given by an RN, parent, or EMS.**

**Parent:** complete the above section, read and sign below, obtain signature from Health Care Provider, and return to school nurse.

As parent/guardian of the above named student, I give permission for my child's healthcare provider to share information with the school nurse for the completion of this order. I understand the information contained in this order will be shared with school staff on a need-to-know basis. It is the responsibility of the parent/guardian to notify the School Nurse of any change in the student's health status, care or medication order. If medication is ordered I authorize school staff to administer medication described below to my child. If prescription is changed a new SMMO must be completed before the school staff can administer the medication. Parents/Guardian are responsible for maintaining necessary supplies, medications and equipment.

Parent Signature:	Date:
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<b>CONTINUED ON NEXT PAGE</b>
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Student Name:	DOB:
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**EMERGENCY SEIZURE RESCUE MEDICATION**

**To Be Completed by Prescriber** - In accordance with these orders, an Individualized Health Care Plan (IHP) must be developed by the School Nurse and parent to be shared with appropriate school personnel, *and cannot be shared with any individual outside of those public education employees without parental consent.* As the student's LIP I confirm that the student has a diagnosis of seizures.

Give Emergency Medication IF:	Medication	Dose	Route	Call
<ul style="list-style-type: none"> <li>• If seizure lasts ___ minutes or greater</li> <li>• If ___ or more consecutive seizures with or without a period of consciousness (in ___ minutes)</li> <li>• Other _____</li> </ul>	<input type="checkbox"/> Midazolam (Versed) (Dose must be provided in 2 syringes)  <input type="checkbox"/> Diazepam (Diastat)  <input type="checkbox"/> Other _____	_____ mg  _____ ml	<input type="checkbox"/> Nasal <input type="checkbox"/> Rectal <input type="checkbox"/> Other	<b>ALWAYS call 911, parent and School Nurse</b>

This medication is necessary during the school day. Trained personnel should and will be allowed to administer this medication.

**Common potential side effects:** respiratory depression, nasal irritation, memory loss, drowsiness, other:

Additional instructions for administration:

**VAGUS NERVE STIMULATOR**

This student has a Vagus Nerve Stimulator. Trained personnel should and will be trained on magnet use. Describe magnet use:

**PRESCRIBER SIGNATURE**

This order can only be signed by an MD/DO; Nurse Practitioner, Certified Physician's Assistant or a provider with prescriptive practice.

Prescriber Name:	Phone:
Prescriber Signature:	Date:
School Nurse Signature:	Date:

# Standards of Care

## **Standards of Care for Allergy and Anaphylaxis Management in the School Setting Utah 2017**

NOTE: School nurses should determine their individual scope of practice regarding new allergy treatment therapies and/or allergy care practices.

Anaphylaxis is a chronic condition affecting 5%-10% of the children in the United States. It can be serious and life-threatening, but it can also be controlled. Symptoms of allergies can be mild, severe, or fatal, regardless of previous reaction.

There are eight foods that account for 90% of all food-allergic reactions. These are: milk, eggs, peanuts, tree nuts (walnuts, cashews, etc.), fish, shellfish, soy, and wheat. Other common allergens include insect stings and latex.

### Allergy and Anaphylaxis Emergency Action Plan

Students with a history of anaphylaxis should have an Allergy and Anaphylaxis Action Plan on file with the school before they attend. This is signed by the healthcare provider and the parent, and is reviewed by the school nurse. This Emergency Action Plan should be reviewed at least annually, or when the student transfers to another school.

The Department of Health along with other stakeholders have developed a State form (IHP104.1) that is recommended for use in Utah. This form is required for any student carrying or carrying and self-administering epinephrine while at school.

### Epinephrine Auto-Injector (EAI)

Utah Code 26-41-101 allows students to carry or carry and self-administer an epinephrine auto-injector when the appropriate form (IHP104.1) has been completed and signed by a parent and healthcare provider, and returned to the school.

Self-care ability level should be determined by the school nurse and parent/guardian. All students with a history of anaphylaxis, regardless of age or expertise, should have an Emergency Action Plan on file with the school, and may need assistance when experiencing a severe anaphylactic episode.

### Management

The school nurse can assist the student who has allergies with managing their condition in the following ways:

- Encourage parents to provide an epinephrine auto-injector to be left at school in case of emergencies.
- Assist teachers in modifying the student's environment as needed to reduce triggers.

### Self-Care Management

- Self-care ability level should be determined by school nurse and parent/guardian.

- All students, regardless of age or expertise, should have an IHP or EAP, and may need assistance when having an allergic reaction.

#### Allergen Free Schools or Classrooms

Declaring a classroom free of allergens should be discouraged. It is not always possible to prevent other students from bringing potential allergens to school. Instead, work to become an allergen 'aware' classroom or school. Sending notes to other parents in the class or school is appropriate asking for their support in not sending allergen-containing items, as long as confidentiality is maintained for the student with the allergen.

#### REFERENCES

Virginia Department of Education. First aid guide for school emergencies. Retrieved from [http://www.doe.virginia.gov/support/health\\_medical/index.shtml](http://www.doe.virginia.gov/support/health_medical/index.shtml)

## **Standards of Care for Asthma Management in the School Setting Utah 2017**

NOTE: School nurses should determine their individual scope of practice regarding new asthma treatment therapies and/or asthma care practices.

Asthma is a chronic condition affecting 5%-10% of the children in the United States. Asthma is responsible for more hospital admissions, emergency room visits, and school absences than any other childhood disease. It can be serious and life-threatening, but it can also be controlled. Symptoms of asthma may be mild, severe, or fatal.

During an acute episode, the airways become narrow or blocked, causing wheezing, coughing, and dyspnea. The most common stimuli are viral infections, exercise, allergens, environmental irritants, and stress.

### Asthma Action Plan

Students with asthma should have an Asthma Action Plan on file with the school before they attend. The plan is signed by the healthcare provider and the parent, and is reviewed by the school nurse. The Asthma Action Plan should be reviewed at least annually, or when the student transfers to another school.

The Department of Health along with other stakeholders have developed a State form (IHP101.1 or IHP101.2) that is recommended for use in Utah. This form is required for any student carrying and self-administering asthma medication while at school.

### Asthma Medication

Utah Code 53A-11-602 allows students to carry and self-administer inhaled asthma medication when the appropriate form (IHP101.1 or IHP101.2) has been completed and signed by parent and healthcare provider, and returned to the school.

### Self-Care Management

Self-care ability level should be determined by school nurse and parent/guardian.

- a. All students, regardless of age or expertise, should have an Asthma Action Plan on file with the school, and may need assistance when experiencing a severe asthma episode.

### Management

The school nurse can assist the student who is asthmatic with managing their condition in the following ways:

- Encourage parents to provide an extra rescue inhaler to be left at school in case of emergencies.

- Keep accurate records of asthmatic episodes at school, including triggers, early warning signs, treatment, and student/family education.
- Assist physical education teachers to modify physical education requirements (as necessary).
- Assist teachers in modifying the student's environment as needed to reduce triggers.
- Assist the student in administering the prescribed medications (as needed).
- Counsel the student about regular class attendance and the importance of pre-medication prior to engaging in activities that trigger asthmatic episodes.
- Monitor the student's activities, medication compliance, and academic performance.

## REFERENCES

Virginia Department of Education. First aid guide for school emergencies. Retrieved from [http://www.doe.virginia.gov/support/health\\_medical/index.shtml](http://www.doe.virginia.gov/support/health_medical/index.shtml)

## **Standards of Care for Diabetes Management in the School Setting Utah 2017**

NOTE: School nurses should determine their individual scope of practice regarding new diabetes treatment therapies and/or diabetes care practices.

*These are general standards of care for students with Type 1 Diabetes to be used in conjunction with the Utah Diabetes Medication Management Orders (DMMO), Individualized Healthcare Plans (IHP) and Emergency Action Plans (EAP). The student's diabetes health care provider may indicate exceptions to these standards on the student's individual orders.*

The Department of Health, along with other stakeholders, has developed state forms. The Diabetes Medication Management Order form (M-2) is required for any student with diabetes who wants glucagon available at the school, and/or needs accommodations made by the school. The IHP form (IHP103.1) is one option of a diabetes healthcare plan, as the EAP form (103.2) is an option for a diabetes emergency action plan. The school nurse may choose to use other forms instead of these, however, some kind of IHP and EAP should be on file for all students with diabetes.

1. Individualized Healthcare Plans (IHP) and Emergency Action Plans (EAP): Students with diabetes should have both an IHP and an EAP on file with the school before they attend. These are written by the school nurse and the parent, and will be based on the Diabetes Medication Management Orders (DMMO) signed by a licensed independent provider. Both the IHP and the EAP should be reviewed at least annually, or when the student transfers to another school.
  - a. The IHP is the daily management plan for the student with diabetes. This should include information on checking blood glucose, the instructions for routine insulin administration during school hours, and other student-specific instructions.
  - b. The EAP describes how to care for the student during hyperglycemia or hypoglycemia events.
2. Diabetes Medication Management Orders (DMMO): Provider orders should be obtained annually for the beginning of each school year and ongoing as needed. If ongoing changes to the insulin dosing is outside the current orders on file, the parents should contact the healthcare provider for new orders to reflect these changes. The DMMO should be attached to the IHP so that the most current orders are available to the school nurse or school staff. The diabetes medication management order form (M-2) is required for any student with diabetes who wants glucagon available at the school, and/or needs accommodations made by the school.

There are two parts to insulin calculations: one is the **insulin to carbohydrate ratio** which should be given with any food, the other is the **correction dose** that is restricted to meal times.

a. The **insulin to carb ratio** should be given for ALL food eaten at school, including meals, snacks, and parties. A student should never be denied the snack or party because a parent can't come in to administer this dose. Arrangements should be made by the schools to dose for these snacks and parties, and may be the same person that would do the lunch dose. This could include having an unlicensed assistive staff member administer the additional doses. Some districts may only have nurses administering insulin, in which case that nurse needs to be available to administer insulin (via pump, syringe, or pen depending on the student). *This is a basic right the student has that must be accommodated.*

Additional information: since this dosing is just for carbs the blood glucose doesn't need to be checked, but can be if requested. Dose would be based only on carbs to be eaten.

b. **Correction doses** are those that can only be done every 3 hours, or at lunch time unless on a pump and the pump recommends it.

3. Monitoring Blood Glucose (BG): The student's healthcare provider should indicate individualized BG target ranges on the student's individual orders (DMMO).
  - a. Standard Target Ranges before Meals: The student's target ranges are indicated by the diabetes healthcare provider. If the target range is not indicated, then these general standards should be used:
    - < 6 years old 100-200 mg/dl
    - 6-17 years old 80-150 mg/dl
    - > 17 years old 70-130 mg/dl

Note: The frequency of routine BG monitoring should take into consideration the student's schedule and participation in classroom learning/activities. *Too frequent routine BG monitoring may impact learning and school participation.* On average, a student would have routine BG monitoring one to three times during a full school day unless otherwise indicated on the DMMO.

4. Hypoglycemia (BG under target range):
  - a. The student should be treated in the classroom if symptomatic or if BG is below target range. If the student needs to go to the health office he/she should be accompanied by a responsible person, which in most cases would be an adult, unless otherwise indicated on the student's Section 504 plan.
  - b. Check blood glucose – if BG meter is not available, treat symptoms.
  - c. If BG is below target range and/or student is symptomatic, treat with 15 gm fast-acting carbohydrate. Retest in 10-15 minutes, repeat 15 gm fast-acting carbohydrate until within target range. When BG is within target range follow

with 15 gm complex carb (protein & carbohydrate) snack or lunch/meal (unless otherwise indicated on DMMO). DO NOT give insulin for this snack.

- d. Mild symptoms: Check BG, treat with 15 gm fast-acting carbohydrates until within target range.
  - e. Moderate symptoms: Check BG, treat with 15 gm fast-acting carbohydrates. Repeat and re-treat until within target range.
  - f. Severe symptoms: These may include seizures, unconsciousness, or being unable or unwilling to eat/drink. Check BG if meter is available and treat accordingly.
    - Call 911 and administer glucagon. Disconnect/suspend pump unless contrary to DMMO. If glucagon is ordered, trained personnel should be available to administer. ALWAYS call 911 if glucagon is administered.
    - **Do not give insulin for carbohydrates given to treat low blood glucose.** Students with a pump should not enter the carbohydrate grams into the pump that were given to treat a low BG.
5. Hyperglycemia (BG over target range):
- a. Treatment for hyperglycemia for students with an insulin pump:
    - If the student is on a pump, correction doses can be given other than at meal times **IF** the BG is tested and entered into the pump, **AND** if the pump recommends a correction dose. No adjustments are to be made to this recommended dose by school personnel (Murray, 2014).
    - If BG is greater than target range but less than 350 mg/dl, give correction as indicated by pump calculation, and recheck in two hours. If after two hours BG is still 300 or higher, this may indicate pump or site malfunction. Contact the parent/guardian. They may want to come to check ketone levels and change pump site.
      1. For a failed site or pump the school should have another means of administering insulin available. This would include an insulin pen, or syringe and vial.
    - Potential pump malfunction: The concern for a student on a pump with hyperglycemia is a malfunctioning pump and the risk of quickly going into diabetic ketoacidosis (DKA). Instructions on how to handle pump malfunctions should be included in the student's IHP, and will typically include administration of insulin via another route, and contacting the parent/guardian to replace the infusion set. An independent student can also insert a new infusion set.
  - b. Treatment for hyperglycemia for students NOT using an insulin pump:
    - Correction doses can only be given at meal times (breakfast and lunch).

- If the parent/guardian wants to give an additional dose, it is their prerogative, but they are required to come to the school and administer the dose personally (Murray, 2014).
  - Allow free and unrestricted access to the restroom, and to water or other non-sugar containing drinks.
- c. For all students (pump or no pump) the school nurse and parent should contact the healthcare provider for insulin dose adjustments if hyperglycemia occurs frequently.
  - d. If the student BG is 350 mg/dl or higher **and the student is symptomatic** (illness, nausea, vomiting) the student must go home to be monitored by the parent/guardian.
  - e. If the student's BG is 350 mg/dl or high and there are no symptoms (illness, nausea, vomiting) the student may remain in school. Notify parent of BG for them to treat later in the day.
6. Pump Management
- a. The computerized features/calculator of pump should be used for insulin boluses.
  - b. Parent/guardians are responsible for ensuring all pump settings align with provider orders.
  - c. The pump bolus calculator should not be overridden.
7. Diet and Nutrition
- a. All students should be encouraged to eat healthy foods.
  - b. Student with diabetes are not restricted on food they can have, but must take insulin to cover the carbohydrates eaten.
  - c. Arrangements should be made between teacher and parent on how to handle class parties.
8. Continuous Glucose Monitors (CGM)
- a. If a CGM alarm sounds indicating a high or low BG level, the school personnel or nurse should check a finger stick BG and then follow the DMMO.
  - b. The CGM alarms should be set so they do not alarm unnecessarily and disrupt the class frequently; but set to warn of possible low BG or high BG levels.
  - c. Parent/Guardian/Independent students are responsible for changing sensor/site. It is not the responsibility of school personnel to change sensor/site or calibrate the CGM.
  - d. **ALWAYS** confirm a CGM reading with a finger stick BG reading. Never enter the sensor reading into a pump.
  - e. Parents should not ask school personnel to review the CGM prior to physical activity and determine by this reading alone if the child can participate.
  - f. Monitoring of the CGM in the school setting is not required by school personnel unless the alarm sounds indicating a possible high or low BG reading.

- g. If anything needs to be done with the CGM a parent/guardian must come to the school and manage it.
- 9. Changing infusion sets is not a daily occurrence and should not be done routinely at school. These are typically done every 2-3 days and should be done at home by a parent/guardian. If the student is independent they can change the site at school, or the parent/guardian can come to school to change the infusion set if necessary. A recent search online found over 82 different kind of infusion sets.
- 10. Self-Care Management
  - a. Self-care ability level should be determined by school nurse and the parent/guardian.
  - b. All students, regardless of age or expertise, should have an IHP or EAP, and may need assistance with hypoglycemia and illness.

#### REFERENCES

Colorado Kids with Diabetes Care and Prevention Collaborative, (2016). Standards of care for diabetes management in the school setting & licensed child care facilities.

Murray, M. MD. (2014). Insulin administration at school (Letter to School Nurses).

Murray, M. MD. (2015). Continuous Glucose Monitors (Letter to School Nurses).

National Diabetes Education Program, (2016). Helping the student with diabetes succeed: A guide for school personnel.

## Standards of Care for Handling Outside Food in the School Setting Utah 2017

Food in the school setting is typically a function of the Nutrition Services for each district or school, however there may be times outside food may be brought in.

### Management

Food provided by the school for meals, including breakfast and lunch, should have nutritional information available for families. This should include carbohydrate counts (essential for students with diabetes) as well as an ingredient list, vital for students with food allergies.

Treats given to students for special occasions should be brought to school in a sealed packaged and labeled with nutritional information. **Homemade treats should not be allowed** for consumption to protect those students with food allergies, since ingredients may include a life-threatening allergen. This will also protect our students with diabetes, who must have access to the nutritional information for the item, including the carbohydrate count, which is necessary for proper insulin administration.

There is also a risk for a food-borne illness if the food is not prepared according to FDA regulations. All food served must come from an approved food source. Proper food preparation, safe handling practices, holding criteria and serving guidelines must also be met when serving food to students. Food should be unopened and in a sealed package prior to use.

- There can be a risk of cross-contamination. Even if parents write down the ingredients, there is no way to be assured that there is no cross contamination.
- Food and beverages should not be used as a reward or discipline for academic performance or behavior.
- Parents may still provide homemade or home-baked foods for their child's snack or lunch. However, those items may not be shared with other students.

### Food Allergies

Students with life-threatening food allergies have the right to expect the food provided to them, either by the school for regular meals or treats brought in for special occasions, will be safe for them to eat. For this reason, all food brought in to the school for consumption by students should be in a sealed package labeled with nutritional information, including all ingredients.

### Diabetes

In order to maintain good control of blood glucose, those with diabetes must dose with insulin for all carbohydrates eaten. For this reason all food brought in to the school for consumption by students should be in a sealed package labeled with nutritional information, including carbohydrate count.

## **Standards of Care for Head Lice Management in the School Setting Utah 2017**

NOTE: School nurses should determine their individual scope of practice regarding new pediculosis treatment therapies.

Adult head lice are roughly 2–3 mm long. Head lice infest the head and neck and attach their eggs to the base of the hair shaft. Lice move by crawling; they cannot hop or fly. They are not known to spread disease (CDC, 2016).

Head lice infestation, or pediculosis, is spread most commonly by close person-to-person contact. Dogs, cats, and other pets do not play a role in the transmission of human lice.

### **TREATMENT**

Several effective pediculicides (lice-killing products) are available. The school nurse should maintain their knowledge of available products and instructions for use. Parents and school staff should be instructed to follow the specific product instructions.

Evidence indicates that many school policies on head lice are more harmful when students are ostracized which can lead to increased bullying and lower school performance. The school nurse should work with school administrators to develop a policy that will meet the district needs.

The school nurse plays an integral role in assisting students and families with cases of pediculosis. It is their responsibility to know the district policy, changes in the standards of care, and evidence that is available for the education of school personnel, families, and students.

### **MANAGEMENT**

- “No-nit” policies should be discouraged. These result in unnecessary absenteeism, and may violate affected children’s civil liberties (NASN, 2016).
- Classroom screenings should be discouraged since subsequent cases are rarely found, nor are they cost-effective (NASN, 2016).
- If a case is found the child should be allowed to remain in school. The parent should be contacted at the end of the day, and given instructions on evidenced-based treatment options (NASN, 2016).
- Classroom or school notifications should be discouraged because it has been shown to increase community anxiety, increase social stigma causing embarrassment of affected infested students, and puts students’ rights to confidentiality at risk (NASN, 2016).
- Refer to an advanced healthcare provider if a prescription is needed. Many effective products are available without a prescription at local pharmacies.
- Instruct family on application of pediculicides, either prescribed medication or over the counter preparations according to package directions.

- Families should be educated on how to assess their children for suspected head lice.
- Control the school environment by considering the following:
  - Children should not be allowed to share hair ornaments, brushes or combs. Hats, coats, scarves and the like should be hung or placed individually for each child and not stacked or hung on top of those belonging to other children.
  - Wall hooks, if used, should be far enough apart that garments hung on adjacent hooks do not touch. Sometimes plastic bags with draw strings are hung to contain garments if hooks are not far enough apart.
  - Headgear, including headsets, should be removed from use if lice are present in the class. If lice are an ongoing problem, headgear and headsets should be stored in an air-tight plastic bag for 2 weeks and not reused until the problem is resolved.
  - Carpeted areas in classrooms should be vacuumed frequently and thoroughly. Lice killing sprays are generally unnecessary. Fumigation of classrooms or buses is not indicated.

## REFERENCES

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National Association of School Nurses. (2014). *Headfirst: Lice lessons*. Retrieved from <http://www.nasn.org/ToolsResources/HeadLicePediculosisCapitis/HeadfirstLiceLessons>

National Association of School Nurses. (2016). *Head lice management in the school setting* (Position Statement). Silver Spring, MD: Author.

## **Standards of Care for Seizure Management in the School Setting Utah 2017**

NOTE: School nurses should determine their individual scope of practice regarding new seizure treatment therapies and/or seizure care practices.

### Seizures

The school nurse can be instrumental in the identification of seizures and in providing education and support to students, teachers, and parents/guardians. Signs and symptoms vary with the type of seizure a student experiences, and the cause of seizures also varies. The school nurse needs to understand the various etiology associated with each type of seizure, the types of anticonvulsant medications that may be prescribed for the seizures, and the individualized plan of care for each student.

### Seizure Action Plan

Students with seizure disorders should have an Individualized Healthcare Plan (IHP) on file with the school before they attend. These are written by the school nurse and the parent, and can be reviewed by the physician. The IHP should be reviewed at least annually, or when the student transfers to another school.

The Department of Health, along with other stakeholders, has developed a State IHP form (IHP102.1) that is recommended for use in Utah. This form is not the only option; the school nurse may choose to use another seizure IHP form.

### Seizure Rescue Medication

Utah Code 53A-11-603.5 allows parents to request a volunteer be trained to administer seizure rescue medication for use in an emergency. The appropriate Seizure Medication Management Order (SMMO) (M-3) must be completed and signed by the parent and a healthcare provider, and returned to the school before this can be initiated.

According to the above referenced code, before this medication can be given at school the student:

- Must have been administered the medication in a non-medically supervised setting without a complication; and
- Must have ceased having a full body prolonged convulsive seizure activity as a result of receiving the seizure rescue medication.

If both of these requirements are not met, a volunteer cannot be trained to administer the medication at school. The training program developed by the Department of Health and its partners must be followed if seizure rescue medication is to be available in a school setting.

Seizure rescue medication is a controlled substance, and as such, should not be carried by the student. The parent/guardian should bring the medication to the school. Medication should be kept in a locked location, yet accessible for use in an emergency.

### Management

Monitoring of seizure activity includes:

- Obtaining and updating the student's health history, including an in-depth history of seizure onset, kind of seizure activity, triggers, aura(s), and prescribed medications.
- Documenting seizure activity. If seizure activity is observed, the observer should document the frequency, date/time/duration, specific behaviors, aura, changes in level of consciousness, etc.
- Implementing emergency medical care as needed.
- Counseling the student, teachers, and other staff regarding safety precautions should a seizure occur.
- Counseling the student regarding social adjustment, self-care needs, activity restrictions, and necessary modifications.
- Reporting any seizure activity to parents/guardians and to advanced healthcare provider.

Note: Access training materials from the Epilepsy Foundation at [www.epilepsyfoundation.org](http://www.epilepsyfoundation.org)

### REFERENCES

Utah Department of Health. (2016). Utah guidelines for administration of seizure rescue medication. Retrieved from <http://choosehealth.utah.gov/prek-12/school-nurses/guidelines/forms.php>

Virginia Department of Health. (1999). First aid guide for school emergencies. Retrieved from [http://www.doe.virginia.gov/support/health\\_medical/index.shtml](http://www.doe.virginia.gov/support/health_medical/index.shtml)

Acuity

## Recommendations for School Nurse Workload (Staffing) Utah 2017

School nurse workload must be determined at a level that provides for the student health, safety, and learning. In the past, ratios were used to determine staffing levels, with one registered nurse per 750 healthy students being recommended. However, there was little evidence to support this ratio.

Laws are in place to protect the right of all students to attend public school, including those with significant health needs. These laws include The Rehabilitation Act of 1973, Section 504 (2000) and Public Law 94-142, the Education for all Handicapped Children Act (1975), reauthorized in 2004 as the Individuals with Disabilities Education Improvement Act (IDEIA) (2004). A one-size-fits-all workload determination is inadequate to fill the increasingly complex health needs of students and communities.

Workloads should be determined at least annually, using student and community specific health data (NASN, 2015). The following factors must be considered when determining safe school nurse staffing levels in the schools:

1. **Student enrollment numbers;** and
2. **Social determinants** of students/community which include (but are not limited to) poverty, language barriers, education level, access to healthcare, safe housing, and transportation needs; and
3. **Health disparities** of students/community which include (but are not limited to) premature birth, race and ethnicity, disability, sexual orientation, and immigration status; and
4. **Health acuity\*** of students/community.

During the June 2017 meeting of the Board of Directors for the National Association of School Nurses, the following statement was written to standardize language regarding staffing:

“To optimize student health, safety and learning, it is the position of the National Association of School Nursing that a professional registered school nurse be present in every school all day, every day.”

While this position is the ideal, it is not always reasonable. This may be the case in some rural schools with populations of less than 100 students. Additionally, some schools may need more than one full-time nurse, based on enrollment or health acuity needs.

The Utah Department of Health (UDOH) believes it optimizes student health, safety, and learning when professional registered school nurses are assigned based on the individual needs of the school and community. Factors that must be included when determining safe school nurse staffing levels are student enrollment numbers, health acuity level of the student population, and social determinants and health disparities of the school and community.

Based on the above criteria UDOH recommends:

1. One full-time registered school nurse per school; or
2. Several full-time registered school nurses per school (for schools with high health acuity/social determinants of health/disparity needs); or
3. One full-time registered school nurse to no more than five schools (for schools with lower health acuity/social determinants of health/disparity needs). This permits the school nurse to visit each school one day per week for supervision/evaluation of delegated tasks to unlicensed assistive personnel (UAP).
4. Districts with less than 5,000 students should make every attempt to meet the above recommendations. If this is not possible, then the following guidelines are recommended:

District Size	Recommended FTE Registered School Nurse staff for districts with less than 5,000 students (Recommendations show range between one school nurse per 5,000 students and one school nurse per 750 students.)
<500	0.1 – 0.7 FTE depending on health acuity/social determinants of health/disparities
500-1000	0.2 – 1.3 FTE depending on health acuity/social determinants of health/disparities
1000-2000	0.4 – 2.7 FTE depending on health acuity/social determinants of health/disparities
2000-3000	0.6 – 4.0 FTE depending on health acuity/social determinants of health/disparities
3000-4000	0.8 – 5.3 FTE depending on health acuity/social determinants of health/disparities
4000-5000	1.0 – 6.7 FTE depending on health acuity/social determinants of health/disparities

**\* Health Acuity Levels**

Level 1	Level 2	Level 3	Level 4	Level 5
No/minimal occasional healthcare concerns— Students whose physical and/or social-emotional condition is stable and sees the nurse once a year for screening and occasionally as needed.	Health Concerns— Students whose physical and/or social emotional condition is currently uncomplicated and predictable. Occasional monitoring varies from biweekly to annually. These students may require an Individualized Healthcare Plan (IHP) or Emergency Action Plan (EAP).	Medically complex—Students whose complex and/or unstable physical and/or social-emotional condition require daily treatments and close monitoring. These students should have an IHP or EAP.	Medically Fragile— Students who have the daily possibility of a life-threatening emergency. These students must have an IHP.	Nursing Dependent— Students who require 24 hours/day, frequently on-to-one, and skilled nursing care for survival. Many are dependent on technological devices for breathing. These students must have an IHP.

**References**

Individuals with Disability Education Improvement Act (2004), 20 U.S.C 1400 et seq.

National Association of School Nurses. (2015). *School nurse workload: Staffing for safe care* (Position Statement). Silver Spring, MD: Author.

Rehabilitation Act of 1973, 29 E.S.C § 504.

## ACUITY SCALE FOR SCHOOL NURSE STAFFING

School Nurse Name: \_\_\_\_\_ School Name: \_\_\_\_\_

This Acuity Scale may be used to help determine adequate staffing needs for school nurses. Start by completing the Calculating Health Conditions section below, then transfer this number to the back and continue with calculations according to instructions.

This Acuity Scale should be used in conjunction with the Utah Department of Health’s “Recommendations for School Nurse Workload (Staffing)” statement, which recommends:

- One full-time registered school nurse per school; or
- Several full-time registered school nurses per school (for schools with high health acuity/social determinants of health/disparity needs); or
- One full-time registered school nurse to no more than five schools (for schools with lower health acuity/social determinants of health/disparity needs). This permits the school nurse to visit each school one day per week for supervision/evaluation of delegated tasks to unlicensed assistive personnel (UAP).
- Districts with less than 5,000 students should make every attempt to meet the above recommendations. If this is not possible, see “Standards of Care – School Nurse Workload” for more specific recommendations.

### Calculating Health Conditions

1. Enter total number of students for each level (total should add up to total student enrollment).
2. Enter total number of IHP/EAP/ECP in place.
3. Score each row:
4. Total all scores. Transfer this number to second page (Health Conditions) Total. Score according to formula.

Health Conditions	Total	Formula	Score
<u>Level 1</u> : No/minimal occasional healthcare concerns – Students whose physical and/or social-emotional condition is stable and sees the nurse once a year for screening and occasionally as needed.		Multiply by 0	0
<u>Level 2</u> : Health Concerns – Students whose physical and/or social emotional condition is currently uncomplicated and predictable. Occasional monitoring varies from biweekly to annually. These students <i>may</i> require an Individualized Healthcare Plan (IHP) or Emergency Action Plan (EAP).		Multiply by 1	
<u>Level 3</u> : Medically complex – Students whose complex and/or unstable physical and/or social-emotional condition require daily treatments and close monitoring. These students <i>should</i> have an IHP or EAP.		Multiply by 2	
<u>Level 4</u> : Medically Fragile – Students who have the daily possibility of a life-threatening emergency. These students <i>must</i> have an IHP.		Multiply by 3	
<u>Level 5</u> : Nursing Dependent – Students who require 24 hours/day, frequently on-to-one, and skilled nursing care for survival. Many are dependent on technological devices for breathing. These students <i>must</i> have an IHP.		Multiply by 4	
<b>Number of IHP/EAP in place</b> (multiply by 1)		Multiply by 1	
<b>Total Health Conditions Score</b> (transfer this number to ‘A’ on back)			

		Total	Formula				Score
A. Health Conditions (See front for instructions)			0-50	1	201-250	5	
			51-100	2	251-300	6	
			101-150	3	301-350	7	
			151-200	4	351+	8	
	<b>Total</b>	<b>Elementary Formula</b>	<b>Secondary Formula</b>			<b>Score</b>	
B. Enrollment		1-500	1	1-1000		1	
		501-1000	2	1001-2000		2	
		1001-1250	3	2001-3000		3	
		1251+	4	3001+		4	
	<b>Total</b>	<b>Formula</b>	<b>Score</b>				
C. Economically Disadvantaged (low income)			1-100	1	401-500	5	
			101-200	2	501-600	6	
			201-300	3	601-700	7	
			301-400	4	701+	8	
	<b>Total</b>	<b>Formula</b>	<b>Score</b>				
D. Students with Disability (Special Education [SpEd])			0-30	1	121-150	5	
			31-60	2	151-180	6	
			61-90	3	181-210	7	
			91-120	4	211+	8	
	<b>Total</b>	<b>Formula</b>	<b>Score</b>				
E. English Learners			1-50	1	201-250	5	
			51-100	2	251-300	6	
			101-150	3	301-350	7	
			151-200	4	351+	8	
	<b>Total</b>	<b>Formula</b>	<b>Score</b>				
F. Additional Programs (SpEd self-contained, PK, etc.)			1-2	1	5-6	3	
			3-4	2	7-8	4	
	<b>Total</b>	<b>Formula</b>	<b>Score</b>				
G. Grade Level			Elem	5	High	0	
			Jr/Mid	2	Specialty	5	
<b>TOTAL ACUITY SCORE</b>							
<b>Acuity Score</b>	<b>FTE</b>	<b>Days per Week</b>					
1-4	0.1	0.5					
5-9	0.2	1					
10-14	0.3	1.5					
15-19	0.4	2					
20-24	0.5	2.5					
25-29	0.6	3					
30-34	0.7	3.5					
35-39	0.8	4					
40-44	0.9	4.5					
45+	1.0	5					

Items B, C, D, and E can be found in the October 1<sup>st</sup> enrollment summary on USBE website (<https://schools.utah.gov/data/reports>, Fall Enrollment by School by gender, race/ethnicity, English learner, students with disabilities, and economically disadvantaged).

Code of Ethics

## National Association of School Nurses CODE OF ETHICS

### Preamble

Acknowledging the diversity of the laws and conditions under which school nurses practice, the National Association of School Nurses (NASN) believes in a commonality of moral and ethical conduct. As such, NASN adopts the American Nurses Association's (ANA) [Code of Ethics for Nurses with Interpretive Statements](#) (2015), which establishes an ethical foundation for all nurses. Furthermore, this foundation is supported by the *School Nursing: Scope and Standards of Practice, 2<sup>nd</sup> Edition* (ANA & NASN, 2011) and ethical guidelines provided by state boards of nursing. School nursing practice, built upon these ethical foundations, is grounded in the NASN core values of child well-being, diversity, excellence, innovation, integrity, leadership, and scholarship (NASN, 2015). It is the responsibility of both the individual nurse and nursing organizations to function within these ethical provisions. For the purpose of this document the term student also refers to families and school communities.

### Organizational Ethics

NASN, a 501(c)(3) non-profit organization established to support student health through the advancement of school nursing practice, has ethical responsibilities to its members and the communities those members serve (NASN, 2015). These organizational responsibilities include:

- Promotion of ethical work environments that support student and community health;
- Development of "...a research agenda that will lead to a culture of ethical practice in diverse settings that is evidence-based and measurable in terms of outcomes..." (Johns Hopkins School of Nursing & Johns Hopkins Berman Institute of Bioethics, 2014, p. 5);
- Development of relationships with organizations whose principles and actions are in harmony with NASN's mission and values and the termination of relationships with organizations whose known actions violate NASN's business and ethical principles; and
- Support of the role of the school nurse through advocacy, integrity, and participation in public policy development and social justice.

### School Nurse Ethics

School nurses straddle two statutory and regulatory frameworks, health and education. Because school nurses practice nursing in an educationally focused system, they face unique legal, policy, funding and supervisory issues that may also have ethical dimensions. These issues may include:

- Unsafe school nurse to student ratios,

- Accountability for care delegated to Unlicensed Assistive Personnel (UAP),
- School administrator request to amend documentation,
- School administrator assignment of nursing tasks to UAP without the input of the school nurse, and
- Parent/guardian request for medical treatment for his/her student, which is inconsistent with school nurse scope of practice (Brent, 2013).

As such, school nurses must have not only the skills to communicate within both the healthcare and education arenas, but also the requisite knowledge and skills to interpret applicable laws, regulations and professional standards, as well as apply ethical theories and principles (ANA & NASN, 2011).

### **Child Well-being**

- School nurses support and promote student abilities to achieve the highest quality of life as understood by each individual and family.
- School nurses integrate “caring, kindness, and respect into nursing practice” (ANA & NASN, 2011, p. 51).
- School nurses serve a unique role in transition planning to address student health needs within the school environment.
- School nurses maintain protection of, and confidentiality with, student health records according to the Health Insurance Portability and Accountability Act (HIPAA), Family Education Rights Protection Act (FERPA), other applicable federal laws, state laws and regulations, and professional standards of practice to safeguard privacy.
- School nurses utilize interventions designed to mitigate the effects of adverse childhood experiences and other social determinants of health.
- School nurses refer students to other health professionals and community health agencies as needed to promote health and well-being.

### **Diversity**

- School nurses deliver care in a manner that promotes and preserves student autonomy, dignity and rights so that all are treated equally regardless of race, gender, socio-economic status, culture, age, sexual orientation, gender identity, disability or religion.
- School nurses deliver care in an inclusive, collaborative manner that embraces diversity in the school community.
- School nurses actively promote student health, safety, and self worth.
- School nurses intervene to eliminate discrimination and bullying.

### **Excellence**

- School nurses must have knowledge relevant to meet the needs of the student and maintain the highest level of competency by enhancing professional knowledge and skills and by collaborating with peers, other health professionals and community agencies.
- School nurses incorporate information from supervisory clinical evaluation to improve their nursing practice.

- School nurses evaluate their own nursing practice in relation to professional standards of practice and applicable laws, regulations and policies.

**Innovation**

- School nurses utilize available research in developing health programs, individual plans of care, and interventions.
- School nurse workplace environments impact the quality of health care; therefore, school nurses collaborate to improve these environments.
- School nurses are aware of social determinants of health in the school community, provide health care to all students, support school staff, and partner with families and other community members to reduce health disparities.

**Integrity**

- School nurses maintain confidentiality within the legal, regulatory and ethical parameters of health and education.
- School nurses understand, follow and inform others about student health record protection according to HIPAA, FERPA, other applicable federal laws, and state laws and regulations.
- School nurses take “appropriate action regarding instances of illegal, unethical, or inappropriate behavior that can endanger or jeopardize the best interest of the healthcare consumer or situation” (ANA & NASN, 2011, p. 50).

**Leadership**

- School nurses are student advocates.
- School nurses support student rights in navigating the educational environment.
- Delegation or assignment of nursing tasks, including accountability for delegated tasks, may be the responsibility of the school nurse. School nurse assignments and delegations must be consistent with state nurse practice guidelines and established best practice.
- School nurses work within educational institutions to define and implement professional standards of practice and school health policy development.

**Scholarship**

- School nurses are life long learners in pursuit of knowledge, training and experiences that enhance the quality of their nursing practice.
- School nurses participate in and promote research activities as a means of advancing student health and school health services.
- School nurses conduct research as appropriate to the nurse's education, position and practice environment.
- School nurses adhere to the ethics that govern research, specifically:
  - Rights to privacy and confidentiality;
  - Voluntary and informed consent; and

- Awareness of and participation in the mechanisms available to ensure the rights of human subjects, particularly vulnerable populations (e.g. minors, disabled).

### Conclusion:

In the course of day-to-day practice and based upon the applicable state nurse practice act and professional scope and standards of practice, school nurses may find themselves in situations that present ethical dilemmas. School nurses and school nurse organizations have a responsibility to practice in accordance with the NASN core values, *NASN Code of Ethics* and professional standards of practice. School nurse decision-making is guided by these principles that promote improved student health, academic success and excellence in school health services. NASN believes the practice of school nursing demands a vigilant focus on ethics.

### References

American Nurses Association. (2015). *Code of ethics for nurses with interpretive statements*. Silver Spring, MD: Nursebooks.org.

American Nurses Association & National Association of School Nurses. (2011). *School nursing: Scope and standards of practice* (2<sup>nd</sup> ed.). Silver Spring, MD: Nursebooks.org.

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## Nurse Practice Act

## **Chapter 31b Nurse Practice Act**

### **Part 1 General Provisions**

#### **58-31b-101 Title.**

This chapter is known as the "Nurse Practice Act."

Enacted by Chapter 288, 1998 General Session

#### **58-31b-102 Definitions.**

In addition to the definitions in Section 58-1-102, as used in this chapter:

- (1) "Administrative penalty" means a monetary fine or citation imposed by the division for acts or omissions determined to constitute unprofessional or unlawful conduct in accordance with a fine schedule established by rule and as a result of an adjudicative proceeding conducted in accordance with Title 63G, Chapter 4, Administrative Procedures Act.
- (2) "Applicant" means a person who applies for licensure or certification under this chapter by submitting a completed application for licensure or certification and the required fees to the department.
- (3) "Approved education program" means a nursing education program that meets the minimum standards for educational programs established under this chapter and by division rule in collaboration with the board.
- (4) "Board" means the Board of Nursing created in Section 58-31b-201.
- (5) "Consultation and referral plan" means a written plan jointly developed by an advanced practice registered nurse and a consulting physician that permits the advanced practice registered nurse to prescribe schedule II-III controlled substances in consultation with the consulting physician.
- (6) "Consulting physician" means a physician and surgeon or osteopathic physician and surgeon licensed in accordance with this title who has agreed to consult with an advanced practice registered nurse with a controlled substance license, a DEA registration number, and who will be prescribing schedule II-III controlled substances.
- (7) "Diagnosis" means the identification of and discrimination between physical and psychosocial signs and symptoms essential to the effective execution and management of health care.
- (8) "Examinee" means a person who applies to take or does take any examination required under this chapter for licensure.
- (9) "Licensee" means a person who is licensed or certified under this chapter.
- (10) "Long-term care facility" means any of the following facilities licensed by the Department of Health pursuant to Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act:
  - (a) a nursing care facility;
  - (b) a small health care facility;
  - (c) an intermediate care facility for people with an intellectual disability;
  - (d) an assisted living facility Type I or II; or
  - (e) a designated swing bed unit in a general hospital.
- (11) "Medication aide certified" means a certified nurse aide who:
  - (a) has a minimum of 2,000 hours experience working as a certified nurse aide;

- (b) has received a minimum of 60 hours of classroom and 40 hours of practical training that is approved by the division in collaboration with the board, in administering routine medications to patients or residents of long-term care facilities; and
  - (c) is certified by the division as a medication aide certified.
- (12)
- (a) "Practice as a medication aide certified" means the limited practice of nursing under the supervision, as defined by the division by administrative rule, of a licensed nurse, involving routine patient care that requires minimal or limited specialized or general knowledge, judgment, and skill, to an individual who:
    - (i) is ill, injured, infirm, has a physical, mental, developmental, or intellectual disability; and
    - (ii) is in a regulated long-term care facility.
  - (b) "Practice as a medication aide certified":
    - (i) includes:
      - (A) providing direct personal assistance or care; and
      - (B) administering routine medications to patients in accordance with a formulary and protocols to be defined by the division by rule; and
    - (ii) does not include assisting a resident of an assisted living facility, a long term care facility, or an intermediate care facility for people with an intellectual disability to self administer a medication, as regulated by the Department of Health by administrative rule.
- (13) "Practice of advanced practice registered nursing" means the practice of nursing within the generally recognized scope and standards of advanced practice registered nursing as defined by rule and consistent with professionally recognized preparation and education standards of an advanced practice registered nurse by a person licensed under this chapter as an advanced practice registered nurse. Advanced practice registered nursing includes:
- (a) maintenance and promotion of health and prevention of disease;
  - (b) diagnosis, treatment, correction, consultation, and referral for common health problems;
  - (c) prescription or administration of prescription drugs or devices including:
    - (i) local anesthesia;
    - (ii) schedule IV-V controlled substances; and
    - (iii) schedule II-III controlled substances in accordance with a consultation and referral plan; or
  - (d) the provision of preoperative, intraoperative, and postoperative anesthesia care and related services upon the request of a licensed health care professional by an advanced practice registered nurse specializing as a certified registered nurse anesthetist, including:
    - (i) preanesthesia preparation and evaluation including:
      - (A) performing a preanesthetic assessment of the patient;
      - (B) ordering and evaluating appropriate lab and other studies to determine the health of the patient; and
      - (C) selecting, ordering, or administering appropriate medications;
    - (ii) anesthesia induction, maintenance, and emergence, including:
      - (A) selecting and initiating the planned anesthetic technique;
      - (B) selecting and administering anesthetics and adjunct drugs and fluids; and
      - (C) administering general, regional, and local anesthesia;
    - (iii) postanesthesia follow-up care, including:
      - (A) evaluating the patient's response to anesthesia and implementing corrective actions; and
      - (B) selecting, ordering, or administering the medications and studies listed in Subsection (13) (d); and
    - (iv) other related services within the scope of practice of a certified registered nurse anesthetist, including:

- (A) emergency airway management;
  - (B) advanced cardiac life support; and
  - (C) the establishment of peripheral, central, and arterial invasive lines; and
- (v) for purposes of Subsection (13)(d), "upon the request of a licensed health care professional":
- (A) means a health care professional practicing within the scope of the health care professional's license, requests anesthesia services for a specific patient; and
  - (B) does not require an advanced practice registered nurse specializing as a certified registered nurse anesthetist to enter into a consultation and referral plan or obtain additional authority to select, administer, or provide preoperative, intraoperative, or postoperative anesthesia care and services.
- (14) "Practice of nursing" means assisting individuals or groups to maintain or attain optimal health, implementing a strategy of care to accomplish defined goals and evaluating responses to care and treatment. The practice of nursing requires substantial specialized or general knowledge, judgment, and skill based upon principles of the biological, physical, behavioral, and social sciences, and includes:
- (a) initiating and maintaining comfort measures;
  - (b) promoting and supporting human functions and responses;
  - (c) establishing an environment conducive to well-being;
  - (d) providing health counseling and teaching;
  - (e) collaborating with health care professionals on aspects of the health care regimen;
  - (f) performing delegated procedures only within the education, knowledge, judgment, and skill of the licensee; and
  - (g) delegating nurse interventions that may be performed by others and are not in conflict with this chapter.
- (15) "Practice of practical nursing" means the performance of nursing acts in the generally recognized scope of practice of licensed practical nurses as defined by rule and as provided in this Subsection (15) by a person licensed under this chapter as a licensed practical nurse and under the direction of a registered nurse, licensed physician, or other specified health care professional as defined by rule. Practical nursing acts include:
- (a) contributing to the assessment of the health status of individuals and groups;
  - (b) participating in the development and modification of the strategy of care;
  - (c) implementing appropriate aspects of the strategy of care;
  - (d) maintaining safe and effective nursing care rendered to a patient directly or indirectly; and
  - (e) participating in the evaluation of responses to interventions.
- (16) "Practice of registered nursing" means performing acts of nursing as provided in this Subsection (16) by a person licensed under this chapter as a registered nurse within the generally recognized scope of practice of registered nurses as defined by rule. Registered nursing acts include:
- (a) assessing the health status of individuals and groups;
  - (b) identifying health care needs;
  - (c) establishing goals to meet identified health care needs;
  - (d) planning a strategy of care;
  - (e) prescribing nursing interventions to implement the strategy of care;
  - (f) implementing the strategy of care;
  - (g) maintaining safe and effective nursing care that is rendered to a patient directly or indirectly;
  - (h) evaluating responses to interventions;
  - (i) teaching the theory and practice of nursing; and

- (j) managing and supervising the practice of nursing.
- (17) "Routine medications":
  - (a) means established medications administered to a medically stable individual as determined by a licensed health care practitioner or in consultation with a licensed medical practitioner; and
  - (b) is limited to medications that are administered by the following routes:
    - (i) oral;
    - (ii) sublingual;
    - (iii) buccal;
    - (iv) eye;
    - (v) ear;
    - (vi) nasal;
    - (vii) rectal;
    - (viii) vaginal;
    - (ix) skin ointments, topical including patches and transdermal;
    - (x) premeasured medication delivered by aerosol/nebulizer; and
    - (xi) medications delivered by metered hand-held inhalers.
- (18) "Unlawful conduct" is as defined in Sections 58-1-501 and 58-31b-501.
- (19) "Unlicensed assistive personnel" means any unlicensed person, regardless of title, to whom tasks are delegated by a licensed nurse as permitted by rule and in accordance with the standards of the profession.
- (20) "Unprofessional conduct" is as defined in Sections 58-1-501 and 58-31b-502 and as may be further defined by rule.

Amended by Chapter 366, 2011 General Session

**58-31b-103 Nurse Education and Enforcement Account.**

- (1) There is created a restricted account within the General Fund known as the "Nurse Education and Enforcement Account."
- (2) The restricted account shall consist of:
  - (a) administrative penalties imposed under Section 58-31b-503; and
  - (b) interest earned on money in the account.
- (3) Money in the account may be appropriated by the Legislature for the following purposes:
  - (a) education and training of licensees or potential licensees under this chapter;
  - (b) enforcement of this chapter by:
    - (i) investigating unprofessional or unlawful conduct;
    - (ii) providing legal representation to the division when legal action is taken against a person engaging in unprofessional or unlawful conduct; and
    - (iii) monitoring compliance of renewal requirements;
  - (c) survey nursing education programs throughout the state;
  - (d) education and training of board members; and
  - (e) review and approve nursing education programs and medication aide certified training programs.

Amended by Chapter 303, 2011 General Session

## **Part 2 Board**

### **58-31b-201 Board.**

- (1) There is created the Board of Nursing that consists of the following 11 members:
  - (a) nine nurses in a manner as may be further defined in division rule; and
  - (b) two members of the public.
- (2) The board shall be appointed and serve in accordance with Section 58-1-201.
- (3) The board shall carry out the duties and responsibilities in Sections 58-1-202 and 58-1-203 and shall:
  - (a)
    - (i) recommend to the division minimum standards for educational programs qualifying a person for licensure or certification under this chapter;
    - (ii) recommend to the division denial, approval, or withdrawal of approval regarding educational programs that meet or fail to meet the established minimum standards; and
    - (iii) designate one of its members on a permanent or rotating basis to:
      - (A) assist the division in reviewing complaints concerning the unlawful or unprofessional conduct of a licensee; and
      - (B) advise the division in its investigation of these complaints.
  - (b) A board member who has, under Subsection (3)(a)(iii), reviewed a complaint or advised in its investigation may be disqualified from participating with the board when the board serves as a presiding officer in an adjudicative proceeding concerning the complaint.
- (4)
  - (a) The director shall appoint an individual to serve as an ex officio member of the Board of Nursing to represent the position of the division in matters considered by the board.
  - (b) The ex officio member shall be a licensed registered nurse, shall have earned a masters degree in nursing, and shall have a minimum of five years of experience working in nursing administration or nursing education.

Amended by Chapter 372, 2010 General Session

## **Part 3 Licensing**

### **58-31b-301 License or certification required -- Classifications.**

- (1) A license is required to engage in the practice of nursing, except as specifically provided in Sections 58-1-307 and 58-31b-308.
- (2) The division shall issue to a person who qualifies under this chapter a license or certification in the classification of:
  - (a) licensed practical nurse;
  - (b) registered nurse;
  - (c) advanced practice registered nurse intern;
  - (d) advanced practice registered nurse;
  - (e) advanced practice registered nurse - CRNA without prescriptive practice; and
  - (f) medication aide certified.

- (3) An individual holding an advanced practice registered nurse license as of July 1, 1998, who cannot document the successful completion of advanced course work in patient assessment, diagnosis and treatment, and pharmacotherapeutics, may not prescribe and shall be issued an "APRN - without prescriptive practice" license.
- (4) The division shall grant an advanced practice registered nurse license to any licensed advanced practice registered nurse currently holding prescriptive authority under any predecessor act on July 1, 1998.
- (5) An individual holding a certified registered nurse anesthetist license as of July 1, 2007, shall be issued an "APRN - CRNA - without prescriptive practice" license.

Amended by Chapter 57, 2007 General Session

**58-31b-302 Qualifications for licensure or certification -- Criminal background checks.**

- (1) An applicant for certification as a medication aide shall:
  - (a) submit an application to the division on a form prescribed by the division;
  - (b) pay a fee to the division as determined under Section 63J-1-504;
  - (c) have a high school diploma or its equivalent;
  - (d) have a current certification as a nurse aide, in good standing, from the Department of Health;
  - (e) have a minimum of 2,000 hours of experience within the two years prior to application, working as a certified nurse aide in a long-term care facility;
  - (f) obtain letters of recommendation from a long-term care facility administrator and one licensed nurse familiar with the applicant's work practices as a certified nurse aide;
  - (g) be in a condition of physical and mental health that will permit the applicant to practice safely as a medication aide certified;
  - (h) have completed an approved education program or an equivalent as determined by the division in collaboration with the board;
  - (i) have passed the examinations as required by division rule made in collaboration with the board; and
  - (j) meet with the board, if requested, to determine the applicant's qualifications for certification.
- (2) An applicant for licensure as a licensed practical nurse shall:
  - (a) submit to the division an application in a form prescribed by the division;
  - (b) pay to the division a fee determined under Section 63J-1-504;
  - (c) have a high school diploma or its equivalent;
  - (d) be in a condition of physical and mental health that will permit the applicant to practice safely as a licensed practical nurse;
  - (e) have completed an approved practical nursing education program or an equivalent as determined by the board;
  - (f) have passed the examinations as required by division rule made in collaboration with the board; and
  - (g) meet with the board, if requested, to determine the applicant's qualifications for licensure.
- (3) An applicant for licensure as a registered nurse shall:
  - (a) submit to the division an application form prescribed by the division;
  - (b) pay to the division a fee determined under Section 63J-1-504;
  - (c) have a high school diploma or its equivalent;
  - (d) be in a condition of physical and mental health that will allow the applicant to practice safely as a registered nurse;
  - (e) have completed an approved registered nursing education program;

- (f) have passed the examinations as required by division rule made in collaboration with the board; and
  - (g) meet with the board, if requested, to determine the applicant's qualifications for licensure.
- (4) Applicants for licensure as an advanced practice registered nurse shall:
- (a) submit to the division an application on a form prescribed by the division;
  - (b) pay to the division a fee determined under Section 63J-1-504;
  - (c) be in a condition of physical and mental health which will allow the applicant to practice safely as an advanced practice registered nurse;
  - (d) hold a current registered nurse license in good standing issued by the state or be qualified at the time for licensure as a registered nurse;
  - (e)
    - (i) have earned a graduate degree in:
      - (A) an advanced practice registered nurse nursing education program; or
      - (B) a related area of specialized knowledge as determined appropriate by the division in collaboration with the board; or
    - (ii) have completed a nurse anesthesia program in accordance with Subsection (4)(f)(ii);
  - (f) have completed:
    - (i) course work in patient assessment, diagnosis and treatment, and pharmacotherapeutics from an education program approved by the division in collaboration with the board; or
    - (ii) a nurse anesthesia program which is approved by the Council on Accreditation of Nurse Anesthesia Educational Programs;
  - (g) to practice within the psychiatric mental health nursing specialty, demonstrate, as described in division rule, that the applicant, after completion of a doctorate or master's degree required for licensure, is in the process of completing the applicant's clinical practice requirements in psychiatric mental health nursing, including in psychotherapy;
  - (h) have passed the examinations as required by division rule made in collaboration with the board;
  - (i) be currently certified by a program approved by the division in collaboration with the board and submit evidence satisfactory to the division of the certification; and
  - (j) meet with the board, if requested, to determine the applicant's qualifications for licensure.
- (5) For each applicant for licensure or certification under this chapter:
- (a) the applicant shall:
    - (i) submit fingerprint cards in a form acceptable to the division at the time the application is filed; and
    - (ii) consent to a fingerprint background check by the Utah Bureau of Criminal Identification and the Federal Bureau of Investigation regarding the application; and
  - (b) the division shall request the Department of Public Safety to complete a Federal Bureau of Investigation criminal background check through the national criminal history system (NCIC) or any successor system.
- (6) For purposes of conducting the criminal background checks required in Subsection (5), the division shall have direct access to criminal background information maintained pursuant to Title 53, Chapter 10, Part 2, Bureau of Criminal Identification.
- (7)
- (a)
    - (i) Any new nurse license or certification issued under this section shall be conditional, pending completion of the criminal background check.
    - (ii) If the criminal background check discloses the applicant has failed to accurately disclose a criminal history, the license or certification shall be immediately and automatically revoked.

- (b)
  - (i) Any person whose conditional license or certification has been revoked under Subsection (7)(a) shall be entitled to a postrevocation hearing to challenge the revocation.
  - (ii) The hearing shall be conducted in accordance with Title 63G, Chapter 4, Administrative Procedures Act.
- (8)
  - (a) If a person has been charged with a violent felony, as defined in Subsection 76-3-203.5(1)(c), and, as a result, the person has been convicted, entered a plea of guilty or nolo contendere, or entered a plea of guilty or nolo contendere held in abeyance pending the successful completion of probation:
    - (i) the person is disqualified for licensure under this chapter; and
    - (ii)
      - (A) if the person is licensed under this chapter, the division:
        - (I) shall act upon the license as required under Section 58-1-401; and
        - (II) may not renew or subsequently issue a license to the person under this chapter; and
      - (B) if the person is not licensed under this chapter, the division may not issue a license to the person under this chapter.
  - (b) If a person has been charged with a felony other than a violent felony, as defined in Subsection 76-3-203.5(1)(c), and, as a result, the person has been convicted, entered a plea of guilty or nolo contendere, or entered a plea of guilty or nolo contendere held in abeyance pending the successful completion of probation:
    - (i) if the person is licensed under this chapter, the division shall determine whether the felony disqualifies the person for licensure under this chapter and act upon the license, as required, in accordance with Section 58-1-401; and
    - (ii) if the person is not licensed under this chapter, the person may not file an application for licensure under this chapter any sooner than five years after having completed the conditions of the sentence or plea agreement.

Amended by Chapter 316, 2014 General Session

**58-31b-303 Qualifications for licensure -- Graduates of nonapproved nursing programs.**

An applicant for licensure as a practical nurse or registered nurse who is a graduate of a nursing education program not approved by the division in collaboration with the board must comply with the requirements of this section.

- (1) An applicant for licensure as a licensed practical nurse shall:
  - (a) meet all requirements of Subsection 58-31b-302(2), except Subsection (2)(e); and
  - (b) produce evidence acceptable to the division and the board that the nursing education program completed by the applicant is equivalent to the minimum standards established by the division in collaboration with the board for an approved licensed practical nursing education program.
- (2) An applicant for licensure as a registered nurse shall:
  - (a) meet all requirements of Subsection 58-31b-302(3), except Subsection (3)(e); and
  - (b)
    - (i) pass the Commission on Graduates of Foreign Nursing Schools (CGFNS) Examination; or
    - (ii) produce evidence acceptable to the division and the board that the applicant is currently licensed as a registered nurse in one of the states, territories, or the District of Columbia of the United States and has passed the NCLEX-RN examination.

Amended by Chapter 291, 2006 General Session

**58-31b-304 Qualifications for admission to the examinations.**

- (1) To be admitted to the examinations required for certification as a medication aide certified, a person shall:
  - (a) submit an application on a form prescribed by the division;
  - (b) pay a fee as determined by the division under Section 63J-1-504; and
  - (c) meet all requirements of Subsection 58-31b-302(1), except the passing of the examination.
- (2) To be admitted to the examinations required for licensure as a practical nurse, a person shall:
  - (a) submit an application form prescribed by the division;
  - (b) pay a fee as determined by the division under Section 63J-1-504; and
  - (c) meet all requirements of Subsection 58-31b-302(2), except Subsection (2)(f).
- (3) To be admitted to the examinations required for licensure as a registered nurse, a person shall:
  - (a) submit an application form prescribed by the division;
  - (b) pay a fee as determined by the division under Section 63J-1-504; and
  - (c) meet all the requirements of Subsection 58-31b-302(3), except Subsection (3)(f).

Amended by Chapter 183, 2009 General Session

**58-31b-305 Term of license -- Expiration -- Renewal.**

- (1) The division shall issue each license or certification under this chapter in accordance with a two-year renewal cycle established by rule. The division may by rule extend or shorten a renewal period by as much as one year to stagger the renewal cycles it administers.
- (2) The division shall renew the license of a licensee who, at the time of renewal:
  - (a) completes and submits an application for renewal in a form prescribed by the division;
  - (b) pays a renewal fee established by the division under Section 63J-1-504; and
  - (c) meets continuing competency requirements as established by rule.
- (3) In addition to the renewal requirements under Subsection (2), a person licensed as a advanced practice registered nurse shall be currently certified by a program approved by the division in collaboration with the board and submit evidence satisfactory to the division of that qualification or if licensed prior to July 1, 1992, meet the requirements established by rule.
- (4) In addition to the requirements described in Subsections (2) and (3), an advanced practice registered nurse licensee specializing in psychiatric mental health nursing who, as of the day on which the division originally issued the licensee's license had not completed the division's clinical practice requirements in psychiatric and mental health nursing, shall, to qualify for renewal:
  - (a) if renewing less than two years after the day on which the division originally issued the license, demonstrate satisfactory progress toward completing the clinical practice requirements; or
  - (b) have completed the clinical practice requirements.
- (5) Each license or certification automatically expires on the expiration date shown on the license or certification unless renewed in accordance with Section 58-1-308.

Amended by Chapter 316, 2014 General Session

**58-31b-306 APRN intern license.**

- (1)

- (a) The division may issue an APRN intern license to a person who meets all qualifications for a license as an advanced practice registered nurse under this chapter, except for the passing of required examinations, if the applicant:
  - (i) is a graduate of an approved nursing education program within the year immediately preceding application for an intern license;
  - (ii) has never before taken the examinations; and
  - (iii) submits to the division evidence of having secured employment conditioned upon issuance of the APRN intern license, and the employment is under the supervision of an advanced practice registered nurse or physician as defined by division rule.
- (b) An APRN intern license issued under Subsection (1)(a) expires on the earlier of:
  - (i) a date following a period established by division rule;
  - (ii) the date upon which the division receives notice from the examination agency that the individual failed to take or pass the examinations upon notification to the applicant; or
  - (iii) the date upon which the division issues the individual an APRN license.
- (2) An applicant specializing in psychiatric mental health nursing may be issued an APRN intern license upon completion of all licensure requirements, except for the passing of required examinations and completion of required clinical practice hours.
- (3)
  - (a) The division may issue an APRN intern license to a person who meets all qualifications for a license as an advanced practice registered nurse under this chapter, except course work in patient assessment or pharmacotherapeutics, if that applicant:
    - (i) is licensed in good standing as an advanced practice registered nurse in another state or jurisdiction; and
    - (ii) submits to the division evidence of having secured employment conditioned upon issuance of the APRN intern license, and the employment is under the supervision of an advanced practice registered nurse or physician as defined by division rule.
  - (b) An APRN intern license issued under Subsection (3)(a) expires on the earlier of:
    - (i) a date following a period established by division rule; or
    - (ii) the date upon which the division issues the individual a regular license.

Enacted by Chapter 288, 1998 General Session

**58-31b-308 Exemptions from licensure.**

- (1) In addition to the exemptions from licensure in Section 58-1-307, the following persons may engage in acts included within the definition of the practice of nursing, subject to the stated circumstances and limitations, without being licensed under this chapter:
  - (a) friends, family members, foster parents, or legal guardians of a patient performing gratuitous nursing care for the patient;
  - (b) persons providing care in a medical emergency;
  - (c) persons engaged in the practice of religious tenets of a church or religious denomination; and
  - (d) after July 1, 2000, a person licensed to practice nursing by a jurisdiction that has joined the Nurse Licensure Compact to the extent permitted by Section 58-31c-102.
- (2) Notwithstanding Subsection (1)(d), the division may, in accordance with Section 58-31c-102, limit or revoke practice privileges in this state of a person licensed to practice nursing by a jurisdiction that has joined the Nurse Licensing Compact.

Amended by Chapter 50, 2005 General Session

Amended by Chapter 134, 2005 General Session

**58-31b-309 Continuing education.**

- (1) The division in collaboration with the board may establish continuing education requirements for each classification of nurse licensure.
- (2) The division may discriminate between classifications of licensure with respect to continuing education requirements upon finding the continuing education requirements are necessary to reasonably protect the public health, safety, or welfare.

Enacted by Chapter 288, 1998 General Session

**Part 4**  
**License Denial and Discipline**

**58-31b-401 Grounds for denial of licensure or certification and disciplinary proceedings.**

- (1) Grounds for refusal to issue a license to an applicant, for refusal to renew the license of a licensee, to revoke, suspend, restrict, or place on probation the license of a licensee, to issue a public or private reprimand to a licensee, and to issue cease and desist orders shall be in accordance with Section 58-1-401.
- (2) If a court of competent jurisdiction determines a nurse is incapacitated as defined in Section 75-1-201 or that the nurse has a mental illness, as defined in Section 62A-15-602, and unable to safely engage in the practice of nursing, the director shall immediately suspend the license of the nurse upon the entry of the judgment of the court, without further proceedings under Title 63G, Chapter 4, Administrative Procedures Act, regardless of whether an appeal from the court's ruling is pending. The director shall promptly notify the nurse in writing of the suspension.
- (3)
  - (a) If the division and the majority of the board find reasonable cause to believe a nurse who is not determined judicially to be an incapacitated person or to have a mental illness, is incapable of practicing nursing with reasonable skill regarding the safety of patients, because of illness, excessive use of drugs or alcohol, or as a result of any mental or physical condition, the board shall recommend that the director file a petition with the division, and cause the petition to be served upon the nurse with a notice of hearing on the sole issue of the capacity of the nurse to competently, safely engage in the practice of nursing.
  - (b) The hearing shall be conducted under Section 58-1-109 and Title 63G, Chapter 4, Administrative Procedures Act, except as provided in Subsection (4).
- (4)
  - (a) Every nurse who accepts the privilege of being licensed under this chapter gives consent to:
    - (i) submitting to an immediate mental or physical examination, at the nurse's expense and by a division-approved practitioner selected by the nurse when directed in writing by the division and a majority of the board to do so; and
    - (ii) the admissibility of the reports of the examining practitioner's testimony or examination, and waives all objections on the ground the reports constitute a privileged communication.
  - (b) The examination may be ordered by the division, with the consent of a majority of the board, only upon a finding of reasonable cause to believe:
    - (i) the nurse has a mental illness, is incapacitated, or otherwise unable to practice nursing with reasonable skill and safety; and

- (ii) immediate action by the division and the board is necessary to prevent harm to the nurse's patients or the general public.
- (c)
  - (i) Failure of a nurse to submit to the examination ordered under this section is a ground for the division's immediate suspension of the nurse's license by written order of the director.
  - (ii) The division may enter the order of suspension without further compliance with Title 63G, Chapter 4, Administrative Procedures Act, unless the division finds the failure to submit to the examination ordered under this section was due to circumstances beyond the control of the nurse and was not related directly to the illness or incapacity of the nurse.
- (5)
  - (a) A nurse whose license is suspended under Subsection (2), (3), or (4)(c) has the right to a hearing to appeal the suspension within 10 days after the license is suspended.
  - (b) The hearing held under this Subsection (5) shall be conducted in accordance with Sections 58-1-108 and 58-1-109 for the sole purpose of determining if sufficient basis exists for the continuance of the order of suspension in order to prevent harm to the nurse's patients or the general public.
- (6) A nurse whose license is revoked, suspended, or in any way restricted under this section may request the division and the board to consider, at reasonable intervals, evidence presented by the nurse, under procedures established by division rule, regarding any change in the nurse's condition, to determine whether:
  - (a) the nurse is or is not able to safely and competently engage in the practice of nursing; and
  - (b) the nurse is qualified to have the nurse's license to practice under this chapter restored completely or in part.
- (7) Nothing in Section 63G-2-206 may be construed as limiting the authority of the division to report current significant investigative information to the coordinated licensure information system for transmission to party states as required of the division by Article VII of the Nurse Licensure Compact in Section 58-31c-102.
- (8) For purposes of this section:
  - (a) "licensed" or "license" includes "certified" or "certification" under this chapter; and
  - (b) any terms or conditions applied to the word "nurse" in this section also apply to a medication aide certified.

Amended by Chapter 364, 2013 General Session

## **Part 5**

### **Unlawful and Unprofessional Conduct - Penalties**

#### **58-31b-501 Unlawful conduct.**

"Unlawful conduct" includes:

- (1) using the following titles, names or initials, if the user is not properly licensed or certified under this chapter:
  - (a) nurse;
  - (b) licensed practical nurse, practical nurse, or L.P.N.;
  - (c) medication aide certified, or M.A.C.;
  - (d) registered nurse or R.N.;
  - (e) registered nurse practitioner, N.P., or R.N.P.;

- (f) registered nurse specialist, N.S., or R.N.S.;
  - (g) registered psychiatric mental health nurse specialist;
  - (h) advanced practice registered nurse;
  - (i) nurse anesthetist, certified nurse anesthetist, certified registered nurse anesthetist, or C.R.N.A.; or
  - (j) other generally recognized names or titles used in the profession of nursing;
- (2)
- (a) using any other name, title, or initials that would cause a reasonable person to believe the user is licensed or certified under this chapter if the user is not properly licensed or certified under this chapter; and
  - (b) for purposes of Subsection (2)(a), it is unlawful conduct for a medication aide certified to use the term "nurse"; and
- (3) conducting a nursing education program in the state for the purpose of qualifying individuals to meet requirements for licensure under this chapter without the program having been approved under Section 58-31b-601.

Amended by Chapter 291, 2006 General Session

**58-31b-502 Unprofessional conduct.**

"Unprofessional conduct" includes:

- (1) failure to safeguard a patient's right to privacy as to the patient's person, condition, diagnosis, personal effects, or any other matter about which the licensee is privileged to know because of the licensee's or person with a certification's position or practice as a nurse or practice as a medication aide certified;
- (2) failure to provide nursing service or service as a medication aide certified in a manner that demonstrates respect for the patient's human dignity and unique personal character and needs without regard to the patient's race, religion, ethnic background, socioeconomic status, age, sex, or the nature of the patient's health problem;
- (3) engaging in sexual relations with a patient during any:
  - (a) period when a generally recognized professional relationship exists between the person licensed or certified under this chapter and patient; or
  - (b) extended period when a patient has reasonable cause to believe a professional relationship exists between the person licensed or certified under the provisions of this chapter and the patient;
- (4)
  - (a) as a result of any circumstance under Subsection (3), exploiting or using information about a patient or exploiting the licensee's or the person with a certification's professional relationship between the licensee or holder of a certification under this chapter and the patient; or
  - (b) exploiting the patient by use of the licensee's or person with a certification's knowledge of the patient obtained while acting as a nurse or a medication aide certified;
- (5) unlawfully obtaining, possessing, or using any prescription drug or illicit drug;
- (6) unauthorized taking or personal use of nursing supplies from an employer;
- (7) unauthorized taking or personal use of a patient's personal property;
- (8) knowingly entering into any medical record any false or misleading information or altering a medical record in any way for the purpose of concealing an act, omission, or record of events, medical condition, or any other circumstance related to the patient and the medical or nursing care provided;
- (9) unlawful or inappropriate delegation of nursing care;

- (10) failure to exercise appropriate supervision of persons providing patient care services under supervision of the licensed nurse;
- (11) employing or aiding and abetting the employment of an unqualified or unlicensed person to practice as a nurse;
- (12) failure to file or record any medical report as required by law, impeding or obstructing the filing or recording of such a report, or inducing another to fail to file or record such a report;
- (13) breach of a statutory, common law, regulatory, or ethical requirement of confidentiality with respect to a person who is a patient, unless ordered by a court;
- (14) failure to pay a penalty imposed by the division;
- (15) prescribing a schedule II-III controlled substance without a consulting physician or outside of a consultation and referral plan;
- (16) violating Section 58-31b-801; and
- (17) violating the dispensing requirements of Section 58-17b-309 or Chapter 17b, Part 8, Dispensing Medical Practitioner and Dispensing Medical Practitioner Clinic Pharmacy, if applicable.

Amended by Chapter 72, 2014 General Session

**58-31b-503 Penalties and administrative actions for unlawful conduct and unprofessional conduct.**

- (1) Any person who violates the unlawful conduct provision specifically defined in Subsection 58-1-501(1)(a) is guilty of a third degree felony.
- (2) Any person who violates any of the unlawful conduct provisions specifically defined in Subsections 58-1-501(1)(b) through (f) and 58-31b-501(1)(d) is guilty of a class A misdemeanor.
- (3) Any person who violates any of the unlawful conduct provisions specifically defined in this chapter and not set forth in Subsection (1) or (2) is guilty of a class B misdemeanor.
- (4)
  - (a) Subject to Subsection (6) and in accordance with Section 58-31b-401, for acts of unprofessional or unlawful conduct, the division may:
    - (i) assess administrative penalties; and
    - (ii) take any other appropriate administrative action.
  - (b) An administrative penalty imposed pursuant to this section shall be deposited in the "Nurse Education and Enforcement Account" as provided in Section 58-31b-103.
- (5) If a licensee has been convicted of violating Section 58-31b-501 prior to an administrative finding of a violation of the same section, the licensee may not be assessed an administrative fine under this chapter for the same offense for which the conviction was obtained.
- (6)
  - (a) If upon inspection or investigation, the division concludes that a person has violated the provisions of Section 58-31b-401, 58-31b-501, or 58-31b-502, Chapter 1, Division of Occupational and Professional Licensing Act, Chapter 37, Utah Controlled Substances Act, or any rule or order issued with respect to these provisions, and that disciplinary action is appropriate, the director or the director's designee from within the division shall:
    - (i) promptly issue a citation to the person according to this chapter and any pertinent administrative rules;
    - (ii) attempt to negotiate a stipulated settlement; or
    - (iii) notify the person to appear before an adjudicative proceeding conducted under Title 63G, Chapter 4, Administrative Procedures Act.

- (b) Any person who is in violation of a provision described in Subsection (6)(a), as evidenced by an uncontested citation, a stipulated settlement, or a finding of violation in an adjudicative proceeding may be assessed a fine:
  - (i) pursuant to this Subsection (6) of up to \$10,000 per single violation or up to \$2,000 per day of ongoing violation, whichever is greater, in accordance with a fine schedule established by rule; and
  - (ii) in addition to or in lieu of the fine imposed under Subsection (6)(b)(i), be ordered to cease and desist from violating a provision of Sections 58-31b-501 and 58-31b-502, Chapter 1, Division of Occupational and Professional Licensing Act, Chapter 37, Utah Controlled Substances Act, or any rule or order issued with respect to those provisions.
- (c) Except for an administrative fine and a cease and desist order, the licensure sanctions cited in Section 58-31b-401 may not be assessed through a citation.
- (d) Each citation issued under this section shall:
  - (i) be in writing; and
  - (ii) clearly describe or explain:
    - (A) the nature of the violation, including a reference to the provision of the chapter, rule, or order alleged to have been violated;
    - (B) that the recipient must notify the division in writing within 20 calendar days of service of the citation in order to contest the citation at a hearing conducted under Title 63G, Chapter 4, Administrative Procedures Act; and
    - (C) the consequences of failure to timely contest the citation or to make payment of any fines assessed by the citation within the time specified in the citation; and
  - (iii) be served upon any person upon whom a summons may be served:
    - (A) in accordance with the Utah Rules of Civil Procedure;
    - (B) personally or upon the person's agent by a division investigator or by any person specially designated by the director; or
    - (C) by mail.
- (e) If within 20 calendar days from the service of a citation, the person to whom the citation was issued fails to request a hearing to contest the citation, the citation becomes the final order of the division and is not subject to further agency review. The period to contest the citation may be extended by the division for cause.
- (f) The division may refuse to issue or renew, suspend, revoke, or place on probation the license of a licensee who fails to comply with the citation after it becomes final.
- (g) The failure of an applicant for licensure to comply with a citation after it becomes final is a ground for denial of license.
- (h) No citation may be issued under this section after the expiration of six months following the occurrence of any violation.

Amended by Chapter 340, 2011 General Session

## **Part 6**

### **Nursing Education Programs**

#### **58-31b-601 Minimum standards for nursing programs -- Medication aide training.**

- (1) Except as provided in Subsection (2), to qualify as an approved education program for the purpose of qualifying graduates for licensure under this chapter, a nursing education program

shall be accredited by an accrediting body for nursing education that is approved by the United States Department of Education.

- (2) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the division, in consultation with the board, may make rules establishing requirements for a nursing education program to qualify for a limited time as an approved education program for the purpose of qualifying graduates for licensure under this chapter, if the program:
  - (a) is in the process of obtaining the accreditation described in Subsection (1);
  - (b) has recently been denied accreditation after seeking to obtain the accreditation described in Subsection (1); or
  - (c) has recently lost the accreditation described in Subsection (1).
- (3) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, and the provisions of this chapter, the division shall make rules defining the minimum standards for a medication aide certified training program to qualify a person for certification under this chapter as a medication aide certified.

Amended by Chapter 29, 2015 General Session

## **Part 7 Immunity Provisions**

### **58-31b-701 Immunity from liability.**

A person licensed, registered, or certified under this chapter:

- (1) who provides emergency care in accordance with Section 78B-4-501 is entitled to the immunity from civil liability provided under that section; and
- (2) is considered a health care provider under Chapter 13, Health Care Providers Immunity from Liability Act, and is entitled to the immunity from civil liability provided under that chapter.

Amended by Chapter 3, 2008 General Session

### **58-31b-702 Reporting of disciplinary action -- Immunity from liability.**

- (1) A licensed health care facility or organization or a professional society of nurses in the state that takes disciplinary action against a person licensed under this chapter relating to any of the following shall report the action in writing to the division within 30 days after the action is taken:
  - (a) that person's professional acts or omissions as a licensed nurse;
  - (b) that person's nursing competence or ability to practice nursing safely; or
  - (c) that person's use of alcohol or drugs in an unlawful manner or to the extent the person is impaired in his ability to practice nursing safely.
- (2) Any person or organization furnishing information in accordance with this section is immune from liability to the extent that the information is furnished in good faith and without malice.

Amended by Chapter 50, 2005 General Session

### **58-31b-703 Opiate antagonist -- Exclusion from unprofessional or unlawful conduct.**

- (1) Title 26, Chapter 55, Emergency Administration of Opiate Antagonist Act, applies to a licensee under this chapter.

- (2) The prescribing or dispensing of an opiate antagonist as defined in Section 26-55-102 by a licensee under this chapter is not unprofessional or unlawful conduct if the licensee prescribed or dispensed the opiate antagonist in a good faith effort to assist:
  - (a) a person who is at increased risk of experiencing or who is likely to experience an opiate-related drug overdose event as defined in Section 26-55-102; or
  - (b) a family member of, friend of, or other person who is in a position to assist a person who may be at increased risk of experiencing or who is likely to experience an opiate-related drug overdose event.
- (3) The provisions of this section and Title 26, Chapter 55, Emergency Administration of Opiate Antagonist Act, do not establish a duty or standard of care in the prescribing, dispensing, or administration of an opiate antagonist.

Enacted by Chapter 130, 2014 General Session

## **Part 8 Practice Standards**

### **58-31b-801 Practice within limits of competency.**

- (1) Each person licensed under this chapter is responsible for confining his practice as a nurse to those acts and practices permitted by law.
- (2) A person licensed under this act may not engage in any act or practice for which he is not competent.

Enacted by Chapter 288, 1998 General Session

### **58-31b-802 Consumer access to provider charges.**

Beginning January 1, 2011, a nurse whose license under this chapter authorizes independent practice shall, when requested by a consumer:

- (1) make a list of prices charged by the nurse available for the consumer which includes the nurse's 25 most frequently performed:
  - (a) clinic procedures or clinic services;
  - (b) out-patient procedures; and
  - (c) in-patient procedures; and
- (2) provide the consumer with information regarding any discount available for:
  - (a) services not covered by insurance; or
  - (b) prompt payment of billed charges.

Enacted by Chapter 68, 2010 General Session

## Nurse Practice Act Rule

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