



UTAH DEPARTMENT OF
HEALTH

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

Utah School Nurse Resource Manual

2020



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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

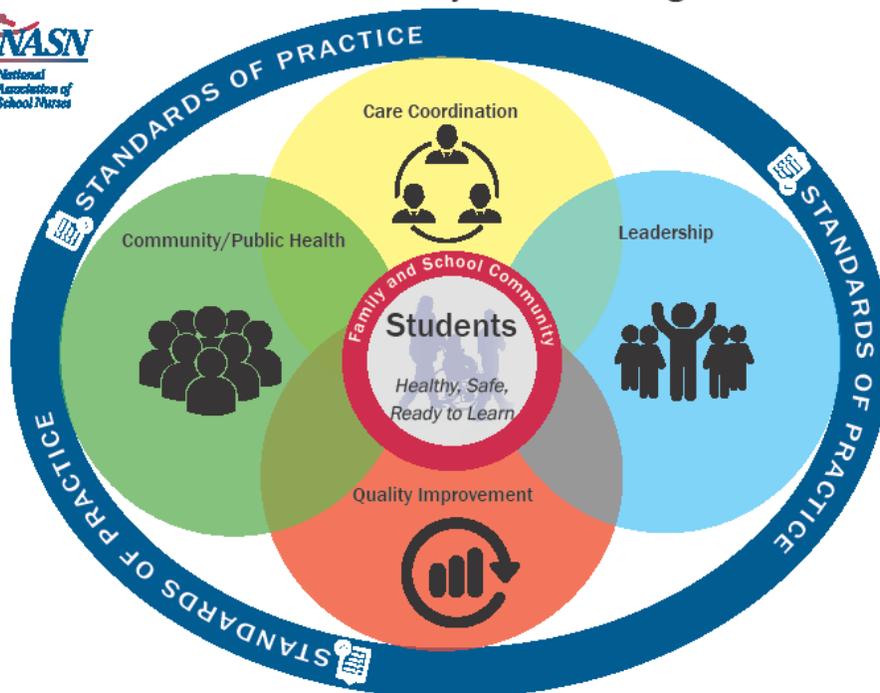
The purpose of this resource manual is to provide current, up-to-date information regarding school nursing practice in Utah. Just as there are geographical and population differences among school districts and charter schools, it is understood that roles and responsibilities of school nurses may vary as well. It is impossible to provide specifics for each school. 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 21st 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 21ST CENTURY SCHOOL NURSING PRACTICE

In 2015, the Framework for the 21st 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 21st Century School Nursing Practice™



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Rev. 9/28/15

The following sections are taken directly from NASN’s Framework for 21st 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 Action Plan (EAP), 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 EAP 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 *Every Student Counts*, a NASN initiative 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 (<https://www.nasn.org/nasn-resources/professional-topics>).

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” (<https://www.nasn.org/about-nasn/about>).

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 or charter school should have a medical advisor who can advise or consult on medical matters. The 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’s 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, 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 schools 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 1st, 3rd, and 5th 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 85th percentile and 95th percentile for age and gender will be defined as “overweight” and students greater than the 95th 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.utahschoolnurses.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.

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: <https://www.nasn.org/nasn/advocacy/professional-practice-documents>

Back to school toolkit: <https://www.pathlms.com/nasn/courses/13256>

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, 2017).

Standard 1. Assessment

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

Standard 2. Diagnosis

The school nurse analyzes assessment data to determine actual or potential diagnoses, problems, and issues.

Standard 3. Outcomes Identification

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

Standard 4. Planning

The school nurse develops a plan that prescribes strategies to attain expected, measurable 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 employs strategies to promote health and a safe environment.

Standard 6. Evaluation

The school nurse evaluates progress toward attainment of goals and 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. Culturally Congruent Practice

The school nurse practices in a manner that is congruent with cultural diversity and inclusion principles.

Standard 9. Communication

The school nurse communicates effectively in all areas of practice.

Standard 10. Collaboration

The school nurse collaborates with key stakeholders in the conduct of nursing practice.

Standard 11. Leadership

The school nurse leads within the professional practice setting and the profession.

Standard 12. Education

The school nurse seeks knowledge and competence that reflects current nursing practice and promotes futuristic thinking.

Standard 13. Evidence-Based Practice and Research

The school nurse integrates evidence and research findings into practice.

Standard 14. Quality of Practice

The school nurse contributes to quality nursing practice.

Standard 15. Professional Practice Evaluation

The school nurse evaluates one's own and others' nursing practice.

Standard 16. Resource Utilization

The school nurse utilizes appropriate resources to plan, provide, and sustain evidence-based services that are safe, effective, and fiscally responsible.

Standard 17. Environmental Health

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

Standard 18. Program Management

The school nurse directs the health services program within the school and community that includes evidence-based practice and accountability measures for quality, student health, and learning outcomes.

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.

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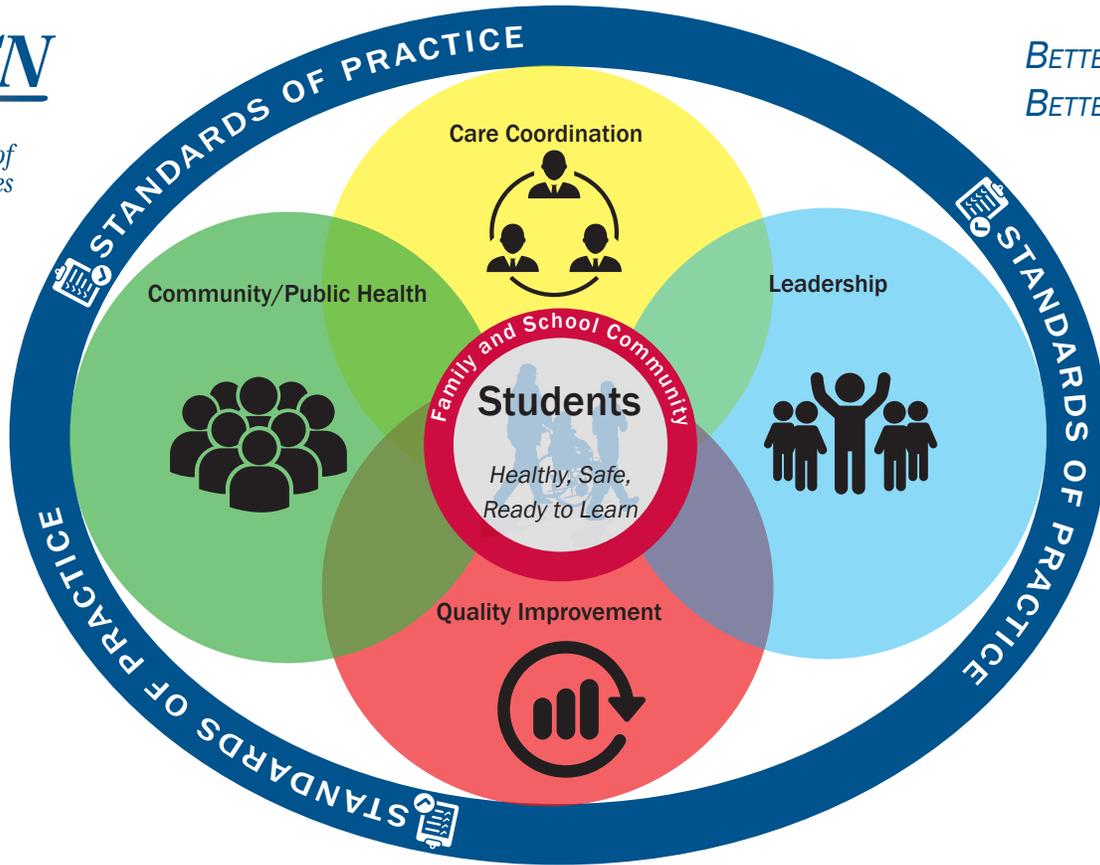
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APPENDIX

Framework for 21st Century School Nursing Practice™



BETTER HEALTH.
BETTER LEARNING.™



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.

 <p>Standards of Practice</p> <ul style="list-style-type: none"> • Clinical Competency • Clinical Guidelines • Code of Ethics • Critical Thinking • Evidence-based Practice • NASN Position Statements • Nurse Practice Acts • Scope and Standards of Practice 	 <p>Leadership</p> <ul style="list-style-type: none"> • Advocacy • Change Agents • Education Reform • Funding and Reimbursement • Healthcare Reform • Lifelong Learner • Models of Practice • Technology • Policy Development and Implementation • Professionalism • Systems-level Leadership 	 <p>Quality Improvement</p> <ul style="list-style-type: none"> • Continuous Quality Improvement • Documentation/Data Collection • Evaluation • Meaningful Health/Academic Outcomes • Performance Appraisal • Research • Uniform Data Set 	 <p>Community/Public Health</p> <ul style="list-style-type: none"> • Access to Care • Cultural Competency • Disease Prevention • Environmental Health • Health Education • Health Equity • Healthy People 2020 • Health Promotion • Outreach • Population-based Care • Risk Reduction • Screenings/Referral/Follow-up • Social Determinants of Health • Surveillance 	 <p>Care Coordination</p> <ul style="list-style-type: none"> • Case Management • Chronic Disease Management • Collaborative Communication • Direct Care • Education • Interdisciplinary Teams • Motivational Interviewing/Counseling • Nursing Delegation • Student Care Plans • Student-centered Care • Student Self-empowerment • Transition Planning
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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"> Identify and review new practice guidelines, policies and documents. Identify any changes needed 	
<i>Care Coordination</i>	<ul style="list-style-type: none"> Set up health room Work with students/parents/guardians to update or develop individual health care plans (IHPs) and emergency action plans (EAPs) Train school staff as appropriate regarding health and emergency action plans Obtain necessary provider information and forms for medications and health procedures to be administered in schools Train other school staff as appropriate regarding medications and procedures to be administered in schools 	
<i>Leadership</i>	<ul style="list-style-type: none"> Confirm forms, IHPs/EAPs, and training methods are current, evidence-based Identify student-based and personal growth goals for the school year Identify required and self-imposed reporting deadlines for the year Send a message to teachers and parents/guardians introducing yourself and sharing about your role keep students and schools health 	
<i>Quality Improvement</i>	<ul style="list-style-type: none"> Set up documentation system for the year; include state workload census 	
<i>Community/ Public Health</i>	<ul style="list-style-type: none"> 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 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) Work with parents/guardians, school staff, and community health care providers to identify and follow up with students needing required immunizations 	

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

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

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

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

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

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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.

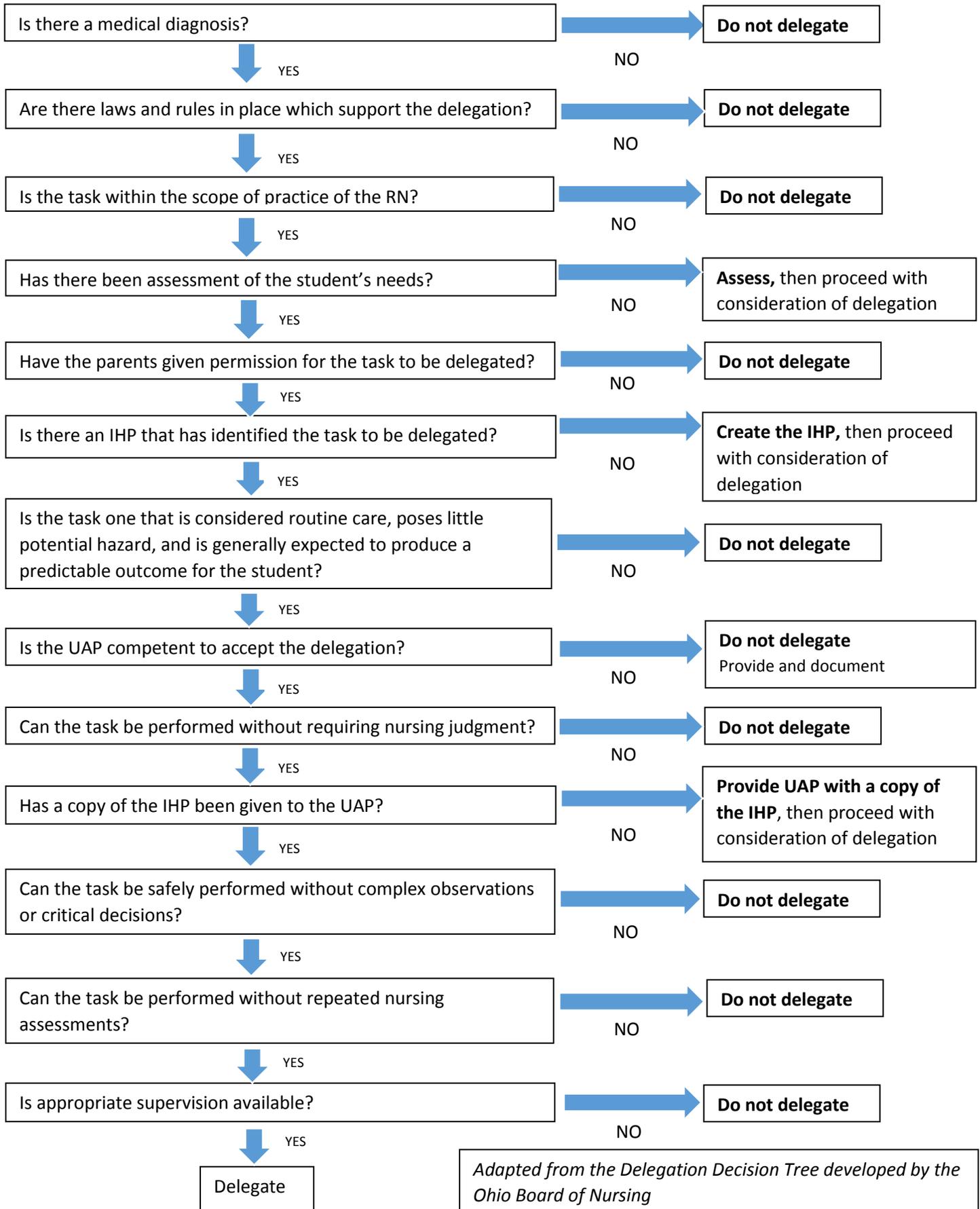
The above was adapted from a similar tool previously developed by Colorado titled "Guidance on Delegation for Colorado School Nurses & Child Care Consultants".

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Delegation Decision-making Tree



Adapted from the Delegation Decision Tree developed by the Ohio Board of Nursing

What Can School Nurses Do to Help You?



Standards of Practice	Leadership	Care Coordination	Quality Improvement	Community/Public Health
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Reference: National Association of School Nurses, (2015). Framework for the 21st century school nursing practice™. Silver Spring, MD: Author.

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
STUDENT INFORMATION					
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:	
MEDICATION INFORMATION					
<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>SIGNATURE 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:					

School Nurse		
<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 B - Medication Administration Log (Sample)

MEDICATION ADMINISTRATION LOG												
(One log per medication)												
STUDENT:				PARENT:				YEAR:		TEACHER:		
MEDICATION				DOSE		ROUTE		TIME		COMMENT:		
DATE												
COUNT												
INITIALS (2 PEOPLE)												
MEDICATION ADMINISTRATION LOG												
August				September				October				November
Notes:												
December				January				February				March
Notes:												
April				May				June				July
Notes:												
CODES												
(initials) = given, X = No School, A = Absent, NP = No med Available, R = Refused, PC = Parent called/notified, OT = Off Track												
STAFF TO ADMINISTER												
Staff Name				Signature				Initial		Date Trained		
Official Use Only: School Nurse to complete						Date Complete Form Received:						
School Nurse Name				Signature				Initial		Date(s) Staff Trained		
Notes:												

This form is not required if Local Education Agency (LEA) has developed their own medication authorization form/log with the same information included.

ATTACHMENT C - Medication Error Reporting Form (Sample)

UTAH MEDICATION ERROR REPORT FORM		
<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:	

Utah Code

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.

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- (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

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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



UTAH SCHOOL VISION SCREENING POLICY AUGUST 2019

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The Vision Screening Protocol and Procedures can be found online at:

<http://choosehealth.utah.gov/prek-12/school-nurses/guidelines/screenings.php>

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May 29, 2019

RE: A Message from the State Superintendent of Public Instruction

The Utah State Board of Education (USBE) 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 thank them for their tremendous efforts.

With appreciation,

Sydney Dickson

Sydney Dickson, Ed.D. State Superintendent of Public Instruction

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INTRODUCTION

Utah State Law (UCA 53G-9-404) mandates 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 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) has an interest in ensuring that vision screening of children is accomplished in a reliable, valid, and consistent manner. This policy was developed with the advice and contributions of the UDOH Vision Screening Policy Task Force to assist school nurses in implementing a successful and evidence-based vision screening program.

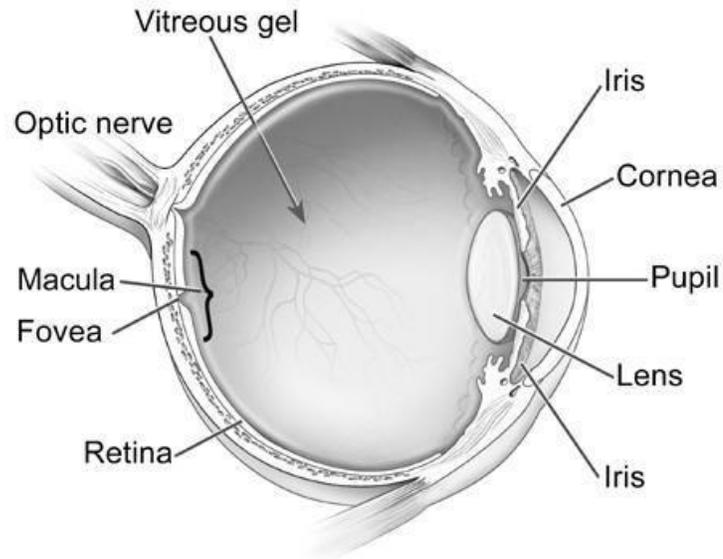
Vision screening, when overseen by a school nurse and performed by properly trained individuals, leads to early identification and appropriate medical referral for diagnosis and treatment of visual disturbances. Children often do not identify a vision deficiency themselves; therefore, school vision screening 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 visual problems in children, it is important for parents to understand vision screening is not a substitute for a complete eye examination and vision evaluation by an eye care professional.

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.

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 vision 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. 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

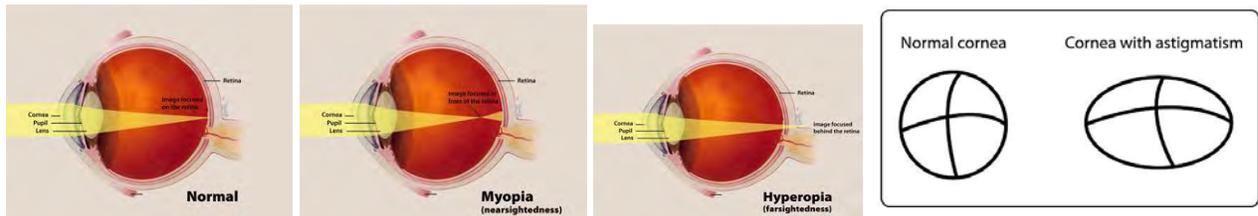
Myopic eyes are too long from the front to the back. The images of distant objects are focused in the front of the retina and appear blurred. This is commonly known as nearsightedness because near objects are seen more clearly than distant objects.

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 objects are seen more clearly than near objects.

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. Vision can be blurred at both near and far distances.



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

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. Early detection and compliance with treatment is critical in preventing permanent vision loss.



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

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

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 nine, but for some disorders the period of visual plasticity is much shorter and treatment needs to be instituted at a much earlier age.

COLOR VISION DEFICIENCY

Children with color vision deficiency have difficulty identifying certain colors. Color vision 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 vision deficiency defects. A student with color vision deficiency can be reasonably accommodated under section 504 of the 1973 Rehabilitation Act.



OBSERVATION OF VISUAL PROBLEMS

Many symptoms of vision problems are behavioral in nature and may be confused with symptoms of Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD) or autism spectrum disorder. 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.

APPEARANCE OF EYES

- Tilts head, squints, or closes or covers one eye when reading
- Gaze issues such as eyes turn in or out, crossed eyes, or eyes wander
- Different size pupils or eyes
- Watery eyes
- Eyes appear hazy or clouded



COMPLAINTS

- Words float, move or jump about while reading
- Headache, dizziness, or nausea when reading
- Itching, burning, or scratchy eyes
- Blurred or double vision
- Sensitivity to light
- Difficulty seeing
- Eyes get tired after reading for a few minutes



BEHAVIORS

- Loses place when reading, or uses finger for orientation
- Skips over or leaves out small words when reading
- Rereads or skips lines unknowingly
- Writes uphill or downhill, or has difficulty writing in a straight line
- Difficulty copying from the board
- Difficulty changing focus from distance to near and back
- Avoids near work such as reading or writing
- Has difficulty lining up numbers when doing math
- Has difficulty finishing assignments on time
- Holds books too close, or leans too close to a computer screen
- Clumsy, bumps into things, or knocks things over
- Slow reading or word-by-word reading
- Reads words aloud or lip reads
- Reverses words or letters
- Blinks to read board or clear eyes after close work
- Thrusts head forward or backward while looking at board
- Rubs eyes or blinks during or after reading
- Restless while working at the desk
- Frequent signs of frustration or tension during close work



THE SCREENING PROCESS

Utah State Statute (UCA 53G-9-404) mandates vision screening in Utah public schools. This section provides guidelines for the recommended charts, required grades to be screened, procedure for

tier 1 screening, and the referral criteria. In addition, this section provides guidance for notification, referral and follow-up for any vision screening performed.

TRAINING

The Utah Department of Health creates all trainings required to perform school vision screening. Training includes the following:

1. Training A: how to plan and implement a tier 1 school vision screening (designed for new school nurses, or schools without a school nurse)
2. Training B: for vision screening volunteers who assist with a tier 1 vision screening
3. Training C: for approved tier 2 vision screeners
4. Training D: for approved outside entities

DESIGNATED VISION POINT-PERSON

School nurses are the ideal individuals to perform the school vision screening. Nurses have specialized skills and training to perform a variety of screenings done in schools, including vision screening. The nurses' training also helps them determine when a student should be referred to an eye care professional for a complete eye examination.

If the school does not have a school nurse, someone at the school should be the Designated Vision Point-Person (DVPP). This person should undergo UDOH training (A) on how to plan and implement a school-wide tier 1 vision screening.

The DVPP is responsible for ensuring all volunteers complete the UDOH training (B) for vision screening volunteers. The DVPP is also responsible for referral and follow-up for students who do not pass the vision screening, as well as documentation of results for all students. Finally, the DVPP should be the person who completes the required annual vision screening report form due to the UDOH by June 30th each year.

The DVPP should not perform tier 2 vision screenings, but should automatically refer any student needing a tier 2 vision screening to an eye care professional for a complete eye examination.

CERTIFICATES

A certificate or health form documenting a vision screening or examination given within one year of entering a Utah public school is acceptable for school entry. All students less than age nine entering a public school in Utah for the first time without proof of screening mentioned above must be screened during the year of entry. Certificates can be completed by a licensed health care

professional, which is defined in UCA 53G-9-404 as an optometrist, medical doctor, advanced practice registered nurse, occupational therapist, or physician assistant.

REQUIRED GRADES

The UDOH requires screening students for distance visual acuity for pre-kindergarten, kindergarten, and grades 1, 3, 5, 7 or 8, and 9 or 10. Tenth grade students may be screened as part of their driver education class. Students referred by a parent or school personnel should also be screened during any grade. Students in the grades listed above must be screened annually. Additional grades may also be screened at the discretion of the local education agency's (LEA).

REFERRAL CRITERIA

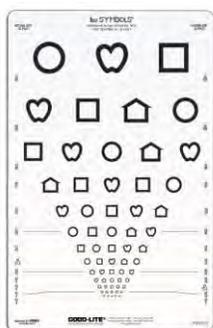
Students should receive a referral if they cannot see the majority of optotypes on the following lines:

- Age three years – 20/50 line
- Ages four and five years – 20/40 line
- Grades 1 and above – 20/32 line

To pass visual acuity screening, the students must correctly identify more than half of the optotypes on the line (e.g., three of five optotypes). The students should be referred when they do not pass the critical line for their age. Students who fail initial screening should be rescreened within one month of the original screening date.

RECOMMENDED CHARTS FOR DISTANCE VISUAL ACUITY SCREENING

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



LEA SYMBOLS®



HOTV

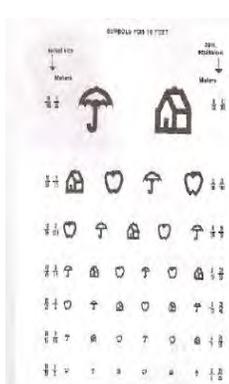


Sloan Letters

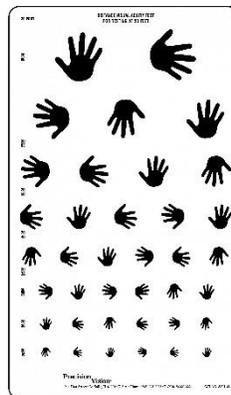
- LEA SYMBOLS® or HOTV letters for younger children (ages three to six years) or preliterate students
 - Five or ten foot charts with the passing line at eye level for students
 - Threshold charts should be proportionally spaced, not wide spaced
- Sloan Letters for older students (ages 7 and older) when students know their letters in random order
 - Ten foot charts with the passing line at eye level for students
 - Threshold charts should be proportionally spaced, not wide spaced

The following charts should **NOT** be used due to their non-standardized and culturally biased optotypes:

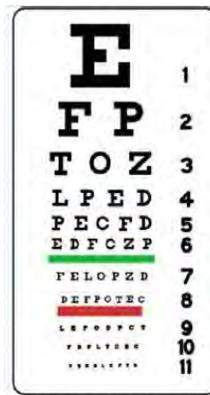
- Allen figures
- Sjøgren hand test
- Lighthouse chart (house, apple, umbrella)
- Blackbird
- Tumbling E
- Snellen
- 20-foot charts
- Charts that are not proportionally spaced



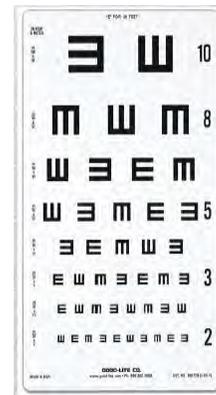
Lighthouse chart



Sjøgren hand test



Snellen



Tumbling E

INSTRUMENT–BASED SCREENING

Some LEAs may choose to use a device for instrument-based screening. These devices are automated screening instruments that facilitate vision screening in students who are difficult to screen such as students with developmental delays. These devices can be an option to optotype-based screening for students aged three, four, and five years. Instruments should not be used for screening in students who are in first grade and older unless they cannot participate in optotype-based screening.

When conducting instrument-based screening, the device will automatically pass or refer a student, based on referral criteria used in the device. There is no need to rescreen the student. Results should be listed as pass/fail, and not converted to a visual acuity value or listed as a potential diagnosis.

NOTIFICATION OF SCHOOL VISION SCREENING

All parents must be notified of scheduled vision screenings by the public school to provide an opportunity to opt-out of screening.

Notification of vision screenings may be disseminated to parents/legal guardians through parent handbooks, school newsletters, computer generated messages, and other means of communication as per the LEA policy. Opt-out instruction should be included in the notification of screening. (See sample of parent notification and opt-out form in the appendix.)

VISION SCREENING VOLUNTEERS

As required by Utah Statute 53G-9-404, vision screening volunteers must be trained by the school nurse or complete the online training module (B) prior to the start of screenings. Trainings shall be provided in compliance with training materials developed by UDOH.

Volunteers who assist with vision screening may not profit financially from volunteering, and may not market, advertise, or promote a business in connection with assisting in a vision screening.

OUTSIDE ENTITY

Only those outside entities approved by the UDOH may provide tier 1 vision screening services to schools. Outside entities may not provide tier 2 vision screening. Outside entities must provide the results of all vision screening to the school for documentation in the student's record. The school is responsible for referral and follow-up. Please contact the UDOH for a current list of approved outside entities.

TIER 1 SCREENING

All schools are required to provide tier 1 vision screening. Tier 1 vision screening is a lower-level vision screening such as basic distance vision screening. Approved tier 1 vision screeners can be school nurses, approved outside entities, trained school volunteers, or trained health care professionals (as defined in statute) who have completed UDOH training (B) for tier 1 vision screening volunteers.

REFERRAL, FOLLOW-UP, AND DOCUMENTATION

REFERRAL

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

Referrals should be made if the student's screening indicates a need for a professional eye exam. Failure of vision screening is not the only reason a student may need to be referred (see Observation of Visual Problems). When findings are inconclusive and professional nursing judgment indicates 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 passed vision screening, the student should be referred to an eye care professional for further evaluation. A student who is unable to perform a vision screening and is currently not under the care of an eye care specialist should also be referred.

AUTOMATIC REFERRAL

Some students should bypass screening and be automatically referred to an eye care professional for a more thorough examination. These students include those with:

- Readily recognized eye abnormalities, such as strabismus or ptosis
- A known diagnosis of a neurodevelopmental disorder (e.g. hearing impairment, motor abnormalities such as cerebral palsy, cognitive impairment, autism spectrum disorders, or speech delay)
- Systemic diseases known to have associated eye disorders (e.g. diabetes and juvenile rheumatoid arthritis)
- A known family history of a first-degree relative with strabismus, amblyopia, or high refractive error

- A history of premature birth and low birthweight (32 weeks gestation and 1,500 grams birthweight) who has not already had a normal comprehensive eye examination
- Parents or caregivers who believe their child has a vision-related problem or have concerns regarding their child reaching age-appropriate developmental or academic milestones

Note: The Utah Special Education rule requires students being evaluated for eligibility for special education, and every three years for their reevaluation, must have vision issues ruled out. Students being referred to Special Education do not need a **new** vision screening. Distance vision (Tier 1) screening done within the current school year is adequate for this requirement. A symptoms questionnaire should be completed by the teacher to determine whether a Tier 2 vision screening should be done, or if the student should be automatically referred to an eye care professional for a complete eye examination.

FOLLOW-UP

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

DOCUMENTATION

Results of all vision screening should be documented in the student's permanent record. Documentation should include whether a student was referred to an eye care professional, and any follow-up. Documentation can be electronic or on paper.

SIGNIFICANT VISION IMPAIRMENT

A significant vision impairment is a visual impairment severe enough to interfere with learning. The term is the designation required for a child to be eligible for services from a teacher of students with visual impairments in an LEA or at the Utah Schools for the Deaf and the Blind (USDB). A significant vision impairment must be determined individually for each student after examination and diagnosis by a licensed health care provider and functional assessment by a qualified vision professional.

SYMPTOMS QUESTIONNAIRE

If a student is referred for a special education evaluation (or reevaluation) of a specific learning disability, does not achieve benchmark on the benchmark reading assessment, or there is another concern regarding his/her vision a Symptoms Questionnaire should be completed by the teacher and given to the school nurse (or other approved tier 2 vision screener) within 45 days of the

benchmark assessment. The school nurse then has 30 days to evaluate the Symptoms Questionnaire to determine the next steps.

The school nurse or other approved tier 2 vision screener may automatically refer the student to an eye care professional for a comprehensive eye examination. If the school does not have a school nurse or other approved tier 2 vision screener, the DVPP should evaluate any Symptoms Questionnaires submitted and refer the student based on criteria listed there.

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 to use alternative vision screening methods.

Some LEAs may choose to use other UDOH approved vision screening instruments at their discretion and expense. These instruments include chart software or instrument-based screening devices.

CONFIDENTIALITY

All those working with students must understand that any results of vision screening must be kept confidential and only shared with the school nurse or DVPP. The school nurse or DVPP will document results and refer any student who does not pass the vision screening to an eye care professional for a more thorough vision examination. The volunteer should never share results of a vision screening with anyone other than the DVPP or school nurse. This includes the student's teacher or parent. If the volunteer shares private confidential information they are in violation of federal privacy laws (FERPA). Any FERPA violations could result in the school losing federal funding.

TIER 2 SCREENING

Tier 2 vision screening is a higher-level evaluation which should include screening of distance (if not done in the current year) and near vision. Optional screening includes eye focusing or tracking problems, color vision deficiency screening, and screening for convergence insufficiency.

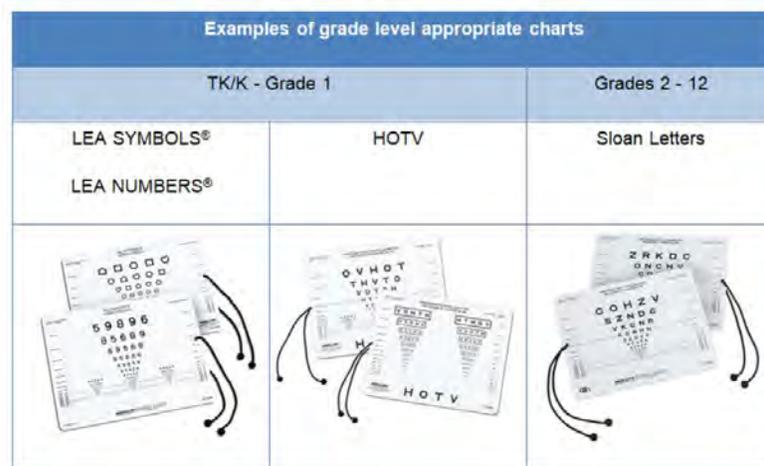
Tier 2 vision screening can be classified as mandatory (students needing educational intervention, special education referral, or failing benchmark assessment) or optional (teacher or parent concern).

Approved tier 2 vision screeners can only be school nurses or health care professionals as defined in 53G-9-404 who have completed the UDOH training for tier 2 vision screening. In lieu of

performing a tier 2 vision screening the school nurse may automatically refer the student to an eye care professional for a comprehensive eye examination. If the LEA does not have an approved tier 2 vision screener the student should be automatically referred to an eye care professional for a comprehensive eye examination following the criteria on the Symptoms Questionnaire.

NEAR VISION ACUITY SCREENING

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. Screening near visual acuity in schools is directed toward the identification of hyperopia, particularly severe, or “high” hyperopia.



EYE FOCUSING OR TRACKING

The student should be able to keep their eyes on a target when asked to look from one object to another, or while moving their eyes along a printed page. The student should also be able to maintain clear vision as they move their focus from distance to near.

CONVERGENCE

Convergence is the ability of the eyes to work together when looking at nearby objects. Convergence insufficiency causes one eye to turn outward instead of inward with the other eye, which may cause double or blurred vision. This condition can cause reading difficulty.

COLOR VISION DEFICIENCY

Color vision is the ability to recognize color. A color vision deficiency exists when there is a deficiency in this ability.

Identification of a childhood color disorder is important information to share with teachers and parents, especially in the student’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.

When screening a student for color vision deficiency follow the test's manufacturer instructions. However, instructions may call for monocular screening, which is to occur in an eye examination where a diagnosis would be provided. *In a school setting, color vision deficiency screening is conducted binocularly, or with both eyes open.*

STATE REPORTS

In addition to recording vision results in each student's individual record, Utah State Statute requires schools to report aggregate vision screening data annually to the UDOH. This can be done in the School Health Workload Census submitted to the UDOH at the end of the school year, or may be reported via the Vision Report form (see the appendix). Aggregate data to be submitted includes the number of distance screenings performed (tier 1), number of tier 2 screenings performed, number of students referred for each screening, and other data points as determined by the UDOH.

VISION RESOURCES

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

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

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 or email billing@healthcare.utah.edu

Prevent Blindness provides resources on vision.

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 the National Association of School Nurses (NASN), can receive free vision vouchers for students in need.**

Vision for Utah is a local program that provides free exams and glasses for low-income and uninsured children 18 years and younger who meet eligibility criteria through a partnership with Utah Optometric Association and Friends for Sight. Social security number is not required.

Online optical businesses may be an economical way for parents to order glasses online with Rx and PD (pupil distance) information. *Use caution ordering glasses online because quality may be compromised. There are not child-specific measurements done by an eye care professional.*

Local businesses such as Walmart, Target, Lens Crafters, America's Best, and private eye care practices often donate services for eye exams and eyeglasses. It is best to check with the local vendors in your area for needed services.

DEFINITIONS

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 alone. 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 the age of six.

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

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

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 older than 55 years of age, but can occasionally occur in infants and young children.

Color vision -- The ability to perceive color.

Color vision deficiency -- The inability to distinguish certain shades of color.

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.

Convergence -- The ability to move both eyes toward each other and focus on a near object.

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 -- A scratched cornea in which visual acuity may be temporarily reduced; may cause photophobia, and result in considerable pain.

Critical line -- The age appropriate passing line for visual acuity screening.

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

Distance vision -- The ability of the eye to see images clearly at a distance.

Double vision -- The perception of two images, one by each fovea, when the eyes have a horizontal or vertical misalignment.

Esotropia -- A type of strabismus in which the movements of one or both eyes go inward or nasally.

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

Eye Care Professional -- A professional eye doctor (an optometrist or an ophthalmologist). It is recommended that students be referred to eye care professionals who are trained and experienced in examining young children.

Farsightedness -- See hyperopia.

Fovea -- A small depression in the retina of the eye where visual acuity is highest. The center of the field of vision is focused in this region, where retinal cones are particularly concentrated.

Glaucoma -- A group of eye diseases that damage the optic nerve.

Hyperopia (farsightedness) -- A condition that causes difficulty with near vision.

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.

Myopia (nearsightedness) -- A vision condition that causes difficulty with distance vision.

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.

Occluder -- a device that occludes one eye while the other eye is being screened. Approved occluders vary depending on the age of the student. Care should be taken so as not to press on the student's eye when occluding.

Ophthalmologist -- A medical physician concerned with the study and treatment of disorders and diseases of the eye. Ophthalmologists are trained in surgical interventions for the eye.

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 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.

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.

Instrument-based screening device -- An automated screening technique that facilitates vision screening in students who are difficult to screen such as children with developmental delays.

Photophobia -- A discomfort or abnormal sensitivity to light. Excessive tearing may be a symptom.

Pink eye -- see conjunctivitis.

Ptosis -- A drooping of the upper eyelid.

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.

Screening -- Simple and quick testing procedures used to identify and refer students with visual impairment or eye conditions.

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

Visual acuity -- Quantifiable measurement of the sharpness or clearness of vision when identifying specific optotype sizes at a standardized distance.

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APPENDIX

53G-9-404. PUBLIC EDUCATION VISION SCREENING.

(1) As used in this section:

(a) "Health care professional" means an individual licensed under:

(i) Title 58, Chapter 16a, Utah Optometry Practice Act;

(ii) Title 58, Chapter 31b, Nurse Practice Act, if the individual is licensed for the practice of advance practice registered nursing, as defined in Section 58-31b-102;

(iii) Title 58, Chapter 42a, Occupational Therapy Practice Act;

(iv) Title 58, Chapter 67, Utah Medical Practice Act;

(v) Title 58, Chapter 68, Utah Osteopathic Medical Practice Act; or

(vi) Title 58, Chapter 70a, Physician Assistant Act.

(b) "Qualifying child" means a child who:

(i) attends an LEA;

(ii) is at least three years old; and

(iii) is not yet 16 years old.

(c) "Tier one vision screening" means a lower-level evaluation of an individual's vision, as determined by Department of Health rule.

(d) "Tier two vision screening" means an individual, higher-level evaluation of an individual's vision, as determined by Department of Health rule.

(2) The Department of Health shall oversee public education vision screening, as described in this section.

(3) A child who is less than nine years old and has not yet attended public school in the state shall, before attending a public school in the state, provide:

(a) a completed vision screening form, described in Subsection (5)(a)(i), that is signed by a health care professional; or

(b) a written statement signed by a parent that the child will not be screened before attending public school in the state.

(4) The Department of Health shall prepare and provide:

(a) training for a school nurse who supervises an LEA tier one vision screening clinic;

and

(b) an online training module for a potential volunteer for an LEA tier one vision screening clinic.

(5) (a) The Department of Health shall provide a template for:

(i) a form for use by a health care professional under Subsection (3)(a) to certify that a child has received an adequate vision screening; and

(ii) a referral form used for the referral and follow up of a qualifying child after a tier one or tier two vision screening.

(b) A template described in Subsection (5)(a) shall include the following statement: "A screening is not a substitute for a complete eye exam and vision evaluation by an eye doctor."

(6) The Department of Health shall make rules to:

(a) generally provide for and require the administration of tier one vision screening in accordance with this section, including an opt-out process;

(b) describe standards and procedures for tier one vision screening, including referral and follow up protocols and reporting a student's significant vision impairment results to the Utah Schools for the Deaf and the Blind;

(c) outline the qualifications of and parameters for the use of an outside entity to supervise an LEA tier one vision screening clinic when an LEA does not have a school nurse to supervise an LEA tier one vision screening clinic;

(d) determine when a potential volunteer at an LEA tier one vision screening clinic has a conflict of interest, including if the potential volunteer could profit financially from

volunteering;

(e) determine the regularity of tier one vision screening in order to ensure that a qualifying child receives tier one vision screening at particular intervals; and

(f) provide for tier two vision screening for a qualifying child, including:

(i) in coordination with the state board, determining mandatory and optional tier two vision screening for a qualifying child;

(ii) identification of and training for an individual who provides tier two vision screening;

(iii) (A) the creation of a symptoms questionnaire that includes questions for a nonprofessionally trained individual to identify an eye focusing or tracking problem as well as convergence insufficiency of a qualifying child; and

(B) protocol on how to administer the symptoms questionnaire in coordination with tier two vision screening;

(iv) general standards, procedures, referral, and follow up protocol; and

(v) aggregate reporting requirements.

(7) (a) In accordance with Department of Health oversight and rule and Subsection (7)(b), an LEA shall conduct free tier one vision screening clinics for all qualifying children

who attend the LEA or a school within the LEA.

(b) If the parent of a qualifying child requests that the qualifying child not participate in a tier one or tier two vision screening, an LEA may not require the qualifying child to receive the tier one or tier two vision screening.

(8) (a) Except as provided in Subsection (8)(b), a school nurse shall supervise an LEA tier one vision screening clinic as well as provide referral and followup services.

(b) If an LEA does not have a school nurse to supervise an LEA tier one vision

screening clinic, an LEA may, in accordance with Department of Health rule, use an outside entity to supervise an LEA tier one vision screening clinic.

- (9) (a) An LEA shall ensure that a volunteer who assists with an LEA tier one vision screening clinic:
- (i) (A) is trained by a school nurse; or
(B) demonstrates successful completion of the training module described in Subsection (4)(b);
 - (ii) complies with the requirements of Subsection (9)(c); and
 - (iii) is supervised by a school nurse or, in accordance with Subsection (8)(b), an outside entity.
- (b) In accordance with Department of Health rule, an LEA may exclude a person from volunteering at an LEA tier one vision screening clinic if the person has a conflict of interest, including if the person could profit financially from volunteering.
- (c) A volunteer who assists with an LEA tier one vision screening clinic may not market, advertise, or promote a business in connection with assisting at the LEA tier one vision screening clinic.
- (d) A volunteer who assists with an LEA tier one vision screening clinic is not liable for damages that result from an act or omission related to the LEA tier one vision screening clinic, if the act or omission is not willful or grossly negligent.

RULE (R384-201):

R384-201-1. Authority.

(1) This rule is authorized by section 53G 9-404 and 26-1-30 (33).

(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 student who fails a vision screening or is identified as needing follow-up care.

R384-201-2. Definitions.

(1) "Eye care professional" means an ophthalmologist or optometrist.

(2) IEP means an Individualized Education Plan.

(3) "Instrument based screening" means an automated screening technique that facilitates vision screening in students who are difficult to screen such as children with developmental delays.

(4) LEA means local education agency.

(5) "Screening certificate" means written documentation of vision screening or comprehensive eye examination by a health care professional as defined in 53G-9-404 (1)(a) done within one year of entering a public school.

(6) "Significant visual impairment" means a visual impairment severe enough to interfere with learning. The term is the designation required for a child to be eligible for services from a teacher of students with visual impairments in an LEA or USDB.

(7) "Screeener" means those trained to support vision screening programs for students.

(8) USDB means Utah Schools for the Deaf and Blind.

(9) UDOH means Utah Department of Health.

(10) "Vision Screening" means a way to identify students with visual impairment.

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 students so

that follow-up for potential concerns may be done by the student'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. Free Screening.

The following students in an LEA shall receive free vision screenings to include tier 1 screening.

(1) Vision screening shall be conducted for all students in grades pre-kindergarten, kindergarten, 1, 3, 5, 7 or 8, and 9 or 10 and any student referred by school personnel, parent or guardian or self to rule out vision as an obstacle to learning;

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

(3) Students who are currently receiving services from USDB or LEA vision specialist who have a diagnosed significant visual impairment will be exempt from screening.

(4) Students may be referred for mandatory or optional tier 2 vision screening under the following circumstances in (a) and (b).

(a) Mandatory tier 2 screening may be done for students requiring education intervention such as special education referral or failing benchmark reading assessment as defined by R277-404.

(b) Optional tier 2 vision screening may be done based on parent or teacher concern.

(c) Students failing a tier 1 screening who have been referred to an eye care professional are not required to complete a tier 2 screening.

(d) Instead of performing a tier 2 vision screening, the LEA may automatically refer the student being referred to a tier 2 vision screening to an eye care professional.

(e) If the LEA does not have a school nurse or other approved tier 2 screener, the student being referred for a tier 2 vision screening should be automatically referred to an eye care professional.

R384-201-5. Required Screening for Students with an Individualized Education Plan.

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

(1) Vision issues have to be ruled out as an obstacle to learning 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.

Certificate or health form documenting a vision screening or examination given within one year of entering a public school are acceptable for school entry. All students less than age 9 entering a public school in Utah for the first time without proof of screening mentioned above, shall be screened during that school year.

R384-201-7. Training of Screeners.

(1) The LEA shall provide training annually to all vision screeners prior to the start of vision screenings.

(a) The school nurse shall provide training to the vision screeners; or

(b) Vision screeners shall view the online module developed by UDOH referred to in 53G-9-404 (4)(b).

(2) The LEA will provide trainings in compliance with UDOH materials.

(3) The LEA will share vision screening training materials with qualified outside entities that provide free vision screening services in Utah schools.

(4) UDOH will create online training modules on:

(a) Tier 1 vision screening; and

(b) Training for tier 1 vision screeners; and

(c) Tier 2 vision screening for school nurses or other approved tier 2 screeners.

R384-201-8. Screening.

(1) Screenings are to be performed following criteria developed by UDOH.

(2) Screeners should do vision screenings early in the school session to provide time in that school year for adequate referral and follow-up to be done.

(3) A Parent or guardian of a student has the right not to have their student participate in vision screening. All parents or guardians must be notified of scheduled vision screenings by the public school to provide an opportunity to opt out of screening for their student. Parent or guardian choosing to opt out of vision screening for their student must do so annually and in writing.

(4) A public school staff member should be present at all times during vision screenings including those done by qualified outside entities.

(5) Screenings are to be done using material and procedures approved by UDOH. Standards and procedures are based on recommendations of American Academy of Pediatrics, the American Academy of Ophthalmology, the American Optometric Association, the National Center for Children's Vision & Eye Health, and National School Nurse Association.

(6) School vision screening is comprised of tier 1 and tier 2 screening.

(a) Tier 1 vision screening is a lower-level vision screening such as basic distance vision screening.

(b) Tier 2 vision screening is a higher-level evaluation that should include screening of distance and near vision. It may also include eye focusing or tracking problems, color screening, and screening for convergence insufficiency.

(i) The approved tier 2 screener may automatically refer the student to an eye care professional in lieu of performing the tier 2 screening.

(ii) If the LEA does not have an approved tier 2 screener the LEA should automatically refer the student to an eye care professional.

(7) Approved vision screeners include the following:

(a) Approved tier 1 vision screeners can be school nurses, qualified outside entities, trained volunteers, or health care professionals as defined in 53G-9-404 (1)(a) who have completed UDOH training for tier 1 vision screening.

(b) Approved tier 2 vision screeners can only be school nurses or health care professionals as defined in 53G-9-404 (1)(a) who have completed UDOH training for tier 2 vision screening.

(c) Persons assisting with vision screening:

(i) May not profit financially from school vision screening; and

(ii) May not market, advertise, or promote a business in connection with assisting with vision screening.

(8) Any qualified outside entity that provides free vision screening services in the LEA will provide results of vision screening to the public school.

(9) Students who are not candidates for regular vision screening may be screened using an approved instrument-based screening device. Only devices approved by UDOH should be used for screening, and then only when screening with a chart is not an option. Devices are not a substitute for clinical judgement and a visual acuity test.

(10) The LEA shall document all vision screening results including referrals and follow-up results in the student's permanent school record.

R384-201-9. Requirements for Referral.

(1) A school nurse may rescreen students who fail initial age appropriate school vision screening to confirm results before notification to student's parent or guardian of any impairment disclosed by the vision screening recommending further evaluation by an eye care professional.

(2) The LEA 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 eye care professional who diagnoses a student with a significant visual impairment shall refer the student to the LEA vision specialist or USDB.

R384-201-10. Symptoms Questionnaire.

(1) The UDOH will provide schools a vision symptoms questionnaire that includes questions for classroom teachers to potentially identify eye focusing or tracking problems as well as convergence insufficiency. The UDOH will update the questionnaire as needed.

(2) For students who fail to achieve benchmark status on the benchmark reading assessment in grades 1-3:

(a) The LEA shall notify the student's teacher within 30 calendar days of student performance on the benchmark reading assessment.

(b) Teachers must complete the vision symptoms questionnaire within 45 calendar days of the administration of the assessment and submit to the school nurse.

(c) Teachers need only complete the vision symptoms questionnaire once per school year.

(d) School nurses or other approved tier 2 vision screeners shall use the vision symptoms questionnaire to perform a secondary assessment and/or refer to an eye care professional.

(3) For students who are being referred to special education for a suspected disability affected by vision difficulties:

(a) Teachers must complete the vision symptoms questionnaire and submit to the school nurse.

(b) School nurses or other approved tier 2 vision screeners shall use the vision symptoms questionnaire to perform a secondary assessment and/or refer to an eye care professional.

(4) For students who are being referred by parent or guardian for vision concern:

(a) Parent or guardian should complete the vision symptoms questionnaire and submit to the school nurse.

(b) School nurses or other approved tier 2 vision screeners shall use the vision symptoms questionnaire to perform a secondary assessment and/or refer to an eye care professional.

R384-201-11. Aggregate Reporting Requirements.

(1) All LEAs shall report aggregate numbers annually to UDOH to include:

(a) Total number of students receiving tier 1 vision screening; and

(b) Total number of students referred to an eye care professional following a tier 1 vision screening; and

(c) Total number of students referred to school nurse for tier 2 screening; and

(d) Total number of students referred to an eye care professional following a tier 2 vision screening; and

(e) Other information as requested by UDOH.

(2) This report may be submitted on the annual vision screening report, or as part of the annual school health workload census, and shall be due on or before June 30 of each year.

(3) No personally identifiable information will be collected.

KEY: eye exams, school vision, vision evaluations

Date of Enactment or Last Substantive Amendment: July 1, 2019

Authorizing, and Implemented or Interpreted Law: 53G-9-404

FORMS

CERTIFICATE OF VISION SCREENING

Certificate of Vision Screening

<p>As required by UCA 53G-9-404 (2019) a student who is less than nine years old and entering school for the first time in Utah is required to submit this certificate showing vision screening (or complete eye exam) done within the last year.</p> <p><i>Vision screening is not a complete eye exam and may not detect other eye disorders. Students unable to pass the vision screening should receive a complete eye exam.</i></p>		
Student name:	DOB:	School Year:
School:	Grade:	Teacher:
A. Parent to Complete		
<input type="checkbox"/> As parent or guardian of the above named student, I have taken my student for a vision screening as required by law. Provider must complete section B or C as appropriate.		
<input type="checkbox"/> As parent or guardian to the above named student, I opt not to have my student's vision screened before attending public school, as allowed by law.		
Parent Name:		
Parent Signature:		Date:
B. Vision Screening		
<input type="checkbox"/> This student has had an <u>vision screening</u> done by a <i>healthcare professional</i> defined as an optometrist (OD), advanced practice registered nurse (APRN), medical doctor (MD), doctor of osteopathy (DO), or physician assistant (PA). This vision screening included the following:		
<input type="checkbox"/> Distance vision screening <input type="checkbox"/> Near vision screening <input type="checkbox"/> Ocular motilities <input type="checkbox"/> Color deficiency <input type="checkbox"/> Convergence <input type="checkbox"/> Other (specify): _____		
This student <input type="checkbox"/> was / <input type="checkbox"/> was not able to pass the vision screening.		
This student <input type="checkbox"/> was / <input type="checkbox"/> was not referred to an eye care professional for a complete eye exam.		
Provider Name:		Type of Provider: <input type="checkbox"/> OD <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> APRN <input type="checkbox"/> PA
Provider Signature:		Date:
C. Complete Eye Exam		
<input type="checkbox"/> This student has had a <u>complete eye exam</u> by an <i>eye care professional</i> done within 1 year of entry into Utah public school.		
Provider Name:	<input type="checkbox"/> Ophthalmologist <input type="checkbox"/> Optometrist	Date of exam:
Provider Signature:		Date:

A screening is not a substitute for a complete eye exam and vision evaluation by an eye doctor.

SAMPLE VISION SCREENING OPT-OUT FORM

SAMPLE VISION SCREENING OPT-OUT FORM

As allowed in UCA 53G-9-404 (2019) a parent may opt their student out of vision screening.		
Student name:	DOB:	School Year:
School:	Grade:	Teacher:
Parent to Complete		
As parent of the above named student, I do not wish for my student to have a vision screening during this school year. I understand that I may change my mind at any time and will do so in writing.		
I understand that this request is for the current school year only. This form may be re-submitted each school year.		
Parent/Guardian Name:		
Parent/Guardian Signature:	Date:	

VISION REFERRAL

VISION REFERRAL Utah Department of Health in Accordance with UCA 53G-9-404		School Name:	
		Address:	
		City, State, Zip:	
		Phone:	
Date of Referral:		Fax:	
Student Name:		DOB:	Grade:
Parent:	Phone:	Email:	
School Nurse:	Phone:	Email:	
<p>Dear Parent/Guardian: Schools routinely screen vision to identify students who have vision problems or might be at risk for vision problems. We refer students for an eye exam when they do not pass vision screening, or are at risk of a vision problem because of a medical or developmental reason. <u><i>Vision screening is not a substitute for a complete eye exam and vision evaluation by an eye doctor.</i></u></p> <p>You are receiving this document because your student (listed above)</p> <ul style="list-style-type: none"> • did not pass the vision screening, or • should have an eye exam because of a medical or developmental risk for vision problem. <p>It is recommended your student receive a comprehensive eye exam with an eye doctor (an optometrist or an ophthalmologist). It is important to schedule this exam as soon as you can. Do not miss this appointment! If the eye doctor finds a vision problem, early treatment leads to the best possible results for your student's vision.</p> <p>If you do not have insurance and need financial assistance in obtaining an eye exam and/or glasses for your student, please contact your school nurse to see if you qualify for our eye care program.</p> <p>Reason(s) for this referral.</p> <p><input type="checkbox"/> Failed visual acuity (<input type="checkbox"/> distance / <input type="checkbox"/> near)</p> <p><input type="checkbox"/> Readily recognized eye abnormality (i.e., strabismus, ptosis)</p> <p><input type="checkbox"/> Known diagnosis of neurodevelopmental disorder (i.e., hearing impairment, cognitive impairment, autism spectrum disorder, speech delay)</p> <p><input type="checkbox"/> Systemic disease known to have associated eye disorder (i.e., diabetes)</p> <p><input type="checkbox"/> Family history of vision problems</p> <p><input type="checkbox"/> Special Education referral/failed benchmark reading assessment</p> <p><input type="checkbox"/> Other (specify): _____</p> <p>Please complete the Consent and Release of Information block below AND the top part of the back of this page. Take this paper with you to the eye exam and give the form to your eye doctor. Return the completed form to the school after the exam, or ask the eye doctor to send/fax exam results to the school.</p>			
CONSENT AND RELEASE OF INFORMATION			
<p>By my signature below, I authorize: (1) my student's eye doctor to send exam results to the school, (2) the school nurse and the eye doctor to discuss eye exam results, and (3) for the school nurse to notify the school of any specific vision problems and recommendations related to my student's specific vision needs. I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain an eye exam for my student.</p>			
Parent/Guardian Signature:			Date:

COMPREHENSIVE EYE EXAM RESULTS Utah Department of Health in Accordance with UCA 53G-9-404		School Name:
Date of Referral:		Address:
		City, State, Zip:
		Phone:
		Fax:
Student Name:	DOB:	Grade:
Parent/Guardian:	Phone:	Email:
School Nurse:	Phone:	Email:

EXAM RESULTS FROM EYE CARE PROVIDER (optometrist or ophthalmologist):	
The above named student is being referred for a comprehensive eye exam based on a recent school screening.	
Please complete the section below and return form to the school (address/fax listed above).	
Date of eye examination:	
Check if appropriate:	
<input type="checkbox"/> No problem on exam	
<input type="checkbox"/> Treatment recommended	
<input type="checkbox"/> glasses or contact lenses	
<input type="checkbox"/> other (specify): _____	
Best visual acuity with correction: Right: _____ Left: _____	
<input type="checkbox"/> Significant vision impairment exists, I recommend referral to the Utah Schools for the Deaf and Blind.	
Additional notes or recommendations:	
EYE CARE PROVIDER CONTACT INFORMATION:	
Provider Name:	Date of exam:
Provider Signature	<input type="checkbox"/> Ophthalmologist
	<input type="checkbox"/> Optometrist
Address:	City: Zip:

SYMPTOMS QUESTIONNAIRE

Vision Symptoms Questionnaire

Utah Department of Health in accordance with UCA 53G-9-404

Teachers are required to complete this form if a student does not achieve benchmark on the benchmark reading assessment (grades 1-3) or is being referred or re-evaluated for special education services related to a specific learning disability. Parent may also complete this form if there is a vision concern. When completed please give this form to the school nurse for tier 2 evaluation and possible referral to an eye care professional.*

Student Name:		Referral Date:	
School:		Grade:	
Teacher:			
Name/Title of person completing form:			
Does student wear glasses? <input type="checkbox"/> yes <input type="checkbox"/> no			
<i>If answer is 'yes' to any areas below, please provide details in the comment section(s).</i>			
	Yes	No	Comments
1. As a teacher or parent are you concerned with this student's vision?			
Appearance Symptoms			
	Yes	No	Comments
2. Tilts head, squints, closes or covers one eye when reading			
3. Gaze issues, eyes turn in or out, crossed eyes, eyes wander			
4. Different size pupils or eyes			
5. Watery eyes, eyes appear hazy or clouded			
Complaints (Student Statements) Symptoms			
	Yes	No	Comments
6. Words float, move, or jump around when reading			
7. Complains of headaches, dizziness, or nausea when reading (please specify)			
8. Complains of itching, burning, or scratchy eyes (please specify)			
9. Complains of blurred or double vision, unusual sensitivity to light, or difficulty seeing (please specify):			
10. History of head injury with vision complaints			
Behavior Symptoms			
	Yes	No	Comments
11. Loses place when reading			
12. Skips over or leaves out small words when reading			
13. Writes uphill or downhill; difficulty writing in a straight line			
14. Has difficulty copying from the board			
15. Avoids near work, such as reading or writing			
16. Has difficulty lining up numbers when doing math			
17. Has difficulty finishing assignments on time			
18. Holds books too close; leans too close to a computer screen			
19. Clumsy; bumps into things; knocks things over			
Other vision concerns:			

For School Nurse Use Only:	
Any parent or teacher concern and/or any 'yes' answers should be evaluated by the school nurse to determine if tier 2 screening or referral to an eye care professional is necessary.	
<i>School nurse should use their professional nursing judgement in determining whether the student receives a tier 2 vision screening and/or is referred to an eye care professional, regardless of the answers.</i>	
Distance vision screened: <input type="checkbox"/> Pass <input type="checkbox"/> Fail (refer)	Near vision screened: <input type="checkbox"/> Pass <input type="checkbox"/> Fail (refer)
Eye Focusing or tracking screened? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pass <input type="checkbox"/> Fail (refer)	Convergence screened? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pass <input type="checkbox"/> Fail (refer)
Referred to eye care professional: <input type="checkbox"/> Yes <input type="checkbox"/> No	Date:
Notes:	
School Nurse Name:	
School Nurse Signature:	Date:

*For Schools without a School Nurse or other approved tier 2 vision screener:		
Schools without a school nurse should have a 'Designated Vision Point-Person' responsible for referring any vision concerns. <i>This person should not perform a tier 2 vision screening</i> , but instead should refer any vision concerns to an eye care professional for a complete eye exam. The Designated Vision Point-Person should evaluate any Symptoms Questionnaires and follow the instructions below. This point-person is also responsible for filing the required Vision Screening Annual Report to UDOH by June 30th each year.		
On any question 1-19	If all answers are 'no'	No referral is necessary
On questions 1-10	If one or more answers are 'yes'	Refer to eye care professional
On questions 11-19	If two or more answers are 'yes'	Refer to eye care professional
Distance vision screened: <input type="checkbox"/> Pass <input type="checkbox"/> Fail (refer)	Referred to eye care professional: <input type="checkbox"/> Yes <input type="checkbox"/> No	Date:
Notes:		
Designated Vision Point-Person name:		
Signature:	Date:	

Vision Screening Annual Report

Please use this form ONLY if the information was not submitted with the School Health Workload Census.

As required by 2019 Utah code 53G-9-404 (6) (f) (v) this report must be submitted annually by all public LEAs. This report is due by June 30th of each year, and should be emailed to bhinkson@utah.gov . Please call (801) 538-6814 if there are any questions or concerns.	
School Year:	School (or district) Name:
Person Reporting:	Email:
Part 1: to be completed by school nurse	
1. Total number of students receiving tier 1 vision screening:	
2. Total number of students referred to eye care professional following a tier 1 vision screening:	
3. Total number of students seen by eye care professional following a tier 1 vision screening:	
4. Total number of students referred for tier 1 vision screening receiving treatment (including rx for glasses or contacts):	
5. Total number of "Vision Symptoms Questionnaires" submitted to the school nurse for evaluation of a tier 2 vision screening:	
6. Total number of students referred to an eye care professional following a tier 2 vision screening by a school nurse:	
7. Total number of students referred automatically to eye care professional in lieu of tier 2 vision screening:	
8. Total number of students seen by eye care professional following a tier 2 vision screening:	
9. Total number of students referred for tier 2 vision screening receiving treatment (including rx for glasses or contacts):	
10. Total number of students receiving financial assistance for glasses or exam with eye care professional (e.g. VSP, Sight for Students, Friends for Sight, Lion's Club):	
Part 2: to be completed by school if there is NOT a school nurse	
11. Total number of students receiving tier 1 vision screening:	
12. Total number of students referred to eye care professional following a tier 1 vision screening:	
13. Total number of students referred for tier 1 vision screening receiving treatment (including rx for glasses or contacts):	
14. Total number of students referred automatically to eye care professional in lieu of tier 2 vision screening:	
Comments	

PROCEDURES

CHECKLIST FOR PLANNING A TIER 1 VISION SCREENING

Checklist for Planning a Tier 1 Vision Screening

- View or review the UDOH online training module (A) on how to administer a tier 1 vision screening.
- Schedule the mass vision screening date with the school administration.
- Notify parent/guardian of mass vision screening date, with an opportunity for the parent to opt-out their child.
- Reserve the room to be used for the vision screening.
- Determine how many volunteers will be needed. Ideally, have two volunteers for each screening line. Small schools may only need 5 lines, larger schools may need 10 lines. NEVER use other students as screeners. UDOH will maintain a list of approved outside entities that may assist with tier 1 vision screening.
- Work with PTA to arrange volunteers. Make sure the volunteers know to be at the school early enough to receive training. All volunteers must be trained prior to assisting with the screening. This can be done by a school nurse OR by volunteers viewing the UDOH online training module (B) for volunteers.
- Determine how students will be brought to the screening room. Will the teachers be given a scheduled time? Will they be called down from the office?
- Determine how results will be recorded. Will each screener be given a list of students to mark results for each child? Will the rescreener record results only for those who don't pass (and assume all other pass)? If using this second option make sure you have a procedure set up to know which students are absent the day of the screening, including those students who are tardy.
- Determine how rescreening will be done. Will it be the same day, different day?

Day of the vision screening:

- Gather equipment. This includes charts, tape or footprints to mark where the student will stand, occluders, pointing devices, garbage bin, class lists, pen/pencil, etc.
- Set up the equipment (place charts on the wall at eye level for the students, tape or footprints on the floor, chairs for volunteers, etc.).
- Determine how results will be recorded. Will volunteers record all results, only those who don't pass, will only rescreener record results, etc.
- Students who were absent the day of the mass screening should be screened on another day.

Instructions for Volunteers:

1. Come early enough to get instruction on how to proceed.
2. Have student positioned correctly on tape or footprints (arch on measured line).
3. Provide a clean occluder for each student. Student should keep both eyes open and not press the occluder on the eye. No part of the eye should show behind the occluder. Do not allow the student to lean the head or torso forward, turn the face, or tilt the head during testing.
4. Have student cover one eye with occluder, read line. Have student cover second eye, read line.

5. Student must get more than 50% correct with EACH eye to pass. Younger students may need help holding occluder.
6. If students get less than 50% correct with EITHER eye they must be rescreened.
7. If the student wears glasses put occluder OVER their glasses. If the student says they forgot their glasses, screen them anyway (many will still pass). If they do not pass – rescreen on another day.
8. If using two volunteers per line those two volunteers should work together to make sure student doesn't peek around the occluder.
9. Remind volunteers that they need to keep results confidential to comply with privacy laws.

Rescreening

1. Rescreening can either be the same day or a different day, but should be within 30 days of initial screening.
2. If the student cannot pass on the critical line, the rescreener should move up the chart until the student can identify the majority of optotypes correctly. Record this line as the results. Vision acuity is recorded as a fraction. The numerator is always 20. When using the 10-foot chart convert to the 20-foot equivalent. The denominator represents the line the student passes. Therefore, if the student read the symbols on the 32-foot line, record the vision as 20/32.
3. Refer any student who does not pass the screening/rescreening using UDOH vision referral form. Follow-up on all referrals

Follow-up

- Document results for all students who were screened.
- Follow-up on all referrals.
- File annual report with UDOH.

Helpful Tips:

- If the student is unable to pass the line with the first eye there is no need to continue screening. The rescreening will determine the line the student passes. This will allow the mass screening to flow faster and more smoothly.
- Window cards should not be used, masking tape can be placed below the critical line to mark it.
- Vision screening can be done without volunteers, but it will take much longer. DO NOT use students as volunteers. If your school cannot get enough volunteers you can work with community resources to find adult volunteers (e.g. approved outside entities, school staff, parents, college students). If you still cannot get volunteers you may need to screen one class at a time yourself. This will take significantly longer than using volunteers.

SCREENING SKILLS: DISTANCE

Screening Skills: Distance Vision

Purpose: To screen for the clearness of vision when looking in the distance; to detect myopia (nearsightedness), amblyopia, and astigmatism	
Equipment: Eye Chart, occluder, place marker for 10 feet (or appropriate distance)	
Who is Screened Yearly: All students in pre-kindergarten, kindergarten, 1st, 3rd, 5th, 7 th or 8th, and 9 th or 10 th . Should also screen students under age 9 who are new to the district, and any referrals from parents, teachers or staff.	
Skill Steps	Notes
Screening Set Up	
Ambient light, maximum natural light, low glare	Tumbling E, Snellen, Allen Pictures, Lighthouse, Sailboat, and Hand charts are no longer acceptable charts for screening.
Eye chart free of yellowing and discoloration	
Appropriate recommended eye chart for age <ul style="list-style-type: none"> Sloan: 1st Grade and older LEA/HOTV: 3yrs – 5yrs or Developmental/Cognitive Delays Sloan Numbers: English Language Learners 	
Placement of chart at student eye level	
Place marker for 10 Feet (or appropriate distance)	
Procedure	
Ask student about glasses/contacts - Keep glasses on if wears glasses full time	See Guidelines for techniques for Pre-K and kindergarten students or students with special needs.
Position student with <u>arches</u> on the line	
Give student age appropriate directions	
Don't allow student to squint, peek, lean forward	
Must identify the MAJORITY of optotypes to pass the critical line <ul style="list-style-type: none"> If they pass the critical line, STOP, record as pass for critical line If they fail the critical line-rescreen either on the same day or another day. Re-screening should occur within 30 working days 	Do not isolate individual optotypes. Only point briefly to optotypes.
Pass Criteria for Majority of Optotypes on Critical Line	
<ul style="list-style-type: none"> 3 years: 20/50 Pass 4 - 5 years: 20/40 Pass Grades 1 and above: 20/30 or 20/32 Pass 	
Referral Criteria	
Recommended that Students Receive an Evaluation by an Eye Care Professional <ul style="list-style-type: none"> Student cannot pass the screening at the critical line Inconclusive results Student, parent, teacher, other school staff has concerns regarding vision Student has associated health issues that may impact vision (e.g. cerebral palsy, down syndrome, autism, history of prematurity, low birth weight, developmental/cognitive delays) Unusual eye appearance Academic concerns Concerns identified on Symptoms Questionnaire 	<u>Regardless</u> if student passes the critical line, a referral is recommended if other concerns exist. May consider bypassing screening and refer for evaluation by eye care professional for listed concerns.

Helpful Tips:

- Explain the process to the student:
- Student may point to a training card to match the optotypes to identify what is seen on the chart.
- Demonstrate how to use the occluder. Care should be taken so as not to press on the student's eye when occluding.
- If the student needs help understanding, test from the top of the chart down, if needed. Otherwise, begin with the critical line.
- Remind students not to squint during the test.
- Present optotypes in reverse or inconsistent order between students.
- Familiarize younger students with the optotypes prior to the screening

SCREENING SKILLS: NEAR VISION

Screening Skills: Near Vision

Purpose: To screen for ability to focus on near objects. This has also been referred to as “farsightedness”.	
Equipment: Sloan near vision chart (or other acceptable chart such as LEA, HOTV, Sloan Numbers) and occluder	
Who is Screened: Optional tier 2 test may be performed on student grade 1 and older upon referral/concern from teacher, parent or nurse. <u>Do NOT screen near vision for pre-school or kindergarten students.</u>	
Skill Steps	Notes
Screening Set Up	
Ensure adequate lighting	
Chair for student	
Appropriate chart for student’s developmental level	
Procedure	
Hold the card at eye level. Make sure that the room is well lit, and that it is free from shadows.	Some near vision cards include a measuring cord. Do not isolate individual optotypes. Only point briefly to optotypes.
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.	
Measure the exact distance from the acuity card to where the student will be positioned. Hold chart the distance recommended by the manufacturer.	
Don’t allow the child to lean the torso forward or tilt the head forward.	
Near screening can either be done with each eye separately (monocular) or both eyes together (binocular). Each LEA should determine which method they will use. Screening both binocular and monocular is unnecessary.	
Screen near vision at critical line appropriate for age. If the student cannot pass the critical line move up on the chart to determine what line they can read.	
Pass Criteria for Near Vision Screening Card	
The ability to identify the majority of optotypes on the 20/30 (or 20/32) line is a <u>PASS</u> . Rescreening is not required for near vision.	Since this test is done on students in first grade and above, only the 20/30 or 20/32 critical line is used
Referral Criteria	
Recommended that Students Receive an Evaluation by an Eye Care Professional <ul style="list-style-type: none"> • Failure in one eye or both constitutes a referral. 	

Helpful Tips:

- Explain the process to the student
- Make sure student does not lean forward
- Follow manufacturer’s instructions

SCREENING SKILLS: COLOR VISION SCREENING

Screening Skills: Color Vision

Purpose: Identify any deficiency in the ability to recognize color.	
Equipment: Pseudoisochromatic plates for screening. There are online programs/apps available.	
Who is Screened: Optional tier 2 test may be performed (not required) on students age pre-kindergarten and older upon referral/concern from teacher, parent or nurse.	
Skill Steps	Notes
Screening Set Up	
Ensure adequate lighting	Dim lighting can result in inaccurate results
Table or desk	
Procedure	
Seat student comfortably at table or desk next to screener	Do not use fingers or pencil to trace. Oil on the skin can cause color change to the plates
Following manufacturer's instructions, show student how to use a clean soft paint brush or clean cotton tipped swab to trace symbols on the color plate.	
Pass Criteria for Color Vision Screening	
Follow manufacturer's instructions for color vision screening. Rescreening is not required for color vision.	
Referral Criteria	
Recommended that Students Receive an Evaluation by an Eye Care Professional <ul style="list-style-type: none"> • Follow manufacturer's instructions for color vision screening • Referral to an eye care professional is not necessary for confirmation of color deficiency. 	

Helpful Tips:

- Inform teachers and counselors of the student's color vision difficulties so that they may adjust educational materials to situations where color discrimination is required.
 - Help the student to develop skills to compensate

SCREENING SKILLS: INSTRUMENT-BASED SCREENING

Screening Skills: Instrument-Based Screening Device

Purpose: Automated device that measures risk factors for amblyopia, such as refractive error, media opacities and eye misalignment.	
Equipment: Approved device (SPOT vision screener, Sure Sight, Plusoptix).	
Who is Screened: Students pre-kindergarten up to age 5 years old, students with difficulty performing traditional vision screening techniques.	
Skill Steps	Notes
Screening Set Up	
Ensure appropriate lighting	Dim lighting is best for pupil dilation and accuracy of screening device
Chair for student	
Procedure	
Seat student in chair.	Some auto-refractors make noise; this is helpful for the students to draw their attention to the machine.
Follow manufacturer's instructions for screening.	
Pass Criteria for Screening Device Screening	
Follow manufacturer's instructions for screening device screening and referral criteria. It has been reported that some devices have inconsistent results. If using the SPOT device the student should be screened twice. If the two results are different, a third screening is recommended.	
Referral Criteria	
Recommended that Students Receive an Evaluation by an Eye Care Professional <ul style="list-style-type: none"> • Follow manufacturer's instructions for screening device screening • Student should be referred to an eye care professional for confirmation of screening device findings if abnormal 	This is only a screening tool, it is not diagnostic nor should the importance of a formal eye exam by an eye care professional be discounted.

Helpful Tips:

- Results will not be given using acuity measures.
- List results as pass or fail, do not list potential diagnosis.

Screening Skills: Special Needs Students

Screening Skills: Student with Special Needs

Purpose: To assist screening of students with special needs.	
Equipment: Vision charts appropriate to student's developmental level.	
Who is Screened: Students with special needs should be screened at the same interval as typical students. Students being evaluated for special education and those with an IEP must be reevaluated every three years.	
Skill Steps	Notes
Screening Set Up	
Ensure adequate lighting	
Follow same set-up for typical students	
Procedure	
If using LEA symbols familiarize student with symbols ahead of time. Accept the name the student suggests.	Use of an instrument-based screening device may be beneficial.
If a student cannot name the optotypes and your eye chart includes response panels and individual flash cards, ask the student to play a matching game by pointing to the symbol on the response panel that matches the symbol on your chart.	
Refrain from giving young students responsibility for their own occlusion. Students are likely to peek, especially if one eye has amblyopia or blurred vision.	
Refrain from displaying one optotype at a time	
For students who are untestable, refer to an eye care professional for a complete eye examination.	
Pass Criteria for	
Same as for typical students.	
Referral Criteria	
Recommended that Students Receive an Evaluation by an Eye Care Professional <ul style="list-style-type: none"> • Same as for typical students • Student is untestable • Student has associated health issues that may impact vision (e.g. cerebral palsy, Down syndrome, autism, history of prematurity or low birth weight, developmental/cognitive delays). 	

Note: Utah rule requires students being evaluated for eligibility for special education, and every three years for their reevaluation, must have vision issues ruled out. These students may be referred to an eye care professional for a thorough eye examination.

SCREENING SKILLS: EYE TRACKING AND FOCUSING

Screening Skills: Oculomotor Testing, Eye Tracking Skills to Include Saccades and Pursuits

Purpose: To screen eye movement	
Equipment: Tools needed: 2 different targets (e.g. different colored pens or pencils, stickers on a tongue depressor).	
Who is Screened: Optional tier 2 test may be performed on students grade 1 and above upon referral/concern from teacher, parent or nurse.	
Skill Steps	Notes
Screening Set Up	
Ensure adequate lighting	
Procedure	
The student stands with feet shoulder-width apart, arms hanging naturally at their side, directly in front of the examiner.	<p>Saccade means horizontal jump eye movement, or side-to-side.</p> <p>Slow pursuit eye movement refers to circular movement, clockwise and counter-clockwise.</p>
Do not give instructions on head or body movement. Scoring of the test is based on whether or not the student is able to track with eyes only or has to use his/her head or body.	
Test distance from the patient: testing is done at the student's reading distance (12 to 16 inches) and is done binocularly.	
<p>Saccades are performed in the horizontal meridian only (five round trips). Saccade extent should be no more than ~ 4 inches on each side of the patient's mid-line (~ 8 inches total). Complete five round trips.</p> <p>Instructions to students for saccades:</p> <ol style="list-style-type: none"> 1. "When I say red, look at the tip of the red pen. 2. "When I say blue, look at the tip of the blue pen. Remember, don't look until I tell you to." 	
<p>Pursuits are performed rotationally, both clockwise (two rotations) and counterclockwise (two rotations). Pursuit path should be no more than ~ 8 inches (20 cm) in diameter. The upper and lower extent of the circular path should coincide with the patient's mid-line. Complete two rotations clockwise and two rotations counterclockwise.</p> <p>Instructions to students for pursuits:</p> <ol style="list-style-type: none"> 1. "Watch the tip of the pen as it goes around. Don't ever take your eyes off the pen." 	
Pass Criteria for Eye Tracking	
<p>Saccades: the student should be able to complete smooth, precise round trips without using large head or body movements or over-jumping or under-jumping the target. No rescreening is required.</p> <p>Pursuits: the student should be able to track the object without using large head or body movements. No rescreening is required.</p>	
Referral Criteria	
<p>Recommended that Students Receive an Evaluation by an Eye Care Professional</p> <ul style="list-style-type: none"> • Referral to an eye care professional is recommended if the student must use large head or body movements instead of his/her eyes to track the target, or if the student is unable to complete the task. 	

Helpful Tips:

- **Consider using the Symptoms Questionnaire to obtain more vision-related information from teachers and parent/guardian**

SCREENING SKILLS: NEAR POINT CONVERGENCE

Screening Skills: Near Point Convergence

Purpose: To determine the ability of the eyes to focus on a single object at close range.	
Equipment: A small hand-held fixation target that requires visual accommodation. Examples: finger puppet, pencil puppet, or tongue depressor with a picture sticker attached to the end.	
Who is Screened: Optional test may be performed on students in pre-kindergarten and older upon referral/concern from teacher, parent or nurse.	
Skill Steps	Notes
Screening Set Up	
Ensure adequate lighting	
Procedure	
Position student directly in front of screener	
If the student was prescribed glasses for full-time use, screen with the glasses. If glasses were prescribed for part-time near use only, screen without glasses. If student doesn't know whether glasses are for near or distance use, screen with and without glasses.	
Hold the fixation target at 18 inches from the student's face.	
Instructions to students: <ol style="list-style-type: none"> 1. Have the student to look at the target as the screener moves it slowly toward the bridge of the student's nose stopping before the student's nose. 2. Let the student know that you will not touch them with the target. 3. Tell the student to let you know right away if the target splits in half or becomes two objects. 	
As the target is moved toward the student's nose, observe the eye movement. Keen observation is needed. Eyes should converge towards nose in a smooth and even manner. Be aware of shaking, uneven or drifting eye movement.	
Repeat the test three times. Watch the eyes to determine the distance from the nose if student reports that the target splits in half or becomes two objects. Record the number in inches. Student should NOT see two targets.	
For all failures, repeat the test to make sure the student did not just look away at that moment. If having difficulty determining a pass or fail, you may repeat the test or refer to an eye care professional.	
Pass Criteria for Near Point Convergence	
The student should be able to converge to at least 3-4 inches, measured from the bridge of the nose. 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 to within 3 inches of the nose may be related to convergence insufficiency, limited accommodation, a problem with the extra ocular muscles, or a frank neurological ocular or systemic condition. Referral to an eye care professional is recommended if the child is unable to maintain convergence to within 3 inches of the nose, one eye turns out, or excessive strain is noted. No rescreening is required.	
Referral Criteria	
Recommended that Students Receive an Evaluation by an Eye Care Professional <ul style="list-style-type: none"> • Document in the student's health file and continue to be on alert for teacher concerns 	

Helpful Tips:

- This skill requires practice
- Consider using the Symptoms Questionnaire to obtain more vision-related information from teachers and parent/guardian

FOOTPRINTS:

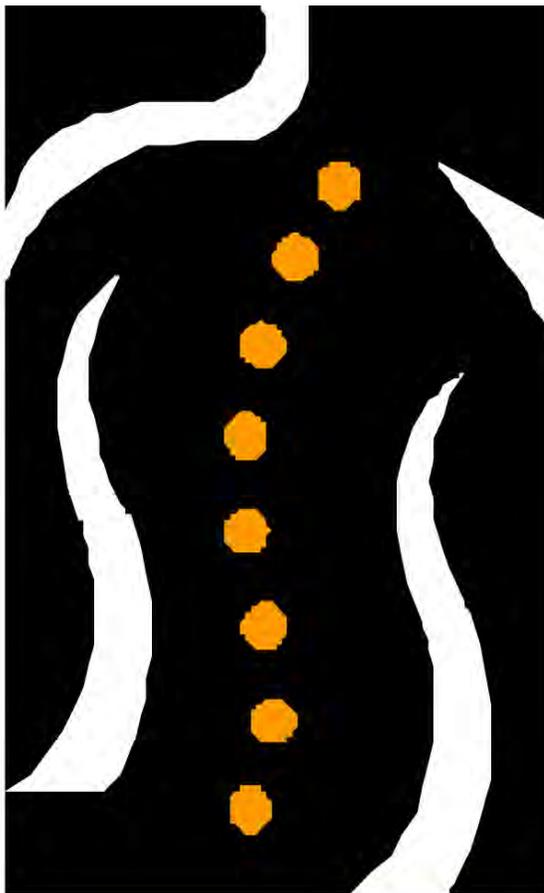
If you use this, ensure the screening distance is between the chart and the child's eyes. The child stands with arches of feet at the end of the screening distance, not toes to the line or heels to the line. If using a chair, the distance is measured to the back of the chair and the student sits with back to back of chair.



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 (5th and 7th grade), and boys be screened once at age 13 or 14 (8th or 9th 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 5th or 6th 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>Physical Examination Report</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>For School Use:</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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EMERGENCY RESPONSE FOR LIFE- THREATENING CONDITIONS IN SCHOOLS

ANAPHYLAXIS GUIDELINES

UTAH DEPARTMENT OF HEALTH

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Anaphylaxis Guidelines

Introduction

There are times when students in school may need medication to help with their chronic health condition. Many students with allergies will need rescue medication to use during an allergy emergency. Students should have their own rescue medication (an epinephrine auto-injector) available at school to use when necessary. This requires a medication authorization form (which may be combined with an Allergy & Anaphylaxis Action Plan) signed by a parent and healthcare provider and submitted every year to the student's school.

Utah Code 26-41 requires schools to stock an epinephrine auto-injector for use by anyone showing signs of anaphylaxis. The intent is to have medication available for students whose own medication has run out, the student who accidentally left their medication at home, or for someone experiencing an undiagnosed allergic reaction. This statute is not meant to replace a student's own rescue medication. The school having an epinephrine auto-injector on hand should not be interpreted to relieve a student's parent or guardian of providing a student's medication or create an expectation that a school will have a stock epinephrine auto-injector available.

These guidelines have been developed to instruct school staff on how to use a stock epinephrine auto-injector, and the requirements of the statute (UCA 26-41).

What are Allergies?

Allergy symptoms occur when the immune system overacts to food proteins, insect stings, or environmental triggers that are harmless to most people but can cause a serious and potentially life-threatening reaction to others. Allergies are sometimes hereditary. While allergies are more common in children, they can appear at any age.

Common triggers include animal dander, grass or tree pollen, insect stings, and food proteins. In the United States the eight most common food allergens are milk, egg, peanut, tree nuts, soy, wheat, fish, and shellfish. Common allergy symptoms include sneezing, coughing, an upset stomach, a skin rash, and difficulty breathing (American College of Allergy, Asthma & Immunology [ACAAI], n.d. & Food Allergy Research & Education [FARE] n.d.).

In the case of most environmental allergens such as animal dander and pollen, reactions consist of mild symptoms such as watery eyes, a runny nose, or a rash. Allergic reactions to food and insect stings can cause a life-threatening allergic reaction known as anaphylaxis. This severe reaction can affect several areas of the body, including breathing, blood circulation, skin symptoms, reduced blood pressure, and gastrointestinal symptoms (American Academy of Allergy Asthma & Immunology [AAAAI], n.d.).

Anaphylaxis is a serious, life-threatening allergic reaction. The most common anaphylactic reactions are to foods, insect stings, medication, and latex.

Anaphylaxis requires immediate medical treatment with epinephrine and a trip to the emergency room. Even after treatment with epinephrine some people have a secondary wave of symptoms called a biphasic reaction. The risk of a biphasic reaction is why they should be observed in the emergency room for an additional four to six hours after successful treatment of anaphylaxis. Antihistamines will not stop the life-threatening symptoms of anaphylaxis.

Certain people with allergies are at greater risk of a fatal outcome with anaphylaxis. If you have asthma, a personal or family history of anaphylaxis, or if epinephrine treatment is delayed, you are at greater risk of suffering a fatal anaphylactic reaction. All allergic reactions have the potential of causing anaphylaxis, even if past reactions have been mild (AAAAI).

Health-Related Forms

All students with a chronic health condition should have a healthcare plan on file if there is a chance the condition might result in a health crisis while at school. This can be an individualized healthcare plan (IHP) or an emergency action plan (EAP). A healthcare plan is written by the school nurse on daily management of students with a chronic health condition. Additionally, if a student requires medication be available at school, a medication authorization must be on file with the school, and signed by a parent and provider every year.

The following are forms that a student with allergies may need:

- Individualized Healthcare Plan (IHP): The IHP is written by the school nurse with input from the family. The IHP outlines the plan of care necessary to keep the student safe at school (National Association of School Nurses [NASN], 2015).
 - Emergency Action Plan (EAP): An EAP is a type of IHP. The EAP is written by the school nurse with input from the family, but is designed for lay staff. The EAP is usually in a “if you see this – do this” format. If combined with the medication authorization, the parent and healthcare provider must sign the document every year.
- Medication authorization: If emergency medication may be required at school this form must be submitted to the school every year, and must be signed by a parent and healthcare provider. This can be a separate document, or may be combined with the EAP (i.e. Allergy & Anaphylaxis IHP/EAP).
- Section 504 of the Rehabilitation Act of 1973 (Section 504 Plan): A written plan to direct the team on accommodations necessary for the student to have Free and Appropriate Public Education (regular education students). The Section 504 plan does not take the place of an IHP, but should be used together with an IHP if the student requires certain accommodations for their chronic health condition.
- Individualized Education Plan (IEP): A written plan for students in special education who are protected by the Individuals with Disabilities Education Act (IDEA, 2004). Accommodations for students with health conditions who are served by special education can be outlined in an IEP, but may also require a separate IHP or EAP.

The Utah Department of Health (UDOH) has created a combination form that includes the Allergy & Anaphylaxis IHP/EAP (AAEAP) and the medication form. This form can be found at [Choosehealth.utah.gov](http://choosehealth.utah.gov).

<http://choosehealth.utah.gov/prek-12/school-nurses/guidelines/forms.php>.

Possible Warning Signs and Symptoms

Symptoms of anaphylaxis typically start within five minutes to two hours of coming into contact with the allergen. Students may not always recognize the symptoms of anaphylaxis. Student specific triggers and symptoms should be listed in the student's AAEAP or IHP.

The best ways to manage allergies is to avoid the allergens that trigger the allergic reactions, and to be prepared for an emergency.

Warning signs typically affect more than one part of the body and may include:

Mild Symptoms:

- Itchy/runny nose
- Itchy mouth
- A few hives, mild itch
- Mild nausea/discomfort

Treatment for mild to moderate symptoms include taking an antihistamine (if ordered by healthcare provider) and watching the student closely for changes. If symptoms worsen, or if there is more than one symptom - give epinephrine.

Severe Symptoms:

- Short of breath, wheezing, repetitive cough
- Skin color pale, blue,
- Faint, weak pulse, dizzy
- Tight throat, hoarse, trouble breathing or swallowing
- Significant swelling of the tongue and/or lips
- Many hives over the body, widespread redness
- Repetitive vomiting, severe diarrhea
- Feeling something bad is about to happen, anxiety, confusion

For severe symptoms **inject epinephrine immediately and call the emergency medical service (EMS) number**. If symptoms do not improve a second dose of epinephrine can be given as soon as 5 minutes after the last dose. The person must be transported to the emergency department even if the symptoms resolve. The person should remain in the emergency department for at least four hours (and up to six) because symptoms may return during a biphasic reaction.

Allergy Medication

People with allergies may take an antihistamine to manage mild symptoms. An antihistamine will not help prevent an anaphylactic reaction. Those at risk for anaphylaxis should never try to treat an anaphylactic reaction with an antihistamine.

People who are at risk of anaphylaxis should carry epinephrine auto-injectors. These contain a prescribed single dose of medication that is injected into the thigh during an anaphylactic emergency. Epinephrine auto-injectors are prescribed in packs of two and are meant to be kept together in case more than one dose of epinephrine is needed before emergency responders arrive. When an epinephrine auto-injector is used call EMS immediately so the person can be transported to the nearest emergency department for evaluation, monitoring and any further treatment by healthcare professionals.

Stock Epinephrine Auto-Injectors

Utah law (26-41-103 (5(a)) requires all schools (primary or secondary, public, and private) to stock at least one emergency epinephrine auto-injector for use in a “person exhibiting potentially life-threatening symptoms of anaphylaxis”.

The intent is to have this medication available for use for students whose own medication has run out, in case the student inadvertently left their medication at home, or if there is someone experiencing an anaphylactic reaction for the first time. This is not meant to replace a student’s own epinephrine auto-injector. Even though the school has stock epinephrine available on hand it should not be interpreted to relieve a student's parent or guardian of providing a student's medication or create an expectation that a school will have stock epinephrine available.

Student Specific Epinephrine

Students may possess or possess and self-administer an epinephrine auto-injector if an authorization is signed annually by parent and provider. If the student is not able to possess or self-administer their medication, the medication should be kept in an unlocked, but secure, location. All student-specific medication (including epinephrine auto-injectors) must have a signed medication authorization (or AAEAP/EAP) on file that is updated annually.

Qualified Epinephrine Auto-Injector Entity

According to Utah law (26-41-102 (7)(b)) the following entities are allowed to carry stock epinephrine auto-injectors:

- recreation camps;
- schools or universities;
- day care facilities;
- youth sports leagues;
- amusement parks;
- food establishments;

- places of employment; and
- recreation areas.

Schools (all primary and secondary, public and private) must keep at least one epinephrine auto-injector on hand for use in an anaphylactic emergency (UCA 26-41-103 (5)(a)).

Qualified Adults

Qualified adults can receive training required to administer stock epinephrine auto-injectors to those experiencing an anaphylactic emergency. To be a qualified adult this person must:

- be 18 years of age or older; and
- volunteer to administer the medication; and
- complete an approved training program

Those outside the school setting may also receive training to administer an epinephrine auto-injector in an emergency. These can include camp counselors, scout leaders, forest rangers, tour guides, and other persons who have contact with the public (UCA 26-41-104 (6)(b)).

Stock Epinephrine Auto-Injector Training

Utah Code 26-41-104 (6)(a)(i) states the UDOH will approve training programs for using epinephrine auto-injectors (EAI). It will include the following:

- proper use and storage of EAI;
- techniques for recognizing symptoms of anaphylaxis;
- standards and procedures for the storage and emergency use of stock epinephrine auto-injectors;
- emergency follow-up procedures, including calling EMS and contacting, if possible, the student's parent; and
- written materials covering the information presented.

If the school has a school nurse, the nurse should be the person who ensures the training has been completed, and that the volunteer is competent to provide the service as required by the Utah Nurse Practice Act/Rules for any medication being administered in the school. If the school does not have a nurse the training may be done by a nationally recognized organization experienced in training laypersons in emergency health treatment of anaphylaxis. Additional authorized trainers include physicians, advanced practice registered nurses, physician assistants, pharmacists, or paramedics.

Approved training programs include the following:

[A Shot to Live \(University of Utah\)](#)

[Get Trained – Epinephrine Administration \(National Association of School Nurses\)](#)

[Epipen4Schools Training Video \(Mylan\)](#)

[How to Use the Auvi Q \(Boston Children's Hospital\)](#)

Procedures to follow after administration

Always follow the instructions on the student's AAEAP when administering any epinephrine auto-injectors.

(See appendix for UDOH Allergy & Anaphylaxis Emergency Action Plan)

Prescription

The qualified entity may obtain a prescription for stock epinephrine from the school medical director, the medical director of the local health department, the local emergency medical services director, or other person or entity authorized to prescribe or dispense prescription drugs.

Obtaining Stock Epinephrine Auto-Injectors

All schools should have at least one epinephrine auto-injector available. These devices require a prescription from a licensed healthcare provider. Each school should obtain a prescription from their medical consultant for the epinephrine auto-injector and may fill that prescription at the pharmacy of their choice (at their cost).

There is currently a program from Mylan Pharmaceuticals that will provide up to four free EpiPens for each school. A school must submit a valid prescription to qualify for this program. More information can be found at <https://www.epipen4schools.com/>. This free program may stop functioning at any time.

Storage of Stock Epinephrine Auto-Injectors

The stock epinephrine auto-injector shall be stored in a secure and easily accessible, but unlocked location known to the school nurse and all school staff who have been designated to administer the medication in case of the nurse's absence.

Disposal

If an epinephrine auto-injector has been administered it should be discarded in a sharps container or sent with the emergency medical services responders for them to discard. It should not be thrown away in the trash.

It is the responsibility of the parent or guardian 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 any medications that are not retrieved (Utah Department of Health (UDOH), 2017).

- 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 whom it was prescribed. Both individuals should sign the documentation.

Documentation

The school's written policy should include documentation of medication given at school and the practice for administering medications. Each dose of medication administered or witnessed by school staff should be documented on a medication log 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 students receive medications as prescribed, and can help reduce medication errors (UDOH, 2017).

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
- Whether the medication administered was the student's own epinephrine or stock epinephrine.

Reporting

The Utah Department of Health asks schools to report aggregate asthma rescue medication data every year. This should be done in the School Health Workload Report submitted to the UDOH at the end of the school year. Aggregate data to be submitted may include but is not limited to:

- Whether the local education agency (LEA) had a policy in place for administration of stock epinephrine;
- Whether the LEA carried stock epinephrine;
- Total number of individual orders in the LEA for student specific epinephrine;
- The number of staff trained to administer the epinephrine; and
- The number of times an epinephrine auto-injector was administered by school staff (non-nurse) and school nurse.

Medication Errors

A medication incident or error report 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 school should retain all medication error forms.

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

Definitions

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

Allergy: a reaction to substances in the environment that are harmless to most people.

Anaphylaxis: is a serious allergic response that often involves swelling, hives, lowered blood pressure and in severe cases, shock or death.

Epinephrine auto-injector: an automatic device designed to deliver a specific dose of epinephrine to a person experiencing an anaphylactic emergency. The most common epinephrine auto-injector is the EpiPen. Other devices include the Auvi-Q, the Adrenaclick, and a generic device.

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 controlled by the U.S. Food and Drug Administration and 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 must be submitted to the school every year, and must be signed by a parent and healthcare provider. This form can be the form designed by the State, or a form created by the LEA (as long as that form meets the requirements of the specific statute).

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 error reporting form designed by the UDOH, or a form created by the LEA.

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

School Employee Volunteer: a school employee who does not have a professional license that allows them to administer medication. These people may also be called unlicensed assistive personnel.

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.

Unlicensed Assistive Personnel (UAP): a school employee who does not have a professional license that allows them to administer medication. This person may also be called a school employee volunteer.

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Utah Department of Health. (2017). Guidelines for medication administration in schools. Retrieved from <http://choosehealth.utah.gov/prek-12/school-nurses/laws-and-policies/medication.php>

APPENDIX

Statute

Chapter 41 Emergency Response for Life-threatening Conditions

Effective 7/1/2020

26-41-101 Title.

This chapter is known as "Emergency Response for Life-threatening Conditions."

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) "Asthma action plan" means a written plan;
 - (a) developed with a school nurse, a student's parent or guardian, and the student's health care provider to help control the student's asthma; and
 - (b) signed by the student's:
 - (i) parent or guardian; and
 - (ii) health care provider.
- (3) "Asthma emergency" means an episode of respiratory distress that may include symptoms such as wheezing, shortness of breath, coughing, chest tightness, or breathing difficulty.
- (4) "Epinephrine auto-injector" means a portable, disposable drug delivery device that contains a measured, single dose of epinephrine that is used to treat a person suffering a potentially fatal anaphylactic reaction.
- (5) "Health care provider" means an individual who is licensed as:
 - (a) a physician under Title 58, Chapter 67, Utah Medical Practice Act;
 - (b) a physician under Title 58, Chapter 68, Utah Osteopathic Medical Practice Act;
 - (c) an advanced practice registered nurse under Section 58-31b-302; or
 - (d) a physician assistant under Title 58, Chapter 70a, Utah Physician Assistant Act.
- (6) "Pharmacist" means the same as that term is defined in Section [58-17b-102](#).
- (7) "Pharmacy intern" means the same as that term is defined in Section [58-17b-102](#).
- (8) "Physician" means the same as that term is defined in Section [58-67-102](#).
- (9) "Qualified adult" means a person who:
 - (a) is 18 years of age or older; and
 - (b) (i) for purposes of administering an epinephrine auto-injector, has successfully completed the training program established in Section [26-41-104](#); and
 - (ii) for purposes of administering stock albuterol, has successfully completed the training program established in Section [26-41-104.1](#).

(10) "Qualified epinephrine auto-injector 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.

(11) "Qualified stock albuterol entity" means a public or private school 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 an asthma emergency.

(12) "Stock albuterol" means a prescription inhaled medication:

- (a) used to treat asthma; and
- (b) that may be delivered through a device, including:
 - (i) an inhaler; or
 - (ii) a nebulizer with a mouthpiece or mask.

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 stock albuterol; or

(b) except as provided in Subsection (5), a qualified epinephrine auto-injector entity to store epinephrine auto-injectors or a qualified stock albuterol entity to store stock albuterol 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 or 26-41-104.1 and to make emergency epinephrine auto-injectors or stock albuterol 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 or 26-41-104.1;

(b) possessing or storing an epinephrine auto-injector or stock albuterol 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 26-41-104.1; or

(c) administering an epinephrine auto-injector or stock albuterol 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 or 26-41-104.1.

(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)

(a) Each primary or secondary school in the state, both public and private, may make stock albuterol available to any school employee who:

(i) is employed at the school; and

(ii) is a qualified adult.

(b) A qualified adult may administer stock albuterol to a student who:

(i) has a diagnosis of asthma by a health care provider;

(ii) has a current asthma action plan on file with the school; and

(iii) is showing symptoms of an asthma emergency as described in the student's asthma action plan.

(c) This Subsection (6) may not be interpreted to relieve a student's parent or guardian of providing a student's medication or create an expectation that a school will have stock albuterol available.

(7) 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.

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 EMS 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 autoinjector; 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 department, in cooperation with the state superintendent of public instruction, shall design forms to be used by public and private 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 epinephrine auto-injector 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.

26-41-104.1 Training in use and storage of stock albuterol.

- (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 stock albuterol available to a teacher or school employee who volunteers to become a qualified adult.
 - (b) The training described in Subsection (1)(a) shall be provided by the department.
- (2) A person who provides training under Subsection (1) or (6) shall include in the training:

- (a) techniques for recognizing symptoms of an asthma emergency;
 - (b) standards and procedures for the storage and emergency use of stock albuterol;
 - (c) emergency follow-up procedures, and contacting, if possible, the student's parent; 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) A public or private school shall permit a student to possess and self-administer asthma medication if:
 - (i) the student's parent or guardian signs a statement:
 - (A) authorizing the student to self-administer asthma medication; and
 - (B) acknowledging that the student is responsible for, and capable of, self-administering the asthma medication; and
 - (ii) the student's health care provider provides a written statement that states:
 - (A) it is medically appropriate for the student to self-administer asthma medication and be in possession of asthma medication at all times; and
 - (B) the name of the asthma medication prescribed or authorized for the student's use.
 - (b) Section 53G-8-205 does not apply to the possession and self-administration of asthma medication in accordance with this section.
- (5) The department, in cooperation with the state superintendent of public instruction, shall design forms to be used by public and private schools for the parental and health care provider statements described in Subsection (4).
- (6) The department:
- (a) shall approve educational programs conducted by other persons to train:
 - (i) people under Subsection (6)(b), regarding the proper use and storage of stock albuterol; and
 - (ii) a qualified stock albuterol entity regarding the proper storage and emergency use of stock albuterol; and
 - (b) may conduct educational programs to train people regarding the use of and storage of stock albuterol.

26-41-105 Authority to obtain and use an epinephrine auto-injector or stock albuterol.

- (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:
- (a) epinephrine auto-injectors for use in accordance with this chapter; or
 - (b) stock albuterol for use in accordance with this chapter.
- (2) (a) A qualified adult may obtain an epinephrine auto-injector for use in accordance with this chapter that is dispensed by:
- (i) a pharmacist as provided under Section [58-17b-1004](#); or
 - (ii) a pharmacy intern as provided under Section [58-17b-1004](#).
- (b) A qualified adult may obtain stock albuterol for use in accordance with this chapter that is dispensed by:
- (i) a pharmacist as provided under Section [58-17b-1004](#); or

(ii) a pharmacy intern as provided under Section 58-17b-1004.

(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) If a school nurse is not immediately available, a qualified adult:

(a) may immediately administer stock albuterol to an individual who:

(i) has a diagnosis of asthma by a health care provider;

(ii) has a current asthma action plan on file with the school; and

(iii) is showing symptoms of an asthma emergency as described in the student's asthma action plan; and

(b) shall initiate appropriate medical follow-up in accordance with the training materials retained under Section 26-41-104.1 after administering stock albuterol.

(5) (a) A qualified entity that complies with Subsection (5)(b) or (c), may obtain a supply of epinephrine auto-injectors or stock albuterol, respectively, from a pharmacist under Section 58-17b-1004, or a pharmacy intern under Section 58-17b-1004 for:

(i) storing:

(A) the epinephrine auto-injectors on the qualified epinephrine auto-injector entity's premises; and

(B) stock albuterol on the qualified stock albuterol entity's premises; and

(ii) use by a qualified adult in accordance with Subsection (3) or (4).

(b) A qualified epinephrine auto-injector 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.

(c) A qualified stock albuterol entity shall:

(i) designate an individual to complete an initial and annual refresher training program regarding the proper storage and emergency use of stock albuterol available to a qualified adult; and

(ii) store stock albuterol in accordance with the standards established by the department in Section 26-41-107.

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 or asthma emergency:

(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 or 26-41-104.1;
 - (d) a qualified epinephrine auto-injector entity; and
 - (e) a qualified stock albuterol entity.
- (2) Section 53G-9-502 does not apply to the administration of an epinephrine auto-injector or stock albuterol 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.

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 Sections 26-41-104 and 26-41-104.1;
- (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:
 - (a) emergency auto-injectors by a qualified epinephrine auto-injector entity under Section 26-41-104; and
 - (b) stock albuterol by a qualified stock albuterol entity under Section 26-41-104.1.

Rules

R426. Health, Family Health and Preparedness, Emergency Medical Services.

R426-5. Emergency Medical Services Training, Endorsement, Certification, and Licensing Standards.

R426-5-2700. Epinephrine Auto-Injector and Stock Albuterol Use.

(1) Any qualified entities or qualified adults shall receive training approved by the Department.

(a) The epinephrine auto-injector training shall include:

- (i) recognition of life threatening symptoms of anaphylaxis;
- (ii) appropriate administration of an epinephrine auto-injector;
- (iii) proper storage of an epinephrine auto-injector;
- (iv) disposal of an epinephrine auto-injector; and
- (v) an initial and annual refresher course.

(b) The stock albuterol training shall include:

- (i) recognition of life threatening symptoms of an asthma emergency;
- (ii) appropriate administration of stock albuterol;
- (iii) proper storage of stock albuterol;
- (iv) disposal of stock albuterol; and
- (v) an initial and annual refresher course.

(2) The annual refresher course requirement may be waived if:

(a) the qualified entities or qualified adults are currently licensed at the EMR or higher level by the state; or

(b) the approved trainings are the Red Cross and American Heart Association epinephrine auto-injector modules.

(3) Training in the school setting shall be based on approved Department trainings found pursuant to Section 26-41-104.

(4) To become qualified, a teacher or school employee who is 18 years of age or older shall successfully complete the training program listed in Subsection R426-5-2700(1).

(5) All epinephrine auto injectors and stock albuterol shall be kept in a secure unlocked location for use in an emergency. Devices should be disposed of following the manufacturer's specifications.

KEY: emergency medical services Date of Enactment or Last Substantive Amendment: 2020

Notice of Continuation: December 6, 2016

Authorizing, and Implemented or Interpreted Law: 26-1-30; 26-8a-302

Allergy & Anaphylaxis IHP/EAP

Model Epinephrine Auto-Injector Policy

Model Policy: Stock Epinephrine Auto-Injectors in Schools

The [insert name of LEA] Board of Education recognizes anaphylaxis is a chronic, life-threatening condition. Students with a diagnosis of anaphylaxis who are prescribed epinephrine are strongly encouraged to self-carry and self-administer their medication, if appropriate. Students who are unable to self-carry and self-administer their medication should bring their epinephrine auto-injector (EAI) to school and follow the allergy and anaphylaxis emergency action plan (AAEAP) written by the school nurse, student's parent/guardian, and healthcare provider.

Under this policy, the school board shall allow the school to provide stock epinephrine to students with anaphylaxis in the event the student is experiencing an anaphylactic emergency and does not have access to their own EAI, as required in UCA 26- 41-103(5)(a).

Conditions for Administering Stock Epinephrine

Persons experiencing an anaphylactic emergency whose personal EAI is temporarily unavailable may receive an emergency dose of school-stocked epinephrine. They do not need to have a previously diagnosed allergy.

The LEA, its employees, and agents, including authorized licensed prescribers providing the standing prescription of stock epinephrine auto-injectors are to incur no liability, with the exception of gross negligence, as a result of injury arising from the administration of stock epinephrine.

This policy should not be interpreted to relieve a student's parent or guardian of providing a student's medication or create an expectation that a school will have stock epinephrine available.

Administering and Storing Stock Epinephrine Auto-Injectors

To administer and store the stock epinephrine follow these procedures:

Only epinephrine auto-injectors shall be used in schools. Epinephrine administered via syringe and vial is not permitted except by parent/guardian or an EMS first responder.

Any trained school staff may administer stock epinephrine. Each school may find volunteer school employees to administer the stock epinephrine when the nurse is not available. All who administer stock epinephrine, including the nurse and other designated personnel, are required to complete the appropriate training.

The stock epinephrine shall be stored in an unlocked, but secure and easily accessible location known to the school nurse and all school staff designated to administer the stock epinephrine in case of the nurse's absence.

Each school shall document each time the stock epinephrine is used, by which student, and make a note of parent/guardian notification.

Obtaining Stock Epinephrine Auto-Injectors

The stock epinephrine auto-injectors shall be prescribed by the school's medical director.

A provider may prescribe stock epinephrine in the name of (insert school district or school) to be maintained for use when deemed necessary based on the provisions of this section.

All stock epinephrine must be obtained from a licensed pharmacy or manufacturer. No epinephrine auto-injector devices can be accepted from private individuals.

All expired medication shall be discarded in accordance with proper procedure.

Effective Date

This policy shall take effect in full on [insert 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

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

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.

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Center for Disease Control and Prevention. (2016). *Head lice*. Retrieved from http://www.cdc.gov/parasites/lice/head/gen_info/faqs.html

Mississippi Department of Health. (2013). *Mississippi School Nurse Procedures & Standards of Care*. Retrieved from <http://www.mde.k12.ms.us/docs/healthy-schools/procedures-manual-.pdf?sfvrsn=0>.

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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

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

ALLERGY & ANAPHYLAXIS Individualized Healthcare Plan (IHP)/Emergency Action Plan (EAP)/Medication Authorization and Self-Administration Form In Accordance with UCA 26-41-104 Utah Department of Health/Utah State Board of Education		School Year:	Picture
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:	
ALLERGEN(S)			
Allergy to:			
<input type="checkbox"/> If checked, give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms. <input type="checkbox"/> If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, even if no symptoms are apparent.			
Yellow: Mild to Moderate Reaction		Action	
<i>MILD Symptoms</i> <ul style="list-style-type: none"> Itchy/runny nose Itchy mouth A few hives, mild itch Mild nausea/discomfort 		For MILD SYMPTOMS from A SINGLE SYSTEM area, follow the directions below: <ul style="list-style-type: none"> Antihistamines may be given, if ordered by a healthcare provider. Stay with the person; alert emergency contacts. Watch closely for changes. If symptoms worsen, give epinephrine. <p style="text-align: center;">For MORE THAN ONE symptom, GIVE EPINEPHRINE</p>	
Red: Severe Reaction		Action	
<i>SEVERE Symptoms</i> <ul style="list-style-type: none"> Short of breath, wheezing, repetitive cough Skin color is pale, blue, Faint, weak pulse, dizzy Tight or hoarse throat, trouble breathing or swallowing Significant swelling of the tongue and/or lips Many hives over body, widespread redness Repetitive vomiting, severe diarrhea Feeling something bad is about to happen, anxiety, confusion 		<ol style="list-style-type: none"> INJECT EPINEPHRINE IMMEDIATELY. Call EMS. Tell them the student is having anaphylaxis and may need epinephrine when they arrive. 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. Give second dose of epinephrine if symptoms get worse, continue, or do not get better in 5 minutes. Alert emergency contacts. Give other medication (only if prescribed). DO NOT use other medication in place of epinephrine. <ul style="list-style-type: none"> Antihistamine Inhaler (bronchodilator) if wheezing Transport them to emergency department even if symptoms resolve. Person should remain in ED for at least 4 hours because symptoms may return. 	
MEDICATION			
Medication Brand	Dose	Side Effects	
Epinephrine:	<input type="checkbox"/> 0.15 mg IM <input type="checkbox"/> 0.3 mg IM		
Antihistamine:			
Other: (e.g., inhaler-bronchodilator of wheezing)			
CONTINUED ON NEXT PAGE			

Allergy & Anaphylaxis Action Plan

Student Name:		DOB:	School Year:
PRESCRIBER TO COMPLETE			
<p>The above named student is under my care. The above reflects my plan of care for the above named student.</p> <p><input type="checkbox"/> It is 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"/> It is not 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> <p><input type="checkbox"/> Additional Orders:</p>			
Prescriber Name:		Phone:	
Prescriber Signature:		Date:	
PARENT TO COMPLETE			
<p>Parental Responsibilities:</p> <ul style="list-style-type: none"> • The parent or guardian is to furnish the Epinephrine Auto Injector medication and bring to the school in the current original pharmacy container and pharmacy label with the student'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 Epinephrine Auto Injector medication within two weeks if the Epinephrine Auto Injector single dose medication is given. • If a student has a change in their 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 Medication Authorization and Self-Administration Form (this form) before the designated staff can administer the updated Epinephrine Auto Injector medication prescription. 			
Parent/Guardian Authorization			
<p><input type="checkbox"/> I authorize my student 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 student and I understand there are serious consequences for sharing any medication with others.</p> <p><input type="checkbox"/> I authorize my student to self-carry and self-administer EAI if needed, when able and appropriate.</p> <p><input type="checkbox"/> I authorize my student to self-carry, but not self-administer EAI.</p> <p><input type="checkbox"/> I do not authorize my student to carry and self-administer this medication. Please have the appropriate/designated school personnel maintain my student's medication for use in an emergency.</p>			
Parent Signature:			Date:
<p><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 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 allergy/anaphylaxis treatment, provided the personnel are following prescriber 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 and the school nurse if 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></p>			
Parent Name (print):		Signature:	Date:
Emergency Contact Name:		Relationship:	Phone:
SCHOOL NURSE (or principal designee if no school nurse)			
<input type="checkbox"/> Signed by prescriber 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"/> 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:



EMERGENCY RESPONSE FOR LIFE-THREATENING CONDITIONS IN SCHOOLS: ASTHMA

UTAH DEPARTMENT OF HEALTH

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Asthma Guidelines

Introduction

There are times when students in school may need medication to help with their chronic health condition. Many students with asthma take a controller medication at home to help manage their chronic condition, but some will also need rescue medication to use during an asthma emergency. Students should have their own rescue medication (typically an albuterol inhaler) available at school to use when necessary. This requires a medication authorization form (which may be combined with an Asthma Action Plan) signed by a parent and healthcare provider and submitted every year to the student's school.

The Utah State Legislature passed House Bill 344 during the 2019 legislative session which allows schools to stock albuterol to use for students:

1. Who have a diagnosis of asthma by a healthcare professional, and
2. Who have a current asthma action plan on file with the school, and
3. Who is showing symptoms of an asthma emergency as described in the student's asthma action plan.

If a student meets all of the requirements listed above, and the school has chosen to carry stock albuterol, the student may be given the medication.

The intent is to have medication available for students whose own medication has run out, or the student who accidentally left their medication at home. This statute is not meant to replace a student's own rescue medication. The choice made by the school to make stock albuterol available should "not be interpreted to relieve a student's parent or guardian of providing a student's medication or create an expectation that a school will have stock albuterol available" (UCA 26-41-103 (6)(c)).

These guidelines have been developed to instruct school staff on how to use stock albuterol since the goal is to help keep students in class and ready to learn.

What is Asthma?

Asthma is a chronic disease of the lungs and airways that may make it difficult to breathe and can be life threatening. Asthma causes inflammation or swelling, production of excess mucus, and tightening of the muscles (bronchospasm) that surround the airway. Together the bronchospasm and inflammation make it harder to move air through the airways.

Asthma may cause respiratory distress that may include symptoms such as wheezing, shortness of breath, coughing, chest tightness, color change, retractions, or breathing difficulty.

Health-Related Forms

All students with a chronic health condition should have a healthcare plan on file if there is a chance the condition might result in a health crisis while at school. This can be an individualized healthcare plan (IHP) or an emergency action plan (EAP). A healthcare plan is written by the school nurse on daily management of students with a chronic health condition. Additionally, if a student requires medication be available at school, a medication authorization must be on file with the school, and signed by a parent and provider every year.

A student with asthma may have the following forms:

- Individualized Healthcare Plan (IHP): The IHP is written by the school nurse with input from the family. The IHP outlines the plan of care necessary to keep the student safe at school.
 - Emergency Action Plan (EAP): An EAP is a type of IHP. The EAP is written by the school nurse with input from the family, but is designed for lay staff. The EAP is usually in a “if you see this – do this” format. If combined with the medication authorization, the parent and healthcare provider must sign every year.
 - Asthma Action Plan (AAP): An AAP is a type of EAP written by the healthcare provider specifically as a plan of care for the person with asthma. If combined with the medication authorization, the parent and healthcare provider must sign every year.
- Medication authorization: If emergency medication is required at school this form must be submitted to the school every year, and must be signed by a parent and healthcare provider. This can be a separate document, or may be combined with the EAP (e.g. AAP/EAP, anaphylaxis EAP).
- Section 504 of the Rehabilitation Act of 1973 (Section 504 Plan): A written plan to direct the team on accommodations necessary for the student to have Free and Appropriate Public Education (regular education students). The Section 504 plan does not take the place of an IHP, but should be used together with an IHP if the student requires certain accommodations for their chronic health condition.
- Individualized Education Plan (IEP): A written plan for students in special education who are protected by the Individuals with Disabilities Education Act (IDEA, 2004). Accommodations for students with health conditions who are served by special education can be outlined in their IEP, but may also require a separate IHP or EAP.

The Utah Department of Health (UDOH) has created a combination form that includes the AAP/EAP and the medication form. This form can be found at [Choosehealth.utah.gov](https://www.choosehealth.utah.gov).

Possible Warning Signs and Symptoms

Early warning signs may progress to an asthma emergency. Not all students will experience all of these symptoms during an asthma emergency. Symptoms may include:

- coughing

- itchy throat or chin (tickle in the throat)
- stomachache
- feeling funny in the chest
- dark circles under eyes
- behavior changes

Late stage asthma episode signs and symptoms may include:

- becoming anxious or scared
- shortness of breath
- rapid labored breathing
- persistent coughing
- tightness in chest
- wheezing while breathing in/out
- unable to talk in full sentences
- shoulders hunched over
- sweaty, clammy skin
- changes to skin color, and dark lips or fingernails
- pallor
- retractions

Student-specific information should be listed in the student's AAP/EAP or IHP.

Asthma Medication

Asthma medications generally fall into two categories: quick relief medication and long-term control medications.

- Quick relief medications (bronchodilators) open the airways by relaxing the muscles around the bronchial tubes. Bronchodilators are taken when symptoms begin to occur or when they are likely to occur (e.g., prior to recess, physical education classes, or sports events). Albuterol is a bronchodilator.
- Long-term control medications generally are anti-inflammatory medications and taken daily on a long-term basis to gain and maintain control of persistent asthma, even in the absence of symptoms.

Student-Specific Albuterol

Students may possess or possess and self-administer asthma medication if authorization is signed every year by a parent and provider. If the student is not able to possess or self-administer their medication, the medication should be kept in an unlocked, but secure location. All student-specific medication (including inhalers) must have a signed medication authorization (or AAP/EAP) on file that is updated every year.

Stock Albuterol

During the 2019 Utah State Legislative session lawmaker passed a bill allowing any public or private school to stock albuterol for use in students who:

- Have a known diagnosis of asthma by a healthcare provider, and
- Have a current AAP/EAP on file with the school, and
- Are showing symptoms of an asthma emergency as shown in that student's AAP/EAP.

Qualified Adults

Only qualified adults can administer stock albuterol to students. To qualify, a person must:

- Be the school nurse, **or**
- Be 18 years of age or older, and
- Be a school employee, and
- Volunteer to administer the medication, and
- Have completed the training program from the school nurse (or other designated healthcare professional if there is no school nurse).

Stock Albuterol Training

The training program will be developed by the UDOH. It will include the following:

- An initial and refresher training program;
- Techniques for recognizing symptoms of an asthma emergency;
- Standards and procedures for the storage and emergency use of stock albuterol;
- Emergency follow-up procedures, and contacting, if possible, the student's parent; and
- Written materials covering the information presented.

If the school has a school nurse, the nurse should be the one ensuring the training has been completed, and that the volunteer is competent to provide the service as required by the Utah Nurse Practice Act/Rules for any medication being administered in the school. If there is not a school nurse the training may be done by a nationally-recognized organization experienced in training laypersons in emergency health treatment. Additional authorized trainers include physicians, advanced practice registered nurses, physician assistants, respiratory therapists, pharmacists, paramedic, or Certified Asthma Educators. Regardless of who administers the training, it must include the stock albuterol training program developed by the UDOH (<https://usbe.instructure.com/enroll/H8KRLR>).

Procedures to Follow After Stock Albuterol Administration

After stock albuterol is administered a student must be observed by a responsible adult until:

- The respiratory distress is resolved, **or**
- The parent takes the student home, **or**
- EMS arrives.

Once the student's breathing has improved (breathing smooth and easy, no coughing or wheezing) the student may return to class.

If EMS has been called for a student experiencing an asthma emergency that student should not return to class. If not transported to the hospital the student should go home with a parent for observation.

Prescription

The qualified entity may obtain a prescription for stock albuterol from the school medical director, the medical director of the local health department, the local emergency medical services director, or other person or entity authorized to prescribe or dispense prescription drugs.

Obtaining Stock Albuterol and Supplies

The recommended device is a metered-dose inhaler with either a plastic one-way valve or cardboard spacer. To prevent the spread of disease a disposable spacer or mask should be used whenever administering stock albuterol.

The UDOH is working with outside organizations for spacer donations and at-cost inhalers. Each school may also obtain a prescription from their medical consultant for the inhaler and then fill that prescription at the pharmacy of their choice (at their cost).

Sanitation of Stock Albuterol devices

Disposable products should be used to prevent the spread of disease. This may include disposable spacers (used with inhalers) or disposable supplies including tubing, mask, or mouthpieces (used with nebulizer). These should all be thrown away after the student is finished with them. Nebulizers shall be cleaned and sanitized properly to avoid spreading infection (American Lung Association (ALA), n.d.).

Storage of Stock Albuterol

The stock albuterol shall be stored in a secure and easily accessible, unlocked location known to the school nurse and all school staff designated to administer the albuterol in case of the nurse's absence (ALA).

Disposal

Expired or empty stock albuterol should be disposed of following manufacturer's instructions.

Documentation

The school's written policy should include documentation of medication given at school and the practice for administering medications. Each dose of medication administered or witnessed by school staff should be documented on a medication log 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 students receive medications as prescribed, and can help reduce medication errors (UDOH, 2017).

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
- Whether the medication administered was the student's own albuterol or stock albuterol.

Reporting

The Utah State Statute (UCA 26-41) requires schools to report aggregate asthma rescue medication data every year to the UDOH. This should be done in the School Health Workload Report submitted to the UDOH at the end of the school year. Aggregate data to be submitted may include but is not limited to:

- The number of staff trained to administer the stock albuterol,
- The number of times the stock albuterol was administered by school staff (non-nurse) and school nurse,
- The number of nurses who are familiar with the stock albuterol law, and
- The disposition of students who received the stock albuterol (returned to class, went home, EMS called).

Medication Errors

A medication incident or error report 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 school should retain all medication error forms.

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

Definitions

Albuterol: A bronchodilator used to open the airways by relaxing the muscles around the bronchial tubes.

Asthma Emergency: An episode of respiratory distress that may include symptoms such as wheezing, shortness of breath, coughing, chest tightness, or breathing difficulty.

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. These include a physician, an advanced practice registered nurse, or a physician assistant.

Inhaler: A device for the delivery of prescribed asthma medication which is inhaled. This includes metered dose inhalers (MDI), dry powder inhalers, soft mist inhalers, and nebulizers.

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

Medication: Prescribed drugs and medical devices controlled by the U.S. Food and Drug Administration and 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 must be submitted to the school every year, and must be signed by a parent and healthcare provider. This form can be the 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 any medication is administered to a student. This form can be the form designed by the UDOH, or a form created by the LEA.

Nebulizer: A compressor device used for the delivery of an inhaled mist containing medication to help relieve respiratory distress.

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.

Spacer: A mouthpiece that attaches to the inhaler allowing for improved medication delivery by slowing the speed of the medication propelled from the inhaler allowing the medication particles to reach deeper into the lungs.

Stock Albuterol: A bronchodilator medication in the form of a metered-dose inhaler or albuterol solution for a nebulizer that is ordered by a healthcare provider, stored in the school to be used by a qualified adult for a student who has a current AAP, EAP, or IHP and does not have their personal albuterol available or easily accessible to use during an asthma attack.

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APPENDIX

Statute

Chapter 41 **Emergency Response for Life-threatening Conditions**

Effective 7/1/2020

26-41-101 Title.

This chapter is known as "Emergency Response for Life-threatening Conditions."

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) "Asthma action plan" means a written plan;
 - (a) developed with a school nurse, a student's parent or guardian, and the student's health care provider to help control the student's asthma; and
 - (b) signed by the student's:
 - (i) parent or guardian; and
 - (ii) health care provider.
- (3) "Asthma emergency" means an episode of respiratory distress that may include symptoms such as wheezing, shortness of breath, coughing, chest tightness, or breathing difficulty.
- (4) "Epinephrine auto-injector" means a portable, disposable drug delivery device that contains a measured, single dose of epinephrine that is used to treat a person suffering a potentially fatal anaphylactic reaction.
- (5) "Health care provider" means an individual who is licensed as:
 - (a) a physician under Title 58, Chapter 67, Utah Medical Practice Act;
 - (b) a physician under Title 58, Chapter 68, Utah Osteopathic Medical Practice Act;
 - (c) an advanced practice registered nurse under Section 58-31b-302; or
 - (d) a physician assistant under Title 58, Chapter 70a, Utah Physician Assistant Act.
- (6) "Pharmacist" means the same as that term is defined in Section [58-17b-102](#).
- (7) "Pharmacy intern" means the same as that term is defined in Section [58-17b-102](#).
- (8) "Physician" means the same as that term is defined in Section [58-67-102](#).
- (9) "Qualified adult" means a person who:
 - (a) is 18 years of age or older; and
 - (b) (i) for purposes of administering an epinephrine auto-injector, has successfully completed the training program established in Section [26-41-104](#); and
 - (ii) for purposes of administering stock albuterol, has successfully completed the training program established in Section [26-41-104.1](#).

(10) "Qualified epinephrine auto-injector 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.

(11) "Qualified stock albuterol entity" means a public or private school 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 an asthma emergency.

(12) "Stock albuterol" means a prescription inhaled medication:

- (a) used to treat asthma; and
- (b) that may be delivered through a device, including:
 - (i) an inhaler; or
 - (ii) a nebulizer with a mouthpiece or mask.

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 stock albuterol; or
- (b) except as provided in Subsection (5), a qualified epinephrine auto-injector entity to store epinephrine auto-injectors or a qualified stock albuterol entity to store stock albuterol 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 or 26-41-104.1 and to make emergency epinephrine auto-injectors or stock albuterol 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 or 26-41-104.1;
- (b) possessing or storing an epinephrine auto-injector or stock albuterol 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 26-41-104.1; or
- (c) administering an epinephrine auto-injector or stock albuterol 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 or 26-41-104.1.

(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)

(a) Each primary or secondary school in the state, both public and private, may make stock albuterol available to any school employee who:

(i) is employed at the school; and

(ii) is a qualified adult.

(b) A qualified adult may administer stock albuterol to a student who:

(i) has a diagnosis of asthma by a health care provider;

(ii) has a current asthma action plan on file with the school; and

(iii) is showing symptoms of an asthma emergency as described in the student's asthma action plan.

(c) This Subsection (6) may not be interpreted to relieve a student's parent or guardian of providing a student's medication or create an expectation that a school will have stock albuterol available.

(7) 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.

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 EMS 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 autoinjector; 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 department, in cooperation with the state superintendent of public instruction, shall design forms to be used by public and private 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 epinephrine auto-injector 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.

26-41-104.1 Training in use and storage of stock albuterol.

- (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 stock albuterol available to a teacher or school employee who volunteers to become a qualified adult.
 - (b) The training described in Subsection (1)(a) shall be provided by the department.
- (2) A person who provides training under Subsection (1) or (6) shall include in the training:

- (a) techniques for recognizing symptoms of an asthma emergency;
 - (b) standards and procedures for the storage and emergency use of stock albuterol;
 - (c) emergency follow-up procedures, and contacting, if possible, the student's parent; 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) A public or private school shall permit a student to possess and self-administer asthma medication if:
 - (i) the student's parent or guardian signs a statement:
 - (A) authorizing the student to self-administer asthma medication; and
 - (B) acknowledging that the student is responsible for, and capable of, self-administering the asthma medication; and
 - (ii) the student's health care provider provides a written statement that states:
 - (A) it is medically appropriate for the student to self-administer asthma medication and be in possession of asthma medication at all times; and
 - (B) the name of the asthma medication prescribed or authorized for the student's use.
 - (b) Section 53G-8-205 does not apply to the possession and self-administration of asthma medication in accordance with this section.
- (5) The department, in cooperation with the state superintendent of public instruction, shall design forms to be used by public and private schools for the parental and health care provider statements described in Subsection (4).
- (6) The department:
- (a) shall approve educational programs conducted by other persons to train:
 - (i) people under Subsection (6)(b), regarding the proper use and storage of stock albuterol; and
 - (ii) a qualified stock albuterol entity regarding the proper storage and emergency use of stock albuterol; and
 - (b) may conduct educational programs to train people regarding the use of and storage of stock albuterol.

26-41-105 Authority to obtain and use an epinephrine auto-injector or stock albuterol.

- (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:
- (a) epinephrine auto-injectors for use in accordance with this chapter; or
 - (b) stock albuterol for use in accordance with this chapter.
- (2) (a) A qualified adult may obtain an epinephrine auto-injector for use in accordance with this chapter that is dispensed by:
- (i) a pharmacist as provided under Section [58-17b-1004](#); or
 - (ii) a pharmacy intern as provided under Section [58-17b-1004](#).
- (b) A qualified adult may obtain stock albuterol for use in accordance with this chapter that is dispensed by:
- (i) a pharmacist as provided under Section [58-17b-1004](#); or

(ii) a pharmacy intern as provided under Section 58-17b-1004.

(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) If a school nurse is not immediately available, a qualified adult:

(a) may immediately administer stock albuterol to an individual who:

(i) has a diagnosis of asthma by a health care provider;

(ii) has a current asthma action plan on file with the school; and

(iii) is showing symptoms of an asthma emergency as described in the student's asthma action plan; and

(b) shall initiate appropriate medical follow-up in accordance with the training materials retained under Section 26-41-104.1 after administering stock albuterol.

(5) (a) A qualified entity that complies with Subsection (5)(b) or (c), may obtain a supply of epinephrine auto-injectors or stock albuterol, respectively, from a pharmacist under Section 58-17b-1004, or a pharmacy intern under Section 58-17b-1004 for:

(i) storing:

(A) the epinephrine auto-injectors on the qualified epinephrine auto-injector entity's premises; and

(B) stock albuterol on the qualified stock albuterol entity's premises; and

(ii) use by a qualified adult in accordance with Subsection (3) or (4).

(b) A qualified epinephrine auto-injector 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.

(c) A qualified stock albuterol entity shall:

(i) designate an individual to complete an initial and annual refresher training program regarding the proper storage and emergency use of stock albuterol available to a qualified adult; and

(ii) store stock albuterol in accordance with the standards established by the department in Section 26-41-107.

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 or asthma emergency:

(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 or 26-41-104.1;
 - (d) a qualified epinephrine auto-injector entity; and
 - (e) a qualified stock albuterol entity.
- (2) Section 53G-9-502 does not apply to the administration of an epinephrine auto-injector or stock albuterol 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.

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 Sections 26-41-104 and 26-41-104.1;
- (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:
 - (a) emergency auto-injectors by a qualified epinephrine auto-injector entity under Section 26-41-104; and
 - (b) stock albuterol by a qualified stock albuterol entity under Section 26-41-104.1.

Rules

R426. Health, Family Health and Preparedness, Emergency Medical Services.

R426-5. Emergency Medical Services Training, Endorsement, Certification, and Licensing Standards.

R426-5-2700. Epinephrine Auto-Injector and Stock Albuterol Use.

(1) Any qualified entities or qualified adults shall receive training approved by the Department.

(a) The epinephrine auto-injector training shall include:

- (i) recognition of life threatening symptoms of anaphylaxis;
- (ii) appropriate administration of an epinephrine auto-injector;
- (iii) proper storage of an epinephrine auto-injector;
- (iv) disposal of an epinephrine auto-injector; and
- (v) an initial and annual refresher course.

(b) The stock albuterol training shall include:

- (i) recognition of life threatening symptoms of an asthma emergency;
- (ii) appropriate administration of stock albuterol;
- (iii) proper storage of stock albuterol;
- (iv) disposal of stock albuterol; and
- (v) an initial and annual refresher course.

(2) The annual refresher course requirement may be waived if:

(a) the qualified entities or qualified adults are currently licensed at the EMR or higher level by the state; or

(b) the approved trainings are the Red Cross and American Heart Association epinephrine auto-injector modules.

(3) Training in the school setting shall be based on approved Department trainings found pursuant to Section 26-41-104.

(4) To become qualified, a teacher or school employee who is 18 years of age or older shall successfully complete the training program listed in Subsection R426-5-2700(1).

(5) All epinephrine auto injectors and stock albuterol shall be kept in a secure unlocked location for use in an emergency. Devices should be disposed of following the manufacturer's specifications.

KEY: emergency medical services Date of Enactment or Last Substantive Amendment: 2020

Notice of Continuation: December 6, 2016

Authorizing, and Implemented or Interpreted Law: 26-1-30; 26-8a-302

Asthma Action Plan

<h2 style="color: green; margin: 0;">Asthma Action Plan (AAP)</h2> <h3 style="margin: 0;">Individualized Healthcare Plan (IHP)/Emergency Action Plan (EAP)/Medication Authorization & Self-Administration Form</h3> <p style="margin: 0;">in accordance with UCA 26-41-104</p> <p style="margin: 0;">Utah Department of Health/Utah State Board of Education</p>		School Year:	Picture	
STUDENT INFORMATION				
Student:	DOB:	Grade:	School:	
Parent:	Phone:	Email:		
Physician:	Phone:	Fax or email:		
School Nurse:	School Phone:	Fax or email:		
Severity Classification <input type="checkbox"/> Intermittent <input type="checkbox"/> Mild Persistent <input type="checkbox"/> Moderate Persistent <input type="checkbox"/> Severe Persistent				
Triggers <input type="checkbox"/> Illness <input type="checkbox"/> Exercise <input type="checkbox"/> Animals <input type="checkbox"/> Smoke <input type="checkbox"/> Dust <input type="checkbox"/> Food <input type="checkbox"/> Weather <input type="checkbox"/> Air Quality <input type="checkbox"/> Pollen <input type="checkbox"/> Other (specify):				
Air Quality Student should stay indoors when Air Quality Index is:		Exercise Take quick-relief medication (see medication order in Yellow section below):		
<input type="checkbox"/> Moderate	<input type="checkbox"/> Unhealthy for sensitive groups	<input type="checkbox"/> Unhealthy	<input type="checkbox"/> Other:	
		<input type="checkbox"/> Before exercise/exposure to a trigger <input type="checkbox"/> Other (specify):		
Green: Doing Great!		Action		
Student has ALL of these: - Breathing is easy - No cough or wheeze - Able to work and play normally		Controller Medication (taken at home)	How Much?	
			How Often?	
Yellow: Mild to Moderate Distress		Action		
Student has ANY of these: - Coughing or wheezing - Tight chest - Shortness of breath - Waking up at night		Quick-Relief Medication	How Much?	
			How Often?	
		Administer Via	<input type="checkbox"/> Student is independent <input type="checkbox"/> Student needs assistance <input type="checkbox"/> Student needs supervision	
		<input type="checkbox"/> Inhaler <input type="checkbox"/> Nebulizer <input type="checkbox"/> Inhaler with spacer		
		1. Restrict physical activity and allow to rest upright. 2. Do not leave student unattended. Observe continuously for 15 minutes. 3. Notify parent/guardian. 4. If improved (breathing smooth and easy, no coughing or wheezing) may return to class. 5. If no improvement call EMS and move to Red section below.		
Red: Severe Respiratory Distress		Action		
Student has ANY of these: - Trouble eating, walking or talking - Breathing hard and fast - Medicine isn't helping - Rib or neck muscles show when breathing in - Color changes in lips, nail beds, skin		Call EMS!		
		1. Repeat ____ puffs of Quick-Relief Medication (each 15-30 seconds apart) every ____ minutes until medical help arrives. 2. Encourage slow breaths and allow individual to rest. 3. Update parent/guardian. 4. Do not leave student unattended. Observe continuously until EMS arrives <input type="checkbox"/> Additional Orders (specify):		
CONTINUED ON NEXT PAGE ▶				

Asthma Action Plan (AAP)

Student Name:		DOB:	School Year:
PRESCRIBER TO COMPLETE			
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"/> It is 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"/> It is not 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:	
PARENT TO COMPLETE			
Parental Responsibilities:			
<ul style="list-style-type: none"> • 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 their 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 designated staff can administer the updated asthma medication prescription. 			
Parent/Guardian Authorization			
<input type="checkbox"/> 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.			
<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.			
<input type="checkbox"/> I authorize 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 prescriber 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:
SCHOOL NURSE (or principal designee if no school nurse)			
<input type="checkbox"/> Signed by prescriber and parent	<input type="checkbox"/> Medication is appropriately labeled	<input type="checkbox"/> Medication log generated	
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"/> 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:

Model Policy and Procedures

Model Policy: Stock Albuterol in Schools

The [insert name of LEA] Board of Education recognizes asthma is a chronic, life-threatening condition. Students with a diagnosis of asthma who are prescribed albuterol are strongly encouraged to self-carry and self-administer their medication, if appropriate. Students who are unable to self-carry and self-administer their medication should bring their inhaler to school and follow the asthma action plan written by the school nurse, student's parent/guardian, and healthcare provider.

Under this policy, the school board may allow the school to provide stock albuterol to students with asthma in the event the student is experiencing an asthma emergency and does not have access to their own inhaler.

Conditions for Administering Stock Albuterol

Students diagnosed with asthma whose personal albuterol is empty or temporarily unavailable may receive an emergency dose of school-stocked albuterol under the following conditions:

1. Have a diagnosis of asthma, and
2. Have a current Asthma Action Plan (IHP/EAP) signed by a healthcare provider and parent on file with the school, and
3. Be experiencing symptoms of an asthma emergency as described in the student's asthma action plan

For students experiencing respiratory distress without a diagnosis of asthma or without a current asthma action plan on file with the school, school personnel should call EMS immediately.

The LEA and its employees and agents, including authorized licensed prescriber providing the standing prescription of stock albuterol are to incur no liability, with the exception of gross negligence, as a result of injury arising from the administration of stock albuterol.

This policy should not be interpreted to relieve a student's parent or guardian of providing a student's medication or create an expectation that a school will have stock albuterol available.

Administering and Storing Stock Albuterol

To administer and store the stock albuterol the following procedures shall be followed:

Only the school nurse and designated personnel who have completed appropriate training shall administer the stock albuterol.

Each school may find volunteer school employees to administer the stock albuterol when the nurse is not available.

All who administer stock albuterol, including the nurse and other designated personnel, are required to complete the appropriate training.

The stock albuterol shall be stored in an unlocked, but secure and easily accessible location known to the school nurse and all school staff designated to administer the stock albuterol in case of the nurse's absence.

To minimize the spread of disease:

- inhalers shall be used with disposable spacers or disposable mouth-pieces.
- disposable tubing with mask or mouthpieces may be used with nebulizers and discarded after the student is finished with it.
- nebulizers shall be cleaned and sanitized properly to avoid spreading infection.

Each school shall document each time the stock albuterol is used, by which student, and make a note of parent/guardian notification.

Obtaining Stock Albuterol

The stock albuterol and appropriate medical devices needed for proper medication delivery shall be prescribed by the school's medical director.

A provider may prescribe stock albuterol in the name of (insert school district or school) to be maintained for use when deemed necessary based on the provisions of this section.

All stock albuterol, devices, and device components needed to appropriately administer the medication must be obtained from a licensed pharmacy, manufacturer, or national asthma organization. No stock albuterol, devices, or device components can be accepted from private individuals.

All expired medication shall be discarded in accordance with proper procedure.

Effective Date

This policy shall take effect in full on [insert date].

Reference

American Lung Association, (n.d.). Model policy on stock bronchodilators. Retrieved from <https://www.lung.org/getmedia/92bd8d3f-c5ca-46c0-9063-9d5719ec690b/model-policy-for-school.pdf.pdf>

DIABETES - Individualized Healthcare Plan (IHP) Utah Department of Health				School Year:	Picture
STUDENT INFORMATION					
Student:	DOB:	Grade:	School:	DMMO <input type="checkbox"/> Yes <input type="checkbox"/> No	
Parent:	Phone:		Email:		
Physician:	Phone:		Fax or Email:		
School Nurse:	School Phone:		Fax or Email:		
<input type="checkbox"/> Type I	<input type="checkbox"/> Type II	Age at diagnosis:			
SECTION 504 PLAN					
All students with diabetes should also have a separate Section 504 plan in place to provide accommodations necessary to access their education.					
STUDENT DIABETES MANAGEMENT SKILLS		Needs Assistance	Needs Supervision	Independent	
Identifying feelings of hypoglycemia					
Checking blood glucose					
Measuring out insulin					
Entering information into pump					
Administering insulin injection					
Independently counts carbohydrates					
CONTINUOUS GLUCOSE MONITORING					
<input type="checkbox"/> Student has a Continuous Glucose Monitoring System: CGMS must have parent signature on CGM Addendum. Not all CGMS readings can be used to make treatment decisions.					
Test blood glucose with a meter if apparent disparity between GGM reading and symptoms!					
INSULIN DELIVERY (per instructions from healthcare provider, correction doses can be given with meal/snack only, unless on a pump)					
Method of insulin delivery: <input type="checkbox"/> Pump <input type="checkbox"/> Insulin Pen <input type="checkbox"/> Syringe/vial					
High Blood Glucose Correction Dose for PUMP only: If BG over _____ mg/dl, give correction per <u>pump calculation</u>					
Lunch: Student will typically eat: <input type="checkbox"/> School Lunch (staff can help with carb counts) <input type="checkbox"/> Home Lunch (parent must provide carb counts)					
HYPOglycemia-Low Blood Glucose		HYPERGlycemia-High Blood Glucose		ADDITIONAL INFORMATION	
Emergency situations may occur with low blood sugar! Symptoms: shaky, feels low, feels hungry, confused, other (specify): <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 or if symptomatic give _____ grams of carbohydrates <input type="checkbox"/> After 15 minutes recheck blood glucose <input type="checkbox"/> Repeat until blood glucose is over _____ mg/dl <input type="checkbox"/> Disconnect or suspend pump		Symptoms: Increased thirst, increase need for urination, other (specify): <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 If vomiting call parent <i>immediately!</i>		<ul style="list-style-type: none"> Student must always be allowed access to fast-acting sugar. Student is allowed to carry a water bottle and have unrestricted bathroom privileges. Student is allowed to test his/her blood glucose when/where needed Substitute teachers must be aware of the student's health situation, but still respecting privacy <p style="color: red;">CALL 911 IF:</p> <ul style="list-style-type: none"> Glucagon is administered Student is unable to cooperate to eat or drink anything Decreasing alertness or loss of consciousness Seizure 	
Notify parent(s)/guardian when blood glucose is below _____ mg/dl or above _____ mg/dl					
CONTINUED ON NEXT PAGE					

Diabetes Individualized Healthcare Plan (IHP)

Student:	DOB:	School Year:
SPECIAL CONSIDERATIONS (Academic testing, Snacks, PE, School Parties, Field Trips)		
PE: <input type="checkbox"/> Check BG before PE <input type="checkbox"/> 15 gram carb (free) snack before PE <input type="checkbox"/> Other (specify): <input type="checkbox"/> Do not exercise if BG is below _____ mg/dl or above _____ mg/dl or symptomatic of hyperglycemia		
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):		
EMERGENCY MEDICATION (See DMMO)		
Person to give Glucagon: <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:		
SIGNATURES		
<i>PARENT TO COMPLETE (as required by UCA 53G-9-504 and 53g-9-506)</i>		
<input type="checkbox"/> I certify that glucagon has been prescribed for my student. <input type="checkbox"/> I request the school identify and train school personnel who volunteer to be trained in the administration of glucagon. I authorize the administration of glucagon in an emergency to my student. <input type="checkbox"/> I authorize my student to possess or possess and self-administer diabetes medication. I acknowledge that my student is responsible for, and capable of, possessing or possessing and self-administering the diabetes medication.		
Parent Name:	Signature:	Date:
As parent/guardian of the above named student, I give permission for my student'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 above to my student. 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:
SCHOOL NURSE		
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):		
IHP (this form) distributed to 'need to know' staff: <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:

Diabetes Emergency Action Plan (EAP)

DIABETES - Emergency Action Plan (EAP) Utah Department of Health			School Year:	Picture
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 _____) <u>Causes:</u> too much insulin; missing or delaying meals or snacks; not eating enough food; intense or unplanned physical activity; being ill. <u>Onset:</u> sudden, symptoms may progress rapidly				
MILD OR MODERATE HYPOGLYCEMIA Please check previous symptoms			SEVERE HYPOGLYCEMIA Please check previous symptoms	
<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:	
ACTIONS FOR MILD OR MODERATE HYPOGLYCEMIA			ACTIONS FOR SEVERE HYPOGLYCEMIA	
1. Give student fast-acting sugar source* 2. Wait 15 minutes. 3. Recheck blood glucose. 4. Repeat fast-acting sugar source if symptoms persist OR blood glucose is less than 80 or _____ 5. Other: *FAST ACTING SUGAR SOURCES (15 grams carbohydrates): 3-4 glucose tablets OR 4 ounces juice OR 0.9 ounce packet of fruit snacks			1. Don't attempt to give anything by mouth. 2. Position on side, if possible. 3. Contact trained diabetes personnel. 4. Administer glucagon, if prescribed. 5. Call 911. Stay with student until EMS arrives. 6. Contact parents/guardian. 7. Stay with student. 8. Other:	
Never send a student with suspected low blood glucose anywhere alone!!!				
CONTINUED ON NEXT PAGE ➔				

Diabetes Emergency Action Plan (EAP)

Student Name:		DOB:	School Year:
<p>HYPERGLYCEMIA - When Blood Glucose is over 250 (or above _____)</p> <p><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.</p> <p><u>Onset:</u> over several hours or days.</p>			
<p>MILD OR MODERATE HYPERGLYCEMIA Please check previous symptoms</p>		<p>SEVERE HYPERGLYCEMIA Please check previous symptoms</p>	
<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:
<p>ACTIONS FOR MILD OR MODERATE HYPERGLYCEMIA</p>		<p>ACTIONS FOR SEVERE HYPERGLYCEMIA</p>	
<input type="checkbox"/> Allow liberal bathroom privileges. <input type="checkbox"/> Encourage student to drink water or sugar-free drinks. <input type="checkbox"/> Administer correction dose if on a pump. <input type="checkbox"/> Contact parent if blood sugar is over _____ mg/dl. <input type="checkbox"/> 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:	
<p>INSULIN PUMP FAILURE (please indicate plan for insulin pump failure)</p>			
<input type="checkbox"/> NA/not on an insulin pump <input type="checkbox"/> Parent to come and replace site <input type="checkbox"/> Student can replace site alone or with minimal assistance		<input type="checkbox"/> Administer insulin via syringe/vial or pen <input type="checkbox"/> School nurse can replace site (only if previously trained) <input type="checkbox"/> Other (specify):	
<p>PARENT SIGNATURE</p> <p>I have read and approve of the above emergency action plan.</p>			
Parent:		Signature:	Date:
Emergency Contact Name:		Relationship:	Phone:
<p>SCHOOL NURSE</p>			
<p>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):</p>			
<p>Glucagon 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</p>			
<p>Copies of EAP (this form) distributed to 'need to know' staff: <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):</p>			
School Nurse Signature:			Date:

Addendum:

Diabetes Medication Management Order (DMMO)

Diabetes Medication Management Orders (DMMO) In Accordance with UCA 53G-9-504 and 53G-9-506 Utah Department of Health/Utah State Board of Education		HEALTHCARE PROVIDER: Name: Phone: Fax:	
STUDENT INFORMATION		School Year:	
Student Name:	<input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2	School:	
DOB:	Age at diagnosis:	School Fax:	
Parent Name:	Phone:	Phone:	
Emergency Contact:	Relationship:	Phone:	
TO BE COMPLETED BY LICENSED HEALTHCARE PROVIDER			
EMERGENCY GLUCAGON ADMINISTRATION			
Immediately for severe hypoglycemia: unconscious, semiconscious (unable to control airway, or seizing)	Glucagon Dose: <input type="checkbox"/> IM 1.0 mg/1.0 ml <input type="checkbox"/> Nasal (Baqsimi) 3 mg <input type="checkbox"/> SQ (Gvoke) 0.5 mg <input type="checkbox"/> SQ (Gvoke) 1.0 mg	Possible side effects: Nausea and Vomiting	
BLOOD GLUCOSE TESTING			
Target range for blood glucose (BG): <input type="checkbox"/> 70-150 <input type="checkbox"/> 80-150 <input type="checkbox"/> 100-200 <input type="checkbox"/> Other:			
Times to test: <input type="checkbox"/> Before meals <input type="checkbox"/> If symptomatic <input type="checkbox"/> Other:			
<input type="checkbox"/> If symptomatic (See student's specific symptoms in Individualized Healthcare Plan (IHP).			
<ul style="list-style-type: none"> • If BG is less than ___ mg/dl, follow management per Diabetes Emergency Action Plan (EAP). • Student should not exercise if BG is below ___ mg/dl or symptomatic of hyperglycemia. 			
CONTINUOUS GLUCOSE MONITORING (CGM): If student has a CGM, the CGM Addendum is required. 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. Student is currently using the following CGM:			
<input type="checkbox"/> Dexcom G4 <input type="checkbox"/> Dexcom G5 <input type="checkbox"/> Dexcom G6 <input type="checkbox"/> Freestyle Libre <input type="checkbox"/> Medtronic 530G <input type="checkbox"/> Medtronic 630G <input type="checkbox"/> Medtronic 670 G <input type="checkbox"/> Guardian Connect <input type="checkbox"/> None <input type="checkbox"/> Other:			
CARBOHYDRATE COUNTING			
<input type="checkbox"/> Student is capable to independently count carbohydrates at meals and snacks for insulin administration.			
<input type="checkbox"/> Student requires a trained adult to supervise carbohydrate counting of meals and snacks for insulin administration.			
<input type="checkbox"/> Student requires a trained adult to carbohydrate count meals and snacks and administer insulin.			
INSULIN ADMINISTRATION			
<input type="checkbox"/> Humalog <input type="checkbox"/> Novolog <input type="checkbox"/> Apidra <input type="checkbox"/> Admelog <input type="checkbox"/> Lispro <input type="checkbox"/> Aspart <input type="checkbox"/> Fiasp <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) Ratio: ___ unit for every ___ grams of carbohydrates before meals.			
CORRECTION DOSE (meals only): ___ unit for every ___ mg/dl for blood glucose above ___ mg/dl.			
SNACKS/PARTIES:			
<input type="checkbox"/> Snacks/parties (use I:C ratio) <input type="checkbox"/> No coverage for snacks/parties <input type="checkbox"/> Contact parent/guardian			
INSULIN PUMP: If using insulin pump, carbohydrate ratio and correction dose are calculated by pump. Correction doses at times other than meals per PUMP calculation ONLY.			
ADDITIONAL PUMP ORDERS: 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. If able to reconnect pump, administer correction dose with (syringe or insulin pen) as calculated by pump.			
CONTINUED ON NEXT PAGE			

Diabetes Medication Management Order (DMMO)

Student Name:	DOB:	School Year:
ADDITIONAL ORDERS: <input type="checkbox"/> None <input type="checkbox"/> Please allow free and liberal access to water and the restroom. <input type="checkbox"/> Please allow student to keep their cell phone with them at all times if it is being used as a medical device to receive and transmit data from their CGM. <input type="checkbox"/> Please allow student to leave class 10 minutes prior to lunch to manage their diabetes. <input type="checkbox"/> Other:		
PRESCRIBER SIGNATURE		
The above named student is under my care. This document reflects my plan of care for the above named student. In accordance with these orders, an Individualized Healthcare Plan (IHP), an Emergency Action Plan (EAP), (and if appropriate) the CGM Addendum must be developed by the school nurse, student, and parent to be shared with appropriate school personnel. As the student's licensed healthcare provider:		
<input type="checkbox"/> I confirm the student has a diagnosis of diabetes mellitus. <input type="checkbox"/> It IS medically appropriate for the student to possess and self-administer diabetes medication. The student should be in possession of diabetes medications at all times. <input type="checkbox"/> It is NOT medically appropriate for the student to possess, or self-administer diabetes medication. The student should have access to their diabetes medications at all times. <input type="checkbox"/> This student may participate in ALL school activities, including sports and field trips, with the following restrictions:		
Prescriber Name (print):	Phone:	
Prescriber Signature:	Date:	
PARENT SIGNATURE		
I understand that a school team, including a parent or guardian, may make decisions about implementation and assistance in the school based on consideration of the above recommendations, 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 student'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:	Signature:	Date:

SCHOOL NURSE (or principal designee if no school nurse)		
<input type="checkbox"/> Signed by licensed healthcare provider and parent	<input type="checkbox"/> Medication is appropriately labeled	<input type="checkbox"/> Medication log generated
Glucagon is kept: <input type="checkbox"/> NA <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:		
Diabetes Emergency 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:	

Diabetes CGM Addendum

DIABETES Continuous Glucose Monitor (CGM) Addendum to IHP			School Year:	Picture
Utah Department of Health/ Utah State Board of Education				
Student:	DOB:	Grade:	School:	
Parent:	Phone:		Email:	
School Nurse:	School Phone:		Fax or Email:	

If CGM requires calibration for treatment parent must check appropriate boxes and sign below.

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.

<p>My student is currently using the following continuous glucose monitoring system <u>which is not FDA approved for making treatment decisions:</u></p>	
<p><input type="checkbox"/> My student uses a Medtronic 530 G and 630 G with Enlite Sensor system which monitors glucose and will automatically turns off basal rates if the low threshold glucose is reached based on the CGM. 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 requests 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.</p> <p><input type="checkbox"/> I verify that I understand that the Medtronic 530G and 630G are not FDA approved for making treatment decisions. I approve the school personnel or school nurse to assist with calibrations (if desired).</p>	
<p><input type="checkbox"/> My student uses a Dexcom G4. When the CGM alarms, treatment should be determined based on a finger-stick blood glucose.</p> <p><input type="checkbox"/> I verify that I understand that the Dexcom G4 is not FDA approved for making treatment decisions.</p>	
<p><input type="checkbox"/> My student uses a Freestyle Libre (which is not FDA approved for making treatment decisions in individuals under the age of 18). Treatment should be determined based on a finger-stick blood glucose.</p> <p><input type="checkbox"/> I verify that I understand that the Freestyle Libre is not FDA approved for making treatment decisions.</p>	
<p><input type="checkbox"/> My student uses a Medtronic 670 G with Guardian sensor system which is a hybrid closed loop system that monitors glucose and automatically adjusts the delivery of basal insulin based on the user's glucose reading. 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 requests 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.</p> <p><input type="checkbox"/> I verify that I understand that the Medtronic 670G is not FDA approved for making treatment decisions. I approve the school personnel or school nurse to assist with calibrations (if desired).</p>	
<p><input type="checkbox"/> My student uses a Medtronic Guardian Connect system. When CGM alarms, treatment should be determined based on a finger-stick blood glucose.</p> <p><input type="checkbox"/> I verify that I understand that the Medtronic Guardian Connect system is not FDA approved for making treatment decisions.</p>	
Parent Signature:	Date:
Continued on Next Page	

Diabetes CGM Addendum

Student Name:	DOB:	School Year:
My student is currently using the following continuous glucose monitoring system <u>which is FDA approved for making treatment decisions</u> :		
<input type="checkbox"/> My student uses a Dexcom G5 . 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. <u><i>Under certain circumstances</i></u> , insulin doses may be adjusted based on trend arrows. If the symptoms of the student do not match the CGM reading, check a finger-stick blood glucose with a meter. <input type="checkbox"/> I verify that I am responsible for calibrating the Dexcom G5 at home two times daily. I approve the school personnel or school nurse to treat hypoglycemia or give insulin doses based on the Dexcom G5.		
<input type="checkbox"/> My student uses a Dexcom G6 . 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 between 80 mg/dl and 350 mg/dL and there is a directional arrow visible on the CGM, unless otherwise directed by the provider. <u><i>Under certain circumstances</i></u> , insulin doses may be adjusted based on trend arrows. 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 emergency action plan. If the symptoms of the student do not match the CGM reading, check a finger-stick blood glucose with a meter. <input type="checkbox"/> I verify that I approve the school personnel or school nurse to treat hypoglycemia or give insulin doses based on the Dexcom G6.		
Parent Signature:	Date:	

<p>New CGMS are released periodically. If a new one is released it must first be verified as FDA approved to make treatment decisions before being used in the school setting. Until then, all readings must be verified by a finger-stick blood glucose before making treatment decisions.</p>	
<input type="checkbox"/> My student uses the following CGM system: <input type="checkbox"/> I verify that I understand this system is <u>not FDA approved for making treatment decisions</u> . When the CGM alarms, all treatment should be based on a finger-stick blood glucose. OR <input type="checkbox"/> I verify that I understand this system <u>is FDA approved for making treatment decisions</u> (any new devices must first be verified as approved by FDA before using for making treatment decisions). <ul style="list-style-type: none"> <input type="checkbox"/> I verify that I am responsible for making any calibrations necessary as required by the manufacturer. <input type="checkbox"/> I verify that I approve the school personnel or school nurse to treat hypoglycemia or give insulin doses based on the readings from this CGM (only after verification of FDA approval for making treatment decisions). 	
<input type="checkbox"/> Additional comments:	
Parent Signature:	Date:

Utah Guidelines for Seizures in Schools

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UTAH STATE BOARD OF EDUCATION
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UTAH GUIDELINES FOR SEIZURES IN SCHOOLS

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Guidelines for Seizures in Schools

INTRODUCTION

Epilepsy is a broad term used for a brain disorder that causes seizures. There are many different types of epilepsy. There are also different kinds of seizures. About 0.6% of children ages 0 to age 17 have active epilepsy in the United States (Russ Larson & Halfon, 2012).

Students with epilepsy are more likely to have difficulties in school (such as problems communicating), use special education services, and have activity limitations (such as less participation in sports or clubs) compared with students with other medical conditions (CDC 2017).

The purpose of this Guide is to assist local education agency (LEA) personnel in ensuring a safe learning environment for students with epilepsy.

SEIZURE CLASSIFICATIONS

Seizures are classified into two groups; generalized seizures that affect both sides of the brain, and focal seizures which are located in just one area of the brain.

Examples of generalized seizures are:

- Absence seizures which can cause rapid blinking or a few seconds of staring into space.
- Bilateral tonic-clonic seizures that may make a person
 - Cry out.
 - Lose consciousness.
 - Fall to the ground.
 - Have muscle jerks or spasms.
 - Lose bowel or bladder control
 - Change from normal breathing pattern.

The person may feel tired after a bilateral tonic-clonic seizure.

Focal seizures are also called partial seizures.

- Simple focal seizures affect a small part of the brain. These seizures can cause twitching or a change in sensation, such as a strange taste or smell.
- Focal seizures with impaired awareness, also known as complex focal seizures can make a person with epilepsy confused or dazed. The person will be unable to respond to questions or direction for up to a few minutes.
- Secondary generalized seizures begin in one part of the brain, but then spread to both sides of the brain. In other words, the person first has a focal seizure, followed by a generalized seizure.

Most seizures last from 30 seconds to two minutes. A seizure that lasts longer than five minutes is a medical emergency.

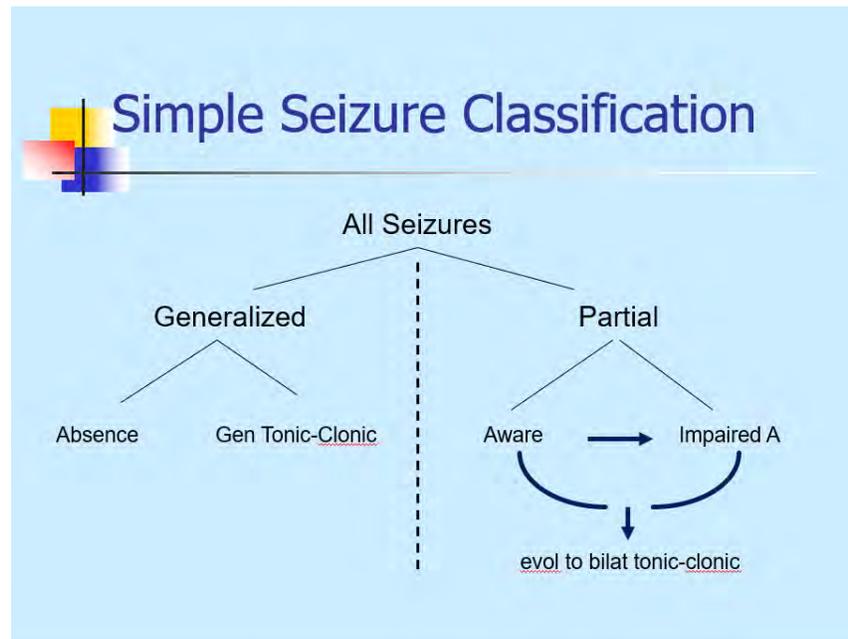


Figure 1. Simple Seizure Classification. (Dr. F. Filloux, 2020)

HEALTH-RELATED FORMS

All students with a chronic health condition should have a healthcare plan on file if there is a chance the condition might result in a health crisis while at school. This can be an individualized healthcare plan (IHP) or an emergency action plan (EAP). A healthcare plan is written by the school nurse on daily management of students with a chronic health condition. Additionally, if a student requires medication be available at school, a medication authorization must be on file with the LEA, and signed by a parent and provider every year.

The following are forms that a student with seizures may have:

- Individualized Healthcare Plan (IHP): The IHP is written by the school nurse with input from the family. The IHP outlines the plan of care necessary to keep the student safe at school (National Association of School Nurses [NASN], 2015).
 - Emergency Action Plan (EAP): An EAP is a type of IHP. The EAP is written by the school nurse with input from the family, but is designed for lay staff. The EAP is usually in an “if you see this – do this” format.
- Medication authorization: If emergency medication is required at school this form must be submitted to the LEA every year, and must be signed by a parent and healthcare provider.
- Section 504 of the Rehabilitation Act of 1973 (Section 504 Plan): A written plan to direct the team on accommodations necessary for the student to have Free and Appropriate

Public Education (regular education students). The Section 504 plan does not take the place of an IHP, but should be used together with an IHP if the student requires certain accommodations for their chronic health condition.

- Individualized Education Plan (IEP): A written plan for students in special education who are protected by the Individuals with Disabilities Education Act (IDEA, 2004). Accommodations for students with health conditions who are served by special education can be outlined in their IEP, but may also require a separate IHP or EAP.

The Utah Department of Health (UDOH) has created a separate Seizure Action Plan and a Seizure Medication Management Order (SMMO) form. These forms can be found at [Choosehealth.utah.gov](http://choosehealth.utah.gov).

<http://choosehealth.utah.gov/prek-12/school-nurses/guidelines/forms.php>.

MEDICATION

Daily seizure control medications are the mainstay of epilepsy treatment, but there are other approaches used to treat epilepsy including surgery, neurostimulation devices, and dietary therapy.

Sometimes additional medications are needed during a seizure emergency. These are called rescue medications. Rescue medications are typically used for seizure clusters, or when seizures are different from a person's typical pattern, such as more frequent, longer, or more severe. Rescue treatments are taken "as needed" to try and prevent a seizure emergency from occurring. Rescue medications are not used instead of daily seizure medications.

DEVICES

In at least three out of 10 people with epilepsy, seizure medications do not control seizures or can cause bothersome side effects. For some of these people surgery may be possible to remove the area of the brain causing the seizures.

Neuromodulation is another option. This therapy involves using a device to send small electric currents to the nervous system. There are different models of stimulators. They can deliver stimulation in response to heart rate changes and time of day.

Vagus nerve stimulation, also called VNS therapy, uses a device to help control seizures. While it does not work for everyone and is not a cure for epilepsy, it can help control seizures in some people.

VNS therapy prevents seizures by sending regular, mild pulses of electrical energy to the brain via the vagus nerve. It's sometimes referred to as a "pacemaker for the brain". A stimulator device is implanted under the skin in the chest. A wire from the device is wound around the vagus nerve in the neck. If a person is aware of when a seizure happens, they can swipe a magnet over the generator in the left chest area to send an extra burst of stimulation to the brain. Some vagus nerve stimulators work automatically in response to an increased heart rate.

Staff should swipe the magnet if they see seizure activity regardless of whether the VNS is set to automatically respond.

Responsive neurostimulation is known as RNS therapy. The RNS system is similar to a heart pacemaker. It can monitor brain waves, then respond to activity different from usual activity or that looks like a seizure. The neurostimulator device is secured into the skull and is fixed so it cannot move. It lies flat under the skin. People cannot feel the stimulation once it's programmed. It doesn't cause pain or any unusual feelings. The RNS system is approved for use in people ages 18 and older.

Deep brain stimulation (DBS) requires a neurosurgeon to place electrodes in a specific area of the brain. The electrodes provide stimulation directly to the brain to help stop the spread of seizures. DBS is approved for use in adults ages 18 and older.

TRAINING RESOURCES

School employees should have training on seizures to include the following (where appropriate):

- General seizure recognition – recommended for all school staff
- Seizure rescue medication – initial and annual refresher training required if school has employee volunteer trained to administer rescue medication
- Student specific training for individual students (which may or may not include seizure rescue medication)

There are existing trainings provided through the Epilepsy Foundation:

- School Nurse Training: <https://www.epilepsy.com/living-epilepsy/our-training-and-education/managing-students-seizures-school-nurse-training-program>
- School Staff Training: <https://www.epilepsy.com/living-epilepsy/our-training-and-education/seizure-training-school-personnel>

FIRST AID FOR SEIZURES

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

How to Help Someone Having a Seizure

STAY with the person until they are awake and alert after the seizure.

- Time the seizure
- Remain calm
- Check for medical ID

Keep the person safe

- Move or guide away from harm

- Turn the person on their side if they are not awake or aware
- Keep airway clear
- Loosen any tight clothing around neck
- Put something small and soft under the head

Rescue medications can be given if prescribed by healthcare provider, and training has been completed by the employee volunteer.

Seizures Requiring First Aid

Types of seizures that might require first aid are: bilateral 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.

General Care for All Types of Seizures

There are many types of seizures, and most end in a few minutes. These are general actions 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.
- Check to see if the person is wearing a medical bracelet or has 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.
- 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.

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 EMS.

Call EMS if:

- The person has never had a seizure before.
- The person has difficulty breathing or waking after the seizure.
- The seizure lasts longer than five 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 such as diabetes, heart disease, or is pregnant.



What Not To Do During a Seizure

- DO NOT restrain
- DO NOT put any objects in the mouth
- Do NOT offer the person water or food until fully alert

SEIZURE RESCUE MEDICATION

This Guide will assist LEA personnel with the management, response, and administration of seizure rescue medication under certain conditions for 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 LEA 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 the public LEA identify and train employees who are willing to volunteer to receive training to administer a seizure rescue medication. If the LEA receives a qualified request from a parent or guardian, meaning one that meets the conditions set forth in Senate Bill 232, the LEA must attempt to recruit for and subsequently provide the LEA 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 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 LEA 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, except in the administration of the medication, and call EMS and 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 employee volunteer must be age 18 or older, complete the training program, demonstrate competency, and complete refresher training.

- The student's parent or guardian and EMS must be called if medication is administered at school.
- The LEA cannot compel an employee to become a trained employee volunteer

Local Education Agencies 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 LEA 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 LEA 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 the proper forms (as required by LEA policy) are submitted to the school, and 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 five minutes or longer. Trained employee volunteers may only give seizure rescue medication for 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) responder. 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 (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 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. A parent or guardian must bring the updated medication with the 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. A 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 EMS must ALWAYS be called if seizure rescue medication is administered at school. The LEA administrator must also be notified.
- If an employee volunteer has not or cannot be identified at an LEA with an order for seizure rescue medication, it cannot be given except by parent or guardian, registered nurse if available, or EMS responder.
- 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. A parent or guardian is responsible for maintaining oxygen. The LEA 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 employee volunteers can only monitor until a parent or guardian, or EMS arrives. If the parent or guardian wants the student to remain in school after receiving seizure rescue medication, the parent or guardian will have to stay with the student.
- 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 LEA should develop protocols on contacting the trained employee volunteer immediately if the student with the seizure rescue medication has a seizure at school. The trained 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 EMS and the LEA's first responders.

Solicitation for trained LEA employee volunteers:

LEAs that receive a qualified request for an employee volunteer to administer a seizure rescue medication to a student shall solicit volunteers. It is imperative 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 LEA is unable to find an employee to function in this trained employee

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

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

Seizure Rescue Medication Training for employee volunteers

A school employee volunteer must be informed of the following:

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

- Schools should make every effort for a trained 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 employee volunteer accompany the student.
- A trained 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 EMS and the school nurse (if available), and to contact the student's parent or guardian.
- Calling EMS 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 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 employee volunteer at least quarterly to determine if additional training is needed.

DISPOSAL OF MEDICATION AND SUPPLIES

All expired and used medication and supplies should be disposed of according to manufacturer's instructions and LEA policy.

DEFINITIONS

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

Bilateral 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.

Emergency Action Plan (EAP): 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 bilateral tonic-clonic seizures.

Individualized Education Plan (IEP): a plan or program developed to ensure that a student 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 forms 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)

Seizure Rescue Medication Management Order (SMMO)

SEIZURE - Medication/Management Order (SMMO) Seizure Rescue Medication Authorization (In Accordance with UCA 53G-9-505) Utah Department of Health/Utah State Board of Education		Healthcare Provider:		Picture
		School Year:		
STUDENT INFORMATION				
Student:	DOB:	Grade:	School:	
Parent:	Phone:	Email:		
Physician:	Phone:	Fax:		
School Nurse:	School Phone:	Fax:		
SEIZURE INFORMATION				
Seizure Type/Description		Length	Frequency	
PARENT TO COMPLETE (must be completed by parent prior to sending to healthcare provider)				
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.				
<input type="checkbox"/> Yes <input type="checkbox"/> No	I certify that the parent/guardian has previously administered the seizure rescue medication in a non medically-supervised setting without a complication.			
<input type="checkbox"/> Yes <input type="checkbox"/> No	I certify student has previously ceased having a full body prolonged or convulsive seizure activity as a result of receiving this medication.			
If No to either, medication cannot be given by a trained volunteer. Can only be given by an RN, parent, or EMS.				
<input type="checkbox"/> Yes <input type="checkbox"/> No	I certify my student's healthcare professional has prescribed a seizure rescue medication for him/her.			
<input type="checkbox"/> Yes <input type="checkbox"/> No	I request the school identify and train school employees who are willing to volunteer to receive training to administer a seizure rescue medication.			
<input type="checkbox"/> Yes <input type="checkbox"/> No	I authorize a trained school employee volunteer to administer the seizure rescue medication.			
Parent Signature:			Date:	
As parent/guardian of the above named student, I give permission for my student'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. I authorize school staff to administer medication described below to my student. 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:	
CONTINUED ON NEXT PAGE				

Seizure Medication Management Order (SMMO)

Student Name:		DOB:	School Year:	
PRESCRIBER TO COMPLETE				
EMERGENCY SEIZURE RESCUE MEDICATION				
<p>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. As the student's licensed healthcare provider I confirm that the student has a diagnosis of seizures.</p> <p><input type="checkbox"/> This medication is necessary during the school day. Trained personnel will be allowed to administer this medication.</p>				
Give Emergency Medication IF:	Medication	Dose	Route	Call
<ul style="list-style-type: none"> • If seizure lasts ___ minutes or greater • If ___ or more consecutive seizures with or without a period of consciousness (in ___ minutes) • Other: 	<input type="checkbox"/> Midazolam <input type="checkbox"/> Diazepam <input type="checkbox"/> Lorazepam <input type="checkbox"/> Other (specify):	_____ mg _____ ml	<input type="checkbox"/> Nasal <input type="checkbox"/> Rectal <input type="checkbox"/> Other	ALWAYS call 911, parent and School Nurse
Common potential side effects: respiratory depression, nasal irritation, memory loss, drowsiness, fatigue. other:				
Additional instructions for administration:				
Additional orders:				
IMPLANTED DEVICES				
This student has a: <input type="checkbox"/> Responsive Neurostimulation (RNS) <input type="checkbox"/> Deep Brain Stimulation (DBS) <input type="checkbox"/> Vagus Nerve Stimulator (VNS): trained personnel will be trained on device 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 (or principle designee if no school nurse)				
<input type="checkbox"/> Signed by prescriber and parent <input type="checkbox"/> Medication is appropriately labeled <input type="checkbox"/> Medication log generated				
Medication is kept: <input type="checkbox"/> Health Office <input type="checkbox"/> Front Office <input type="checkbox"/> Other (specify-must be locked):				
IHP/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:	

APPENDIX B – Seizure Action Plan (SAP)

SEIZURE ACTION PLAN			School Year:	Picture
Individualized Healthcare Plan (IHP) Emergency Action Plan (EAP) Utah Department of Health/ Utah State Board of Education			SMMO <input type="checkbox"/> Yes <input type="checkbox"/> No	
STUDENT INFORMATION				
Student:	DOB:	Grade:	School:	
Parent:	Phone:		Email:	
Physician:	Phone:		Fax:	
School Nurse:	School Phone:		Fax:	
History:				
SECTION 504 PLAN				
Students with epilepsy or seizure disorder may also need a separate Section 504 plan in place to provide accommodations necessary to access their education.				
SEIZURE INFORMATION				
Seizure Type/Description		Length	Frequency	
Seizure triggers or warning signs:				
Student specific information:				
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: <input type="checkbox"/> School Nurse <input type="checkbox"/> Parent <input type="checkbox"/> EMS <input type="checkbox"/> Volunteer (specify): _____ <input type="checkbox"/> Other (specify): _____ Attach volunteer(s) training documentation				
Location of seizure rescue medication (must be locked but accessible):				
IMPLANTED DEVICES				
This student has the following device: <input type="checkbox"/> Responsive Neurostimulation (RNS). No action required by staff. <input type="checkbox"/> Deep Brain Stimulation (DBS). No action required by staff. <input type="checkbox"/> Vagus Nerve Stimulator (VNS) <ul style="list-style-type: none"> • Location of magnet (where in the school): • Describe magnet use and location of implanted device: 				
Person(s) trained on magnet use: <input type="checkbox"/> School Nurse <input type="checkbox"/> Teacher <input type="checkbox"/> Aide <input type="checkbox"/> Volunteer (specify): _____ <input type="checkbox"/> Other (specify): _____ Attach volunteer(s) training documentation				
CONTINUED ON NEXT PAGE				

Seizure Action Plan

Student Name:		DOB:	School Year:
SEIZURE ACTION PLAN – Mark all behaviors that apply to student			
If you see this:		Do this:	
<input type="checkbox"/> Sudden cry or squeal <input type="checkbox"/> Loss of bowel or bladder control <input type="checkbox"/> Staring <input type="checkbox"/> Rhythmic eye movement <input type="checkbox"/> Lip smacking <input type="checkbox"/> Gurgling or grunting noises <input type="checkbox"/> Falling down <input type="checkbox"/> Rigidity or stiffness <input type="checkbox"/> Thrashing or jerking <input type="checkbox"/> Change in breathing <input type="checkbox"/> Blue color to lips <input type="checkbox"/> Froth from mouth <input type="checkbox"/> Loss of consciousness <input type="checkbox"/> Other (specify):		<input type="checkbox"/> Stay calm & track time <input type="checkbox"/> Report symptoms and duration to parent <input type="checkbox"/> Keep student safe <input type="checkbox"/> Do not restrain <input type="checkbox"/> Protect head <input type="checkbox"/> Keep airway open/watch breathing <input type="checkbox"/> Turn student on side <input type="checkbox"/> Do not put anything in mouth <input type="checkbox"/> Do not give fluids or food during or immediately after seizure <input type="checkbox"/> Stay with student until fully conscious <input type="checkbox"/> Ensure symptoms resolve before student leaves classroom <input type="checkbox"/> Swipe VNS magnet (if applicable) <input type="checkbox"/> Other (specify):	
Expected Behavior after Seizure		EMERGENCY SEIZURE PROTOCOL	
<ul style="list-style-type: none"> ▪ Tiredness ▪ Weakness ▪ Sleeping, difficult to arouse ▪ Somewhat confused ▪ Regular breathing ▪ Other (specify): <p>Follow-Up</p> <ul style="list-style-type: none"> • Notify school nurse • Document observations 		<input type="checkbox"/> Call EMS at _____ minutes for transport to: _____ hospital <input type="checkbox"/> Call parent or emergency contact <input type="checkbox"/> Administer emergency medications and/or oxygen as indicated on SMMO <input type="checkbox"/> Other (specify):	
		<p>A seizure is generally considered an emergency when:</p> <ul style="list-style-type: none"> ▪ Convulsive (tonic-clonic) seizure lasts longer than 5 minutes ▪ Repeated seizures with or without regaining consciousness ▪ Breathing difficulties continue after seizure ▪ Seizure occurs in water 	
SIGNATURES			
As parent/guardian of the above named student, I give permission for my student’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. Parents/Guardian are responsible for maintaining necessary supplies, medications and equipment.			
Parent Name (print):		Signature:	Date:
Emergency Contact Name:		Relationship:	Phone:
SCHOOL NURSE			
Seizure Emergency Action 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:

Addendum:

APPENDIX C – Medication Administration/Adverse Event Report

 UTAH DEPARTMENT OF HEALTH <small>The Best Living Through Evidence of Policy and Improved Clinical Care (EPPIC)</small>		SEIZURE RESCUE MEDICATION Administration/Adverse Event (AE) Report Form	
<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:			
Medication		Route	Dose
<input type="checkbox"/> Midazolam		<input type="checkbox"/> Intranasal	_____ ml
<input type="checkbox"/> Diazepam		<input type="checkbox"/> Rectal	_____ mg
<input type="checkbox"/> Lorazepam		<input type="checkbox"/> Oral	
<input type="checkbox"/> Other:		<input type="checkbox"/> Feeding Tube	
		<input type="checkbox"/> Other:	
Description of the medication administration:			
Was there a staff member available certified in CPR and rescue breathing when medication was administered?			
<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):			
Outcome (check all that apply)	Adverse Event (AE)?	Action Taken for AE	
<input type="checkbox"/> 911 called	<input type="checkbox"/> No	<input type="checkbox"/> None/Not applicable	
<input type="checkbox"/> Seizure resolved	<input type="checkbox"/> Yes	<input type="checkbox"/> CPR (with rescue breathing)	
<input type="checkbox"/> Ongoing/continuing treatment	If yes, please describe:	<input type="checkbox"/> Dose modification	
<input type="checkbox"/> Condition worsening (AE)		<input type="checkbox"/> Medical intervention	
<input type="checkbox"/> Respiratory depression (AE)		<input type="checkbox"/> Hospitalization	
<input type="checkbox"/> Death (AE)		<input type="checkbox"/> Medication discontinued	
<input type="checkbox"/> Unknown		<input type="checkbox"/> Medication changed	
<input type="checkbox"/> Other:		<input type="checkbox"/> Other:	
Seizure Rescue Medication was administered by:			
<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):		
Had the person who administered the medication been trained by an authorized trainer?			
<input type="checkbox"/> Yes <input type="checkbox"/> No (if No, please explain):			
What steps were taken to resolve any adverse event?			

Please email completed report to 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

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 HIGHLY recommended) 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	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"> ▪ When to call EMS (911) ▪ When to administer the medication 									
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"> • Demonstrates how to place student in the rescue position • Explains how to, and why it is important to stay with student, closely monitor breathing until parent / guardian, EMS or school nurse arrives 						
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"> • Reviewed the Individualized Healthcare Plan (IHP) and 504/IEP (if applicable) for the student(s) listed above. • Completed the required training program. • Demonstrated competency in the described skills for the student(s) listed above. • Understands the need to maintain skills and will be observed on an ongoing basis by the trainer. • Is willing to complete required refresher training to remain a trained school employee volunteer. • Has had the opportunity to ask questions and received satisfactory answers. 	<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: _____		
* Six Rights in Medication Administration	** CPR (with rescue breathing) / AED					
<ul style="list-style-type: none"> • Right Student • Right Medication • Right Dose • Right Time • Right Route • Right Documentation 	<ul style="list-style-type: none"> • If student stops breathing or is only gasping, CALL 911, begin CPR and use the AED. • Demonstrates CPR (with rescue breathing) and using the AED • Turn student onto back and recheck for breathing/responsiveness for no longer than 10 seconds (breathing, moving, gasping) • Performs 30 effective compressions • Opens airway using Head-tilt/Chin-lift, and gives 2 breaths using a mask that makes chest rise • Appropriately used the AED when it arrives 					

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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.						

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

Developed in accordance to UCA 52A-11-405.4 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



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:

- 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 ICA 43B(1)-43B(3) by the Utah Seizure Rescue Medication Task Force. A collaborative effort between:

Utah State Department of Health
Utah State Board of Education
ICDM 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.



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 the student. Do not put anything in the student's mouth.

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



APPENDIX H – Seizure First Aid Poster

Seizure First Aid

How to help someone having a seizure

1

STAY with the person until they are awake and alert after the seizure.

- ✓ Time the seizure
- ✓ Remain calm
- ✓ Check for **medical ID**



2

Keep the person **SAFE**.

- ✓ Move or guide away from **harm**



3

Turn the person onto their **SIDE** if they are not awake and aware.

- ✓ Keep **airway clear**
- ✓ **Loosen tight clothes** around neck
- ✓ Put **something small and soft** under the head



Call
911
if...

- ▶ Seizure lasts longer than 5 minutes
- ▶ Person does not return to their usual state
- ▶ Person is injured, pregnant, or sick
- ▶ Repeated seizures
- ▶ First time seizure
- ▶ Difficulty breathing
- ▶ Seizure occurs in water

Do
NOT

- ✗ Do **NOT** restrain.
- ✗ Do **NOT** put any objects in their mouth.
- ✓ **Rescue medicines can be given** if prescribed by a health care professional

Learn more: [epilepsy.com/firstaid](https://www.epilepsy.com/firstaid)



[epilepsy.com](https://www.epilepsy.com)

24/7 Helpline: 1-800-332-1000

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:

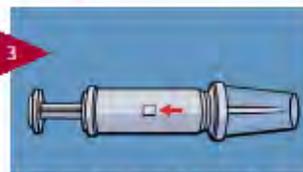
CHILD ADMINISTRATION INSTRUCTIONS



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.

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® 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

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 Questions

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

UDOH 8/25/16

Assessment for Rectal Medication Administration

Name: _____

Date: _____

Please circle the correct answer and take the completed test to the trainer for scoring.

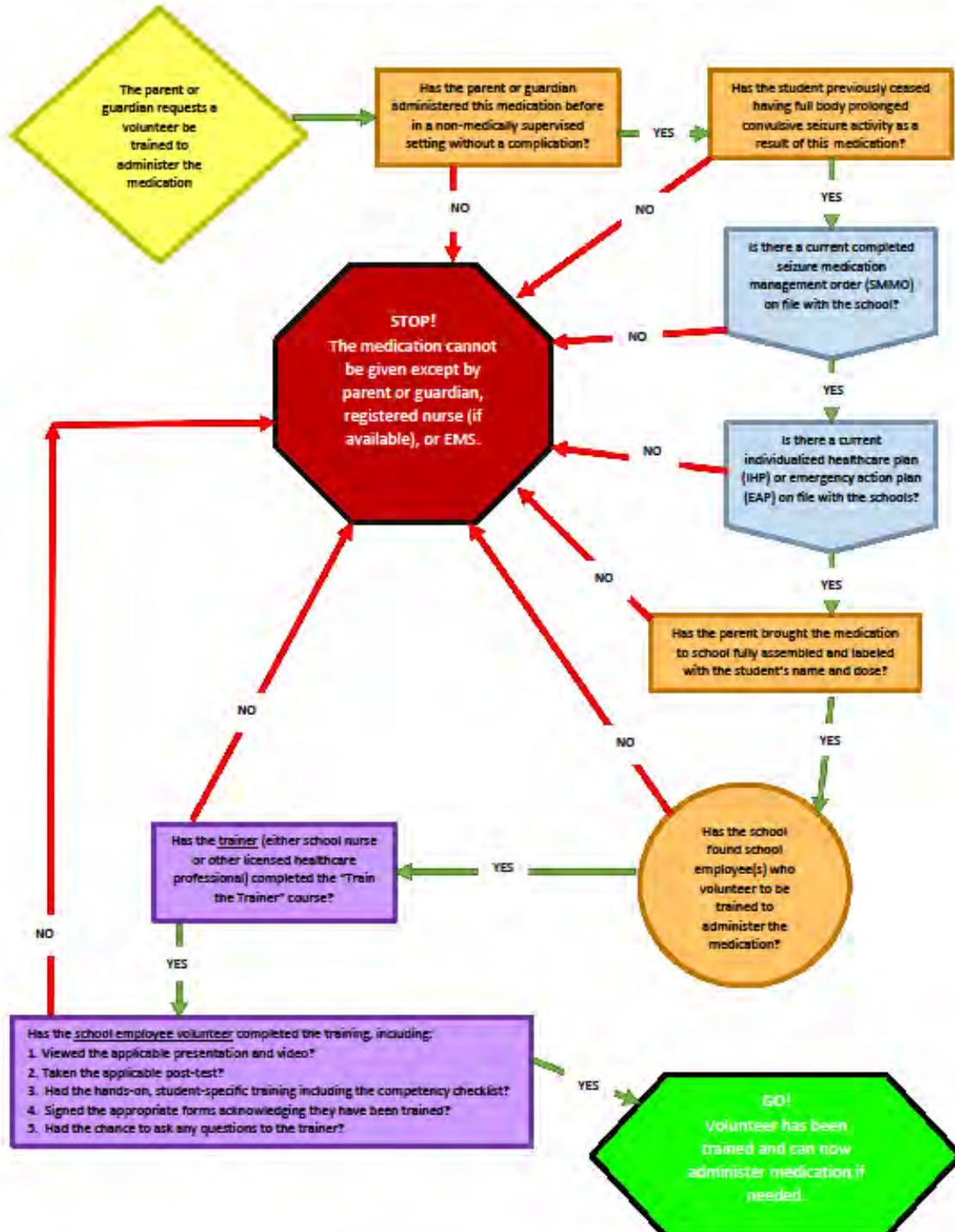
- The three "threes" refers to counting to three while performing all of the following activities except:
 - Delivery of the medication in the rectum.
 - Before removing syringe from rectum.
 - Insertion of the syringe in the water soluble lubricant.
 - Hold the buttock after withdrawal of the syringe.
- If alone with student, what immediate action is recommended after the administration of rectal diazepam?
 - Encourage the student to become physically active
 - Feed the student a snack with carbohydrate and protein foods
 - Call emergency medical services or 9-1-1
 - Monitoring the student's gait
- Before administration of rectal diazepam, school personnel should make sure the applicator has the ready collar exposed on the barrel of the syringe.
 - True
 - False
- After administering the medication, observe the student for the following:
 - Breathing
 - Walking
 - Eating
 - You do not need to monitor the student
- When documenting the event, include the following information:
 - Date, time of seizure and medication, observations
 - Student's last meal eaten
 - What the child was wearing
 - When the child was last seen at the doctor's office
- Who may designate personnel to be trained to give emergency seizure medication in the school?
 - Principal
 - Teacher
 - Parent
 - The individual must volunteer
- Seizure rescue medication can be given for the first time at school if necessary.
 - True
 - False
- A volunteer may give seizure rescue medication:
 - Anytime
 - After being trained by the student
 - After being trained by the parent
 - After completing the required training and demonstrating skills competency
- How do you determine the point at which seizure rescue medication should be given?
 - As outlined in IHP
 - When the seizure has gone on for awhile
 - When the student turns blue
- A trained volunteer in seizure rescue medication administration can use the medication for any student in the school who exhibits the appropriate seizure symptoms.
 - True
 - 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.

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**



Located at:





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

Nursing Services in Utah Public Schools

2019-2020

Annual Report

Utah Department of Health

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

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School Nursing Highlights

Students are best able to achieve their educational potential when they are healthy. Many students in Utah schools have been diagnosed with chronic health conditions that may need interventions while at school. Nursing services to students are individualized to meet the variety of needs of each student. During the 2002 General Legislative Session, the Utah State Legislature encouraged each school district to provide nursing services equivalent to one registered nurse for every 5,000 students, or in school districts with fewer than 5,000 students, the level of services recommended by the Utah Department of Health, as indicated on page 6.

The National Association of School Nurses (NASN) defines school nursing as follows:

“School nursing: a specialized practice of public health nursing, protects and promotes student health, facilitates normal 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 (NASN, 2016).”

SCHOOL NURSING SERVICES IN UTAH

The NASN Board of Directors passed a motion stating:

“To optimize student health, safety and learning, it is the position of the National Association of School Nursing that a professional registered school nurse is present in every school all day, every day (NASN, 2017).”

The NASN further states that school nurse workloads should be determined annually, using student and community specific health data (NASN, 2015).

Although data on nursing services in the public schools has been collected for the past several years, data was collected in different ways. It is unclear in the past if ratios included special education students and special education only-school nurses. It is believed the most accurate way to determine school nurse to student ratios for Utah would be to eliminate the special education students and special education only-nurses from the calculations.

What Can School Nurses Do for You?

Based on the Framework for the 21st Century School Nursing Practice, the following are things a school nurse can do for children in Utah:

- Care Coordination – This involves case management, chronic disease management, direct care, nursing delegation, and student-centered care. The school nurse develops individualized healthcare plans and emergency action plans for those students with chronic health conditions and ensures the staff in the schools are trained on how to care for those students.
- Leadership – School nurses are advocates for the students and the health of the communities they serve. They should be involved in policy development and implementation at the district and school level. They should participate on interdisciplinary teams, sharing their knowledge on how to address the individual needs of the students.
- Quality Improvement – School nurses submit data each year through the annual School Health Workload Census. This data shows the school nurse what services are provided to students in Utah. This process also allows them to see where improvements could be made. Evaluation is an important part of the nursing process and a standard of school nursing practice.
- Community and Public Health – School nurses are often the only healthcare professional in the school, so they must be knowledgeable on how to expand their focus to the entire school community, not just the students. They should be culturally competent and help their community understand the levels of disease prevention in order to reduce risks. These include vision, dental, and hearing screenings (in some districts) as well as follow-up activities in the event a problem is detected. School nurses also support healthy food service programs and promote healthy physical activity, safe sports policies, and other best practices.
- Standards of Practice – The school nurse provides the specialized knowledge, skills, decision-making, and standards for school nursing practice. These include clinical competence, critical thinking, evidence-based practice, and practicing in an ethical way. All of these are guided by the Utah Nurse Practice Act and accompanying rules (UCA 58-31b and R156-31b).

The center of this framework is the student, their families, and the community. By working within the Framework of the 21st Century School Nursing Practice, school nurses can ensure students are healthy, safe, and ready to learn.

Utah School Health Workload Census

Each year, student health information is collected by school nurses and compiled as aggregate data. Some data points collected include the number of registered school nurses, licensed practical nurses, and health aides in schools; total number of students; number of students with chronic health conditions; types and amount of medication administered in schools; and screenings and trainings done by school nurses. The following is a summary of some of the data collected in the 2019-2020 school year.

COVID-19

During the 2019-20 school year the world experienced a pandemic which resulted in the closure of all Utah public schools in March 2020. Data submitted may not reflect actual numbers.

CHRONIC HEALTH CONDITIONS IN UTAH

In the 2019-2020 school year, Utah school nurses submitted data on the following:

Asthma

- 17,896 students were documented to have asthma by a healthcare provider
- Of these, 6,988 students had an individualized healthcare plan or emergency action plan on file

Anaphylaxis (to anything)

- 10,379 students were documented to have anaphylaxis by a healthcare provider
- Of these, 5,863 students had an individualized healthcare plan or emergency action plan on file
- 31 doses of epinephrine auto-injector were administered at school

Type I Diabetes

- 2,257 students were documented to have type I diabetes by a healthcare provider
- Of these, 2,120 students had an individualized healthcare plan on file
- Three doses of glucagon were administered to students while at school

Type II Diabetes

- 91 students were documented to have type II diabetes by a healthcare provider
- Of these, 68 students had an individualized healthcare plan or emergency action plan on file

Seizures (all types)

- 3,450 students were documented to have any type of seizure diagnosis by a healthcare provider
- Of these, 2,347 students had an individualized healthcare plan or emergency action plan on file
- 819 school employee volunteers were trained to administer emergency seizure rescue medication
- 327 students had physician orders for emergency seizure rescue medication at school
- 74 doses of emergency rescue medication were administered at school

MEDICATIONS IN UTAH SCHOOLS

- 31 students received emergency epinephrine injections at school
- 3 students received glucagon at school
- Currently 28 school districts in Utah have a naloxone policy in place and have a supply of naloxone on hand in case of an opioid overdose. Two doses of naloxone were administered at school.

HEALTH SCREENINGS IN UTAH SCHOOLS

School nurses in Utah perform a variety of screenings, including vision screening as required by law (UCA 53A-11-203). They may also provide hearing, oral, and postural (scoliosis) screenings, as determined by district or school policy.

- 334,075 students received distance vision screening
- 25,041 students received referrals for distance vision screening
- 7,219 students received treatment for vision issues
- 2,352 students received financial help for vision exam/glasses
- 16,592 students received an oral health screening
- 10,197 students received an oral health varnish application
- 198 students received restorative dental services as part of a school-sponsored program

TRAINING BY SCHOOL NURSES IN UTAH SCHOOLS

Because there is not a nurse in every Utah school, nurses regularly train school staff to care for the students with chronic health conditions. This is done annually to ensure all staff (with a need to know) are ready to meet the needs of students with certain chronic conditions.

- 20,417 staff were trained by a school nurse on general asthma information
- 24,573 staff were trained by a school nurse on general anaphylaxis information
- 18,606 staff were trained by a school nurse on general diabetes information
- 20,274 staff were trained by a school nurse on general seizure information

In the 2019-2020 school year, students received the following trainings by a school nurse:

- 20,539 students attended a school nurse-led maturation class
- 3,655 students attended a school nurse-led asthma class
- 41,668 students attended a school nurse-led hygiene class
- 52,717 students attended a school nurse-led handwashing class
- 26,510 students attended a school nurse-led dental care class
- School nurses also taught classes/trainings on healthy eating, lifestyle, nursing careers, basic first aid, nutrition, tobacco cessation, HIV/AIDS, STD prevention, hearing loss prevention, bullying, abstinence, adoption, bloodborne pathogens, heart disease, head injury, bike safety, diabetes awareness, food allergy awareness, poison control, lice, sleep, human relationships, mental illness, body image, media influence, addiction, vaping/chewing tobacco, and alcohol and drug abuse

UTAH SCHOOL NURSE TO STUDENT RATIOS FOR SCHOOL YEAR 2019-2020

Each school district and charter school is a different community with different needs. Where some school local education agencies (LEAs) may need one nurse for each school, another may have one registered nurse covering several schools, while yet other school districts may have the assistance of health clerks (who must be supervised by a registered nurse). The National Association of School Nurses (NASN) recommends a professional registered school nurse be present in every school all day, every day, to optimize student health, safety, and learning.

2019-2020 School Year	Number of Utah Students Enrolled in School Districts	Number of Utah School Nurse (RN) FTEs in School Districts	Ratio of School Nurses to Students
<u>K-12 students enrolled in school districts</u> Does not include students with disabilities	519,570	166*	1:3,130
<u>K-12 students enrolled in school districts</u> All K-12 students, including those with disabilities	589,276	188**	1:3,134
<p>*School nurses providing services only to students enrolled in general education. Does not include nurses who only provide services to students receiving special education services.</p> <p>**Including school nurses providing services to students in general education and those students receiving special education services. Does not include nurses who only provide services to students in pre-kindergarten.</p>			

UTAH DEPARTMENT OF HEALTH RECOMMENDATIONS FOR SCHOOL NURSE STAFFING

The Utah Department of Health 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 these criteria, the Utah Department of Health 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 and evaluation of delegated tasks to unlicensed assistive personnel.

2019-2020 School Nurse (RN) to Student Ratios by District

District	Student Enrollment (2019 Oct)	Total School Nurse (RN) FTE	Nurse to Student Ratio
Alpine	81,532	25.25	2,718
Beaver	1,524	0.27	5,644
Box Elder	11,914	4	2,979
Cache	18,802	4.5	4,178
Canyons	34,178	8	3,418
Carbon	3,472	0.75	4,629
Daggett	189	0.09*	2,100*
Davis	72,897	16	3,471
Duchesne	5,164	3	1,721
Emery	2,141	0.4	5,353
Garfield	899	0.25	3,596
Grand	1,498	1	1,498
Granite	63,989	11	4,266
Iron	9,544	5	1,909
Jordan	56,339	13	2,617
Juab	2,655	1.25	2,124
Kane	1,275	0.05	25,500
Logan	5,420	No RN	0*
Millard	2,973	1	2,973
Morgan	3,194	1	3,194
Murray	6,425	2.37	2,711
Nebo	33,379	8.5	3,338
North Sanpete	2,507	1.48	1,694
North Summit	1,044	0.87	1,166
Ogden	11,460	3	3,820
Park City	4,757	6.35	749
Piute	279	0.15	1,860
Provo	16,603	4.25	3,321
Rich	498	0.075*	6,760*
Salt Lake City	22,017	6	3,670
San Juan	2,891	2	1,446
Sevier	4,548	1.3	3,498
South Sanpete	3,230	2.2	1,468
South Summit	1,701	2	851
Tintic	214	No RN	0*
Tooele	16,608	4.2	4,192
Uintah	6,989	3	2,330
Wasatch	7,146	1.75	4,083
Washington	33,884	9.3	3,405
Wayne	436	0.15	2,907
Weber	32,588	11.7	3,595

*Last year's data, no data submitted this school year

Students with Chronic Health Conditions

Utah Nurse Practice Act (58-31b-101) and Rules (R156-31b-701a) allows school nurses to train and delegate nursing responsibilities to non-health professionals or unlicensed assistive personnel to meet the needs of medically complex students under certain circumstances. In Utah, it is common for one nurse to train and oversee many unlicensed assistive personnel who then perform the medical related tasks delegated by the school nurse.

Specific numbers of students with health concerns, medically complex students, medically fragile students, and nursing-dependent students were collected for the first time during the 2019-2020 school year.

Students were classified into five levels:

- **Level 1:** No/minimal occasional healthcare concerns: The student's physical and/or social-emotional condition is stable and they see the school nurse only once a year for screening and occasionally as needed.

- **Level 2:** Health concerns: The student's physical and/or social emotional condition is currently uncomplicated and predictable. Occasional monitoring by the school nurse varies from biweekly to annually. These students may require an individualized healthcare plan or emergency action plan. Examples of chronic health conditions these students may have include, but are not limited to:
 - Attention Deficit Disorder (ADD) or Attention Deficit with Hyperactivity Disorder (ADHD)
 - Mild asthma
 - Mild allergies
 - A condition which requires administration of medication

- **Level 3 –** Medically complex: The medically complex student has a complex and/or unstable physical and/or social-emotional condition that requires daily treatments and close monitoring by the school nurse. These students should have an individualized healthcare plan or emergency action plan. Examples of chronic health conditions these students may include, but are not limited to:
 - Anaphylaxis potential (requires epinephrine)
 - Cancer
 - Diabetes without complications
 - Moderate to severe asthma (requires use of an inhaler)

- Mild to moderate seizure disorder (may or may not need to have emergency seizure rescue medication)
 - Spina Bifida who self-catheterize
 - Students requiring fewer than 15 minutes of daily care (such as catheterizing, supervising diabetes care, tube feeding, etc.)
- **Level 4 – Medically fragile:** These students live with the daily possibility of a life-threatening emergency. These students must have an individualized healthcare plan. Examples of chronic health conditions these students may have include, but are not limited to:
 - Unstable or newly diagnosed diabetes (needs supervision)
 - Spina Bifida that requires assistance with catheterization
 - Frequent, severe seizure disorder requiring emergency seizure rescue medication
 - Students requiring more than 15 minutes of daily care (such as catheterizing, supervising diabetes, tube feeding, etc.)
 - **Level 5 – Nursing dependent:** Nursing dependent students require 24 hours/day, frequently one-to-one, skilled nursing care for their survival. Many are dependent on technological devices for breathing. These students must have an IHP. Examples of chronic health conditions these students may have include, but are not limited to:
 - Students with a trach requiring suctioning

During the 2019-2020 school year, there were 59,326 students with health concerns (level 2), 16,703 students with a medically complex health condition (level 3), 2,550 students who were medically fragile (level 4), and 163 students considered nursing dependent (level 5) in Utah public schools.

School Nurse Funding

Funding sources vary across the country for school nurses. Most school nurses in Utah are hired by the school or school district, with about one-third of school nurses being funded through a local health department. In one school district, the school nurse is hired through the local medical center and their home health division.

There are two grants which LEAs can apply for through the Utah State Board of Education to provide matching funds for the LEA to hire school nursing services.

WHAT WOULD IT TAKE TO FULLY FUND NURSES?

- There were 666,858 students in Utah public schools in the 2019-2020 school year
- 1,035 total public schools in Utah (charter and school district)
- 247 total school nurses in Utah (including part-time, charter schools, typical, and special education nurses)
- 170 school nurse full-time employee (FTE) equivalent (not including special education or pre-kindergarten nurses)
- For each school in Utah to have a full-time nurse, an additional 865 school nurses would need to be hired
- \$100,000 estimated additional cost for one FTE school nurse (**including benefits**, Bachelor's degree prepared registered nurse)
- \$86,500,000 estimated additional cost to have one full-time school nurse for every Utah school¹

SUMMARY

There are many factors to consider when determining the appropriate school nurse staffing level in each school or school district. While total student enrollment has been used primarily in the past, student needs should also be addressed, such as specific healthcare needs of the population and social determinants of health (poverty, language barriers, etc.). As a result, there is no “one size fits all” number that will work in all cases.

¹1035 schools minus 170 current FTE = 865 x \$100,000

References

National Association of School Nurses, (2015). *School nurse workload: Staffing for safe care* (Position Statement). Silver Spring, MD: Author.

Oregon Department of Education, (2015). 2015 Nursing Services in Oregon Public Schools.

Utah Department of Health, (2017). Recommendations for school nurse workload (staffing).

This brochure highlights the data submitted to the Utah Department of Health during the 2019-2020 school year by 37 of 41 school districts (90%), and 14 of 132 charter schools.

This information represents 99% of students in school districts, 23% of charter school students, and 90% of all Utah public school students.

Facts:

School nurses view the student as a complete person with physiologic and emotional states that can alter the child's educational readiness. School nurses are trained to calmly handle both medical and emotional crises in students. This frees the teacher to focus on teaching.

School nurses have specialized training and assessment skills necessary to provide competent caring hands and a confident calming voice which brings immediate comfort to a frightened child who is ill or injured.

School nurses allow districts to meet legal requirements by providing medical care to students at school by training, delegating, and utilizing proper documentation procedures. School nurses prevent legal liability for schools by promoting correct care delivery.

School Nurse Staffing in Utah 2019-2020

- 249 (203 FTE) licensed registered nurses
- 3 (2.2 FTE) licensed practical nurses
- 157 (68.20 FTE) health assistants
- 666,858 students on 1035 public school campuses
- Only 27 of 1035 (2.6%) of Utah public schools meet the national recommendations of one registered nurse per school

"School nurses enhance each child's educational potential by promoting physical and emotional wellness, increasing school attendance, and decreasing non-academic barriers to learning."
Dr. William Cosgrove

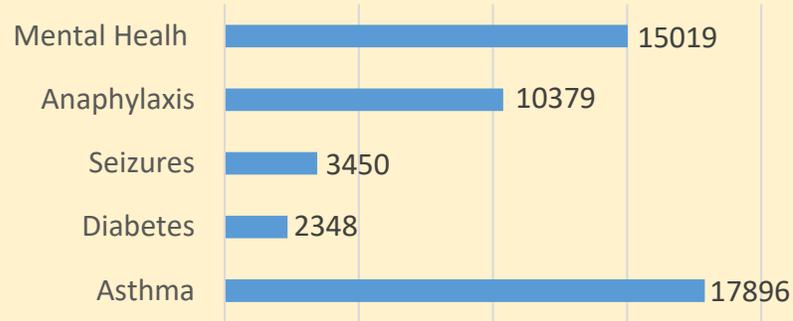


Nursing Services in Utah Public Schools Summary Report 2019-2020

School Nurses in Utah: Keeping Students Healthy, Safe, and Ready to Learn



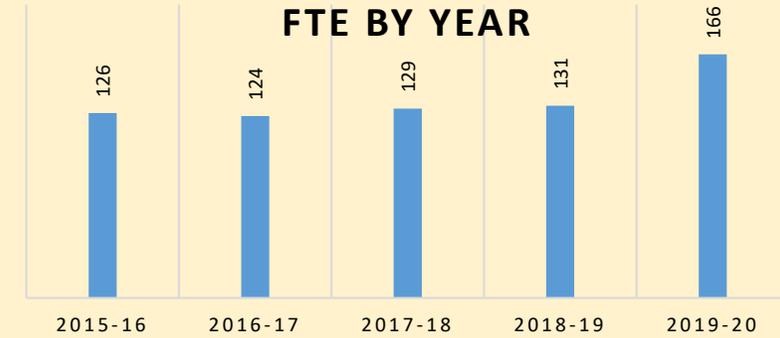
Health Conditions of Students, 2019-2020



Emergency Rescue Medication Administered at School, 2019-2020

- Naloxone was administered 2 times
- Epinephrine was administered 31 times
- Seizure rescue medications were administered 74 times
- Glucagon was administered 3 times

TOTAL UTAH SCHOOL NURSE FTE BY YEAR

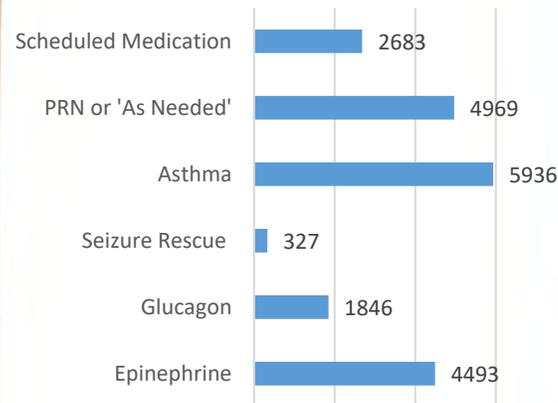


(*Does not include SpEd/PK nurses)

Students with a Medical Diagnosis, 2019-2020

- 17,896 students had an asthma diagnosis
- 10,379 students had a life-threatening allergy diagnosis
- 2,348 students had a diabetes diagnosis (2,257 with type 1 diabetes, 91 with type 2 diabetes)
- 3,450 students had a seizure disorder diagnosis
- 15,019 students had a mental health diagnosis

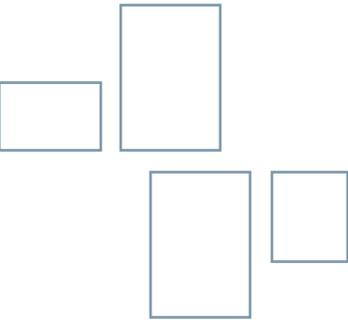
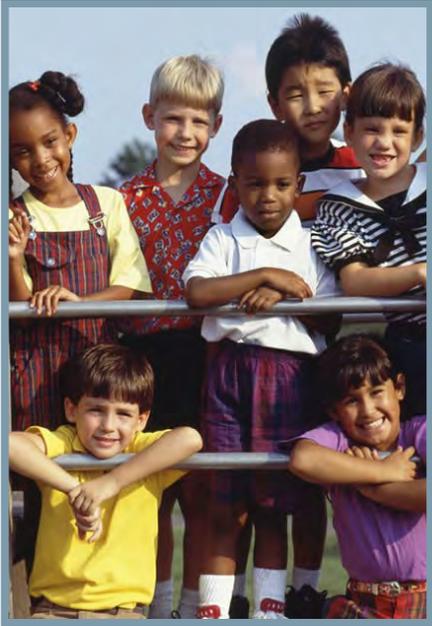
Medication Orders 2019-2020



Student Screenings, 2019-2020

- 334,075 students received a vision screening at school
- 25,041 students were referred to an eye care professional
- 16,592 students received an oral health screening
- 198 students received restorative services through a school sponsored oral health program

Utah Immunization Guidebook



2020 | 2021

For Schools, Early Childhood Programs
and Healthcare Providers

UTAH IMMUNIZATION GUIDEBOOK

INTRODUCTION

The Utah Immunization Program is pleased to provide you with the *Utah Immunization Guidebook for Schools, Early Childhood Programs and Healthcare Providers*. The Guidebook is designed to clarify the Utah Statutes and Rules for Immunization, which have been included in this guidebook in Appendix A. Each required vaccine and the schedule to be followed, including minimum intervals between each dose, are outlined in this Guidebook. The appendices include frequently asked questions and sample forms that can be used to assist in implementing the requirements.

Since the implementation of the Utah Immunization Rule for Students, consistent requirements have protected children attending Utah schools and early childhood programs from many vaccine-preventable diseases. In the past, these diseases caused significant illness and death. The success of the Immunization Rule for Students is a direct result of the tremendous collaboration among schools and early childhood program personnel, school nurses, healthcare professionals, local health departments, statewide immunization coalitions, pharmacies, and parents.

The Utah Immunization Program recognizes that immunization schedules are very complex and often require time and effort to ensure Utah's children are adequately protected from vaccine preventable diseases. The Utah Statewide Immunization Information System (USIIS) is a free, confidential, web-based information system that contains immunization histories for Utah residents of all ages. USIIS consolidates immunizations from multiple providers into one centralized record. Schools and early childhood programs can enroll in USIIS and benefit from its many features such as determining whether the vaccines a child has received are current, due, or overdue. For more information, visit the USIIS website at <https://immunize.utah.gov/usiis/> or call the Utah Immunization Program at 801-538-9450.

We appreciate your continued support of the Immunization Rule for Students and your dedication to Utah's children. If you have questions concerning immunization requirements or this Guidebook, please call the Utah Immunization Program at 801-538-9450 or email nzandkar@utah.gov.



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SECTION 1 INDIVIDUAL VACCINE REQUIREMENTS



Diphtheria, tetanus, acellular pertussis (DTaP)

A student must be immunized with Diphtheria, Tetanus, and Pertussis (DTaP) vaccine for entering a Utah kindergarten or early childhood program*.

Five doses of Diphtheria, tetanus, and pertussis (DTaP) vaccine are required for kindergarten entry. The first, second, and third doses must be administered a minimum of four weeks apart. The fourth dose must follow the third dose by a minimum of six months.

The fourth dose may be given as early as age 12 months if at least six months have elapsed since the third dose. However, for auditing purposes only, the fourth dose need not be repeated if given at least four months after the third dose. The fourth and fifth dose must be administered a minimum of six months apart. The fifth dose (booster dose) is required before the student enters kindergarten.

If the fourth dose is administered on or after a student's fourth birthday, the fifth dose is not required. In such a case the fourth DTaP dose should be administered at least 6 months after the third DTaP dose and should not be administered to a child aged < 12 months.

A student age 7-18 years not fully vaccinated** with DTaP should receive 1 dose of Tdap as part of the catch-up series (preferably the first dose); if additional doses are needed, use Td or Tdap.

*Children enrolled in early childhood programs must be immunized for DTaP according to their appropriate age. The number of doses required varies by a child's age and how long ago they were vaccinated.

** Fully vaccinated = 5 valid doses of DTaP OR 4 valid doses of DTaP if dose 4 was administered at age 4 years or older.

For DTaP/Td/Tdap/DT catch-up guidance for children 4 months through 18 years of age see the next few pages.

Diphtheria, Tetanus, Pertussis Recommended Immunization Schedule

Birth	2 months	4 months	6 months	12 months	15 months	18 months	2 years	4-6 years	11-12 years
	DTaP #1	DTaP #2	DTaP #3		DTaP #4			DTaP #5	Tdap

Shaded boxes indicate the vaccine can be given during shown age range.

SECTION 1 INDIVIDUAL VACCINE REQUIREMENTS

Catch-Up Guidance for Children 4 Months through 6 Years of Age Diphtheria-, Tetanus-, and Pertussis Containing Vaccines: DTaP/DT¹

Table #1- The table below provides guidance for children whose vaccinations have been delayed. Start with the child's age and information on previous doses (previous doses must be documented and must meet minimum age requirements and minimum intervals between doses).

IF current age is	AND # of previous doses of DTaP or DT is	AND	THEN	Next dose due
4 months through 11 months	Unknown or 0	→	Give Dose 1 (DTaP) today	Give Dose 2 (DTaP) at least 4 weeks after Dose 1
	1	It has been at least 4 weeks since Dose 1	Give Dose 2 (DTaP) today	Give Dose 3 (DTaP) at least 4 weeks after Dose 2
		It has not been at least 4 weeks since Dose 1	No dose today	Give Dose 2 (DTaP) at least 4 weeks after Dose 1
	2	It has been at least 4 weeks since Dose 2	Give Dose 3 (DTaP) today	Give Dose 4 (DTaP) at least 6 calendar months after Dose 3 and at 15 months of age or older ²
		It has not been at least 4 weeks since Dose 2	No dose today	Give Dose 3 (DTaP) at least 4 weeks after Dose 2
	1 through 3 years	Unknown or 0	→	Give Dose 1 (DTaP) today
1		It has been at least 4 weeks since Dose 1	Give Dose 2 (DTaP) today	Give Dose 3 (DTaP) at least 4 weeks after Dose 2
		It has not been 4 weeks since Dose 1	No dose today	Give Dose 2 (DTaP) at least 4 weeks after Dose 1
2		It has been at least 4 weeks since Dose 2	Give Dose 3 (DTaP) today	Give Dose 4 (DTaP) at least 6 calendar months after Dose 3
		It has not been 4 weeks since Dose 2	No dose today	Give Dose 3 (DTaP) at least 4 weeks after Dose 2
3		It has been at least 6 calendar months since Dose 3	If 12 through 14 months of age, no dose today ²	Give Dose 4 (DTaP) at 15 through 18 months of age
			If 15 months of age or older, give Dose 4 (DTaP) today	Give Dose 5 (DTaP) at least 6 months after Dose 4 and at 4 through 6 years of age
		It has not been 6 calendar months since Dose 3	No dose today	Give Dose 4 (DTaP) at least 6 months after Dose 3

¹ Vaccine information: DTaP—Administer to children 6 weeks through 6 years of age without a contraindication or precaution to diphtheria, tetanus, or pertussis vaccine. DTaP products include Daptacel, Kinrix, Infanrix, Pediarix, Pentacel, and Quadracel. Use the correct product based on the approved age indications. DT—Administer to children 6 weeks through 6 years of age with a contraindication to pertussis vaccine.

² The fourth dose may be administered as early as age 12 months, provided at least 6 months have elapsed since the third dose.

SECTION 1 INDIVIDUAL VACCINE REQUIREMENTS

Catch-Up Guidance for Children 4 Months through 6 Years of Age Diphtheria-, Tetanus-, and Pertussis Containing Vaccines: DTaP/DT¹

IF current age is	AND # of previous doses of DTaP or DT is ¹	AND	AND	THEN	Next dose due
4 through 6 years	Unknown or 0	→	→	Give Dose 1 (DTaP) today	Give Dose 2 (DTaP) at least 4 weeks after Dose 1
	1	It has been at least 4 weeks since Dose 1	→	Give Dose 2 (DTaP) today	Give Dose 3 (DTaP) at least 4 weeks after Dose 2
		It has not been 4 weeks since Dose 1	→	No dose today	Give Dose 2 (DTaP) at least 4 weeks after Dose 1
	2	It has been at least 4 weeks since Dose 2	→	Give Dose 3 (DTaP) today	Give Dose 4 (DTaP) at least 6 calendar months after Dose 3
		It has not been at least 4 weeks since Dose 2	→	No dose today	Give Dose 3 (DTaP) at least 4 weeks after Dose 2
	3	It has been at least 6 calendar months since Dose 3	→	Give Dose 4 (DTaP) today	Give Tdap at 11 to 12 years of age
		It has not been at least 6 calendar months since Dose 3	→	No dose today	Give Dose 4 (DTaP) at least 6 calendar months after Dose 3
	4	All doses were given prior to the 4 th birthday	It has not been at least 6 months since Dose 4	No dose today	Give Dose 5 (DTaP) at least 6 calendar months after Dose 4
			It has been at least 6 months since Dose 4	Give Dose 5 (DTaP) today	Give Tdap at 11 to 12 years of age
		At least one dose was given at/after the 4 th birthday	→	No dose today	

¹Vaccine information: DTaP—Administer to children 6 weeks through 6 years of age without a contraindication or precaution to diphtheria, tetanus, or pertussis vaccine. DTaP products include Daptacel, Kinrix, Infanrix, Pediarix, Pentacel, and Quadracel. Use the correct product based on the approved age indications. DT—Administer to children 6 weeks through 6 years of age with a contraindication to pertussis vaccine.

Reference: Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger—United States, 2020. www.cdc.gov/vaccines/schedules/downloads/child/0-18yrs-child-combined-schedule.pdf

SECTION 1 INDIVIDUAL VACCINE REQUIREMENTS

Catch-Up Guidance for Children 7 through 9 Years of Age

Tetanus-, Diphtheria-, and Pertussis-Containing Vaccine: Tdap/Td¹

Table #2- The table below provides guidance for children whose vaccinations have been delayed. Start with the child's age and information on previous doses (previous doses must be documented and must meet minimum age requirements and minimum intervals between doses).

IF current age is	AND # of previous doses of DTaP, DT, Td, or Tdap is	AND	AND	AND	THEN	Next dose due
7 through 9 years ¹	Unknown or 0	→	→	→	Give Dose 1 (Tdap) today	Give Dose 2 (Td or Tdap) at least 4 weeks after Dose 1
	1	Dose 1 was given before 12 months of age	→	→	Give Dose 2 (Tdap) today	Give Dose 3 (Td or Tdap) at least 4 weeks after Dose 2
			Dose 1 was given at 12 months of age or older	It has been at least 4 weeks since Dose 1	Dose 1 was Tdap	Give Dose 2 (Td or Tdap) today
		Dose 1 was not Tdap		Give Dose 2 (Td or Tdap) today		
		It has not been 4 weeks since Dose 1		Dose 1 was Tdap	No dose today	Give Dose 2 (Td or Tdap) at least 4 weeks after Dose 1
				Dose 1 was not Tdap	No dose today	Give Dose 2 (Tdap) at least 4 weeks after Dose 1
		2	Dose 1 was given before 12 months of age	It has been at least 4 weeks since Dose 2	Dose 2 was Tdap ¹	Give Dose 3 (Td or Tdap) today
	No dose was Tdap				Give Dose 3 (Tdap) today	
	It has not been 4 weeks since Dose 2			Dose 2 was Tdap	No dose today	Give Dose 3 (Td or Tdap) at least 4 weeks after Dose 2
				No dose was Tdap	No dose today	Give Dose 3 (Tdap) at least 4 weeks after Dose 2
	Dose 1 was given at 12 months of age or older		It has been at least 6 calendar months since Dose 2	Any dose was Tdap ¹	Give Dose 3 (Td or Tdap) today	Give Tdap at 11–12 years of age ^{1,2}
				No dose was Tdap	Give Dose 3 (Tdap) today	
			It has not been 6 calendar months since Dose 2	Any dose was Tdap ¹	No dose today	Give Dose 3 (Td or Tdap) at least 6 calendar months after Dose 2 ¹
				No dose was Tdap	No dose today	Give Dose 3 (Tdap) at least 6 calendar months after Dose 2

¹For persons 7–9 years of age who receive a dose of Tdap, the routine adolescent Tdap dose should be administered at age 11–12.

²Tdap may be administered regardless of the interval since the last tetanus-and diphtheria-toxoid-containing vaccine.

SECTION 1 INDIVIDUAL VACCINE REQUIREMENTS

Catch-Up Guidance for Children 7 through 9 Years of Age

Tetanus-, Diphtheria-, and Pertussis-Containing Vaccines: Tdap/Td¹

The table below provides guidance for children whose vaccinations have been delayed. Start with the child's age and information on previous doses (previous doses must be documented and must meet minimum age requirements and minimum intervals between doses).

IF current age is	AND # of previous doses of DTaP, DT, Td, or Tdap is	AND	AND	AND	THEN	Next dose due
7 through 9 years ¹	3	Dose 1 was given before 12 months of age	It has been at least 6 calendar months since Dose 3	Any dose was Tdap ¹	Give Dose 4 (Td or Tdap) today	Give Tdap at 11–12 years of age ^{1,2}
				No dose was Tdap	Give Dose 4 (Tdap) today	
		It has not been 6 calendar months since Dose 3	Any dose was Tdap ¹	No dose today	Give Dose 4 (Td or Tdap) at least 6 calendar months after Dose 3 ¹	
			No dose was Tdap	No dose today		Give Dose 4 (Tdap) at least 6 calendar months after Dose 3 ¹
	Dose 1 was given at 12 months of age or older	No dose was Tdap	→	Give Dose 4 (Tdap ²) today	Give Tdap at 11–12 years of age ^{1,2}	
		Any dose was Tdap	→	No dose today		
	4	→	Dose of DTaP or Tdap given after 4 th birthday	→	No dose today	Give Tdap at 11–12 years of age ^{1,2}
			No DTaP or Tdap given after 4 th birthday	→	Give a dose of Tdap today	Give Tdap at 11–12 years of age ^{1,2}

¹ For persons 7–9 years of age who receive a dose of Tdap, the routine adolescent Tdap dose should be administered at age 11–12.

² Tdap may be administered regardless of the interval since the last tetanus- and diphtheria-toxoid-containing vaccine.

Revised 02/2020

SECTION 1 INDIVIDUAL VACCINE REQUIREMENTS

Catch-Up Guidance for Children 10 through 18 Years of Age

Tetanus-, Diphtheria-, and Pertussis-Containing Vaccines: Tdap/Td

Table #3- The table below provides guidance for children whose vaccinations have been delayed. Start with the child's age and information on previous doses (previous doses must be documented and must meet minimum age requirements and minimum intervals between doses).

IF current age is	AND # of previous doses of DTaP, DT, Td, or Tdap is	AND	AND	AND	THEN	Next dose due
10 through 18 years of age	Unknown or 0	→	→	→	Give Dose 1 (Tdap) today	Give Dose 2 (Td or Tdap) at least 4 weeks after Dose 1
	1	Dose 1 was given before 12 months of age	→	→	Give Dose 2 (Tdap) today	Give Dose 3 (Td or Tdap) at least 4 weeks after Dose 2
			Dose 1 was given at 12 months of age or older	It has been at least 4 weeks since Dose 1	Dose 1 was Tdap	Give Dose 2 (Td or Tdap) today
		Dose 1 was not Tdap		Give Dose 2 (Td or Tdap) today		
		It has not been 4 weeks since Dose 1		Dose 1 was Tdap	No dose today	Give Dose 2 (Td or Tdap) at least 4 weeks after Dose 1
				Dose 1 was not Tdap	No dose today	Give Dose 2 (Tdap) at least 4 weeks after Dose 1
		2	Dose 1 was given before 12 months of age	It has been at least 4 weeks since Dose 2	Any dose was Tdap ¹	Give Dose 3 (Td or Tdap) today ²
	No dose was Tdap ³				Give Dose 3 (Tdap) today	
	It has not been 4 weeks since Dose 2			Any dose was Tdap ¹	No dose today	Give Dose 3 (Td or Tdap) at least 4 weeks after Dose 2 ²
				No dose was Tdap ³	No dose today	Give Dose 3 (Tdap) at least 4 weeks after Dose 2
	Dose 1 was given at 12 months of age or older		It has been at least 6 calendar months since Dose 2	Any dose was Tdap ¹	Give Dose 3 (Td or Tdap) today ²	Give Td or Tdap 10 years after Dose 3
				No dose was Tdap ²	Give Dose 3 (Tdap) today	
			It has not been 6 calendar months since Dose 2	Any dose was Tdap ¹	No dose today	Give Dose 3 (Td or Tdap) at least 6 calendar months after Dose 2 ²
				No dose was Tdap ³	No dose today	Give Dose 3 (Tdap) at least 6 calendar months after Dose 2

¹Given at 10 years of age or older.

²If the previous Tdap dose(s) administered before the 10th birthday, then a dose of Tdap is recommended now.

³Or Tdap administered at 9 years of age or younger.

Revised 02/2020

SECTION 1 INDIVIDUAL VACCINE REQUIREMENTS

Catch-Up Guidance for Children 10 through 18 Years of Age

Tetanus-, Diphtheria-, and Pertussis-Containing Vaccines: Tdap/Td

The table below provides guidance for children whose vaccinations have been delayed. Start with the child's age and information on previous doses (previous doses must be documented and must meet minimum age requirements and minimum intervals between doses).

IF current age is	AND # of previous doses of DTaP, DT, Td, or Tdap is	AND	AND	AND	THEN	Next dose due
10 through 18 years of age	3	Dose 1 was given before 12 months of age	It has been at least 6 calendar months since Dose 3	Any dose was Tdap ¹	Give Dose 4 (Td or Tdap) today ²	Give Td or Tdap 10 years after Dose 4
				No dose was Tdap ³	Give Dose 4 (Tdap) today	
		Dose 1 was given at 12 months of age or older	It has not been 6 calendar months since Dose 3	Any dose was Tdap ¹	No dose today	Give Dose 4 (Td or Tdap) at least 6 calendar months after Dose 3 ²
				No dose was Tdap ³	No dose today	Give Dose 4 (Tdap) at least 6 calendar months after Dose 3
		Dose 1 was given at 12 months of age or older	No dose was Tdap ¹	→	Give Dose 4 (Tdap) today	Give Td or Tdap 10 years after Dose 4
			Any dose was Tdap ²	→	No dose today	Give Td or Tdap 10 years after Dose 3
	4	→	No Tdap was given after 7 th birthday	→	Give a dose of Tdap today ⁴	Give Td or Tdap 10 years after Tdap dose
			Any dose of Tdap was given at age 7 years or older ¹	No Tdap was given after 10 th birthday		
			Tdap was given after 10 th birthday	No dose today	Give Td or Tdap 10 years after Tdap dose 4	

¹Given at 10 years of age or older.

²If the previous Tdap dose(s) was administered before 10th birthday, then a dose of Tdap is recommended now.

³Or Tdap administered at 9 years of age or younger.

⁴The preferred age at administration for this dose is 11-12 years. However, if Tdap is administered at age 10 years, the Tdap dose may count as the adolescent Tdap dose.

Revised 02/2020

INDIVIDUAL VACCINE REQUIREMENTS



Polio

A student must be immunized with Polio vaccine for entering a Utah school or early childhood program*.

A student must receive four doses of inactivated polio vaccine (IPV). The first three doses must be administered a minimum of four weeks apart. The final dose of IPV must be administered according to the following:

- (a) on or after the student's fourth birthday **regardless of the number of previous doses**; and
- (b) at least of six months after receiving the previous dose.

If the third dose is administered on or after a student's fourth birthday, the fourth dose is not required.

The above schedule does not apply to polio vaccines given prior to August 7, 2009.

The final dose of polio vaccine given PRIOR to August 7, 2009 will fall under the previous recommendation with a minimum interval of four weeks between doses three and four (the final dose does not require a minimum age of four years). Reference: Immunization Action Coalition Ask the Experts http://www.immunize.org/askexperts/experts_pol.asp

NOTES:

- When evaluating doses of polio vaccine administered to children outside the U.S., it is important to know that if oral polio vaccine (OPV) was used. Only trivalent OPV (TOPV) counts toward the U.S. vaccination requirements. Trivalent OPV was used for routine poliovirus vaccination in all OPV using countries until April 1, 2016. Doses of oral polio vaccine administered outside U.S. after April 2016 are not trivalent OPV and do not count toward the U.S. vaccination requirements. If such vaccinations can not be validated children aged <18 years should be revaccinated with IPV according to the U.S. IPV schedule. Polio vaccine given outside the United States is valid if written documentation indicates that all doses were given after 6 weeks of age and the vaccine received was IPV or trivalent OPV.
- If a student received both types of vaccine, four doses of any combination of IPV or trivalent OPV by 4-6 years of age is considered a complete poliovirus vaccination series.
- For all-IPV or all-trivalent OPV series, a fourth dose is not necessary if the third dose was given on or after the fourth birthday AND at least six months after the previous dose.
- A polio vaccination schedule begun with trivalent OPV should be completed with IPV. If only trivalent OPV was administered, and all doses were given prior to four years of age, one dose of IPV should be given at four years or older, at least six months after the last trivalent OPV dose.
- If three doses of IPV are administered, the third dose must be administered at least six months following the second dose.
- If four or more doses are administered before age four years, an additional dose should be administered at age 4-6 years and at least six months after the previous dose. This rule does not apply to a complete polio vaccination given prior to August 7, 2009. Reference Immunization Action Coalition Immunization Experts http://www.immunize.org/askexperts/experts_pol.asp.

*Children enrolled in early childhood programs must be immunized for Polio vaccine according to their appropriate age. The number of doses required varies by a child's age and how long ago they were vaccinated.

Polio Recommended Immunization Schedule									
Birth	2 months	4 months	6 months	12 months	15 months	18 months	19-23 months	4-6 years	11-12 years
	IPV #1	IPV #2	IPV #3					IPV #4	

Shaded boxes indicate the vaccine can be given during shown age range.

INDIVIDUAL VACCINE REQUIREMENTS

Catch-Up Guidance for Children 4 Months through 17 Years of Age

Inactivated Polio Vaccine (IPV)

The table below provides guidance for children whose vaccinations have been delayed. Start with the child's age and information on previous doses (previous doses must be documented and must meet minimum age requirements and minimum intervals between doses). Use this table in conjunction with table 2 of the Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger, found at www.cdc.gov/vaccines/schedules/hcp/child-adolescent.html.

IF current age is	AND # of previous doses ¹ is	AND		THEN	Next dose due ²
4 through 18 months	Unknown or 0	→		Give Dose 1 today	Give Dose 2 at least 4 weeks after Dose 1
	1	It has been at least 4 weeks since Dose 1		Give Dose 2 today	Give Dose 3 at least 4 weeks after Dose 2 and at 6 months of age or older
		It has not been at least 4 weeks since Dose 1		No dose today	Give Dose 2 at least 4 weeks after Dose 1
	2	It has been at least 4 weeks since Dose 2	Child is 6 months of age or older	Give Dose 3 today	Give Dose 4 (Final Dose) at 4 through 6 years of age
			Child is younger than 6 months of age	No dose today	Give Dose 3 at 6 months of age
		It has not been at least 4 weeks since Dose 2	→	No dose today	Give Dose 3 at least 4 weeks after Dose 2 and at 6 months of age or older
19 months through 3 years	Unknown or 0	→		Give Dose 1 today	Give Dose 2 at least 4 weeks after Dose 1
	1	It has been at least 4 weeks since Dose 1		Give Dose 2 today	Give Dose 3 at least 4 weeks after Dose 2
		It has not been at least 4 weeks since Dose 1		No dose today	Give Dose 2 at least 4 weeks after Dose 1
	2	It has been at least 4 weeks since Dose 2		Give Dose 3 today	Give Dose 4 (Final Dose) at least 6 months after Dose 3 and at 4 through 6 years of age
		It has not been 4 weeks since Dose 2		No dose today	Give Dose 3 at least 4 weeks after Dose 2

¹Series containing oral polio vaccine (OPV), either mixed OPV-IPV or OPV only: Total number of doses needed to complete the series is the same as that recommended for the U.S. IPV schedule. www.cdc.gov/mmwr/volumes/66/wr/mm6601a6.htm

²Next dose due is not the final dose in the series unless explicitly stated.

INDIVIDUAL VACCINE REQUIREMENTS

Catch-Up Guidance for Children 4 Months through 17 Years of Age Inactivated Polio Vaccine (IPV)

IF current age is	AND # of previous doses ¹ is	AND			THEN	Next dose due ²	
4 through 17 years	Unknown or 0	→			Give Dose 1 today	Give Dose 2 at least 4 weeks after Dose 1	
	1	It has been at least 4 weeks since Dose 1			Give Dose 2 today	Give Dose 3 (Final Dose) at least 6 months after Dose 2	
		It has not been 4 weeks since Dose 1			No dose today	Give Dose 2 at least 4 weeks after Dose 1	
	2	It has been at least 6 months since Dose 2			Give Dose 3 (Final Dose) today	No additional doses needed	
		It has not been 6 months since Dose 2			No dose today	Give Dose 3 (Final Dose) at least 6 months after Dose 2	
	3	Dose 3 was given before 4 years of age	It has been at least 6 months since Dose 3	→	Give Dose 4 (Final dose) today	No additional doses needed	
			It has not been at least 6 months since Dose 3	→	No dose today	Give Dose 4 (Final Dose) at least 6 months after Dose 3	
		Dose 3 was given at 4 years of age or older	Dose 3 was given at least 6 months from previous dose	→	No dose today	No additional doses needed	
			Dose 3 was not given at least 6 months from previous dose	It has been at least 6 months since Dose 3	→	Give Dose 4 (Final dose) today	No additional doses needed
				It has not been at least 6 months since Dose 3	→	No dose today	Give Dose 4 (Final Dose) at least 6 months after Dose 3

¹Series containing oral polio vaccine (OPV), either mixed OPV-IPV or OPV only: Total number of doses needed to complete the series is the same as that recommended for the U.S. IPV schedule. www.cdc.gov/mmwr/volumes/66/wr/mm6601a6.htm

²Next dose due is not the final dose in the series unless explicitly stated.

INDIVIDUAL VACCINE REQUIREMENTS



Measles, mumps, and rubella (MMR)

A student must be immunized with Measles, Mumps, and Rubella (MMR) vaccine for entering a Utah school or early childhood program*.

School entry: A student attending school, **kindergarten through twelfth grade**, must receive **two** doses of Measles, Mumps, Rubella (MMR) vaccine. The first dose must be administered **on** or **after** the student's first birthday. The second dose must be administered prior to entering kindergarten. The minimum interval between dose one and dose two is four weeks.

Early childhood program entry: A child one year of age or older attending an early childhood program must have received one dose of Measles, Mumps, Rubella vaccine prior to entry.

NOTES:

- *It is recommended that children receive the second dose of MMR at 4-6 years of age, however, the second dose of MMR can be accepted if it was administered four weeks (28 days) after the first dose. If MMR vaccine is NOT administered on the same day as Varicella, a minimum of 28 days must separate the two vaccines. If two live vaccines, such as MMR and Chickenpox, are given less than four weeks apart, the vaccine given second should be repeated.*
- *If the first dose was given before the student's first birthday, it is not a valid dose and must be repeated.*
- *The four-day "grace period" does not apply to the 28-day interval between two live vaccines not administered at the same visit.*
- *If MMRV was administered instead of MMR, minimum interval between doses is three months. If the second dose of MMRV was given at least four weeks after the first dose, it can be accepted as valid. MMRV is approved for children 12 months through 12 years.*

**Children enrolled in early childhood programs must be immunized for MMR vaccine according to their appropriate age. The number of doses required varies by a child's age and how long ago they were vaccinated.*

Measles, Mumps, Rubella (MMR) Recommended Immunization Schedule

Birth	2 months	4 months	6 months	12 months	15 months	18 months	19-23 months	4-6 years	11-12 years
				MMR #1				MMR #2	

Shaded boxes indicate the vaccine can be given during shown age range.

INDIVIDUAL VACCINE REQUIREMENTS



Varicella (Chickenpox)

A student must be immunized with Varicella vaccine for entering a Utah school or early childhood program.

Kindergarten entry*: A student entering kindergarten must be immunized for two doses of Varicella (Chickenpox) vaccine. The first dose must be administered **on** or **after** the student's first birthday.

Seventh grade entry*: A student entering seventh grade must be immunized for two doses of Varicella (Chickenpox) vaccine.

Early childhood program entry*: A child one year of age or older attending an early childhood program must have received one dose of Varicella (Chickenpox) vaccine prior to entry. It is recommended that children receive the second dose of Varicella vaccine at 4-6 years of age. Children enrolled in early childhood programs must be immunized for varicella vaccine according to their appropriate age. The number of doses required varies by a child's age and how long ago they were vaccinated.

* If a student has a history of Chickenpox disease, the student must submit a document signed by a healthcare provider to the school as proof of immunity.

NOTES:

- For auditing purposes, the second dose can be accepted if administered earlier than 4-6 years of age if at least three months have elapsed following the first dose. However, the second dose of Varicella vaccine can be accepted if it was previously administered at least four weeks following the first dose. Varicella vaccine doses administered to persons 13 years or older must be separated by four weeks.
- For children aged 7-12 years, the recommended minimum interval between doses is three months. For auditing purposes, if the second dose was previously administered at least four weeks after the first dose, it can be accepted as valid.
- If a student has a history of Chickenpox disease, the student must submit a document signed by a healthcare provider to the school as proof of immunity.
- If two live vaccines, such as MMR and Chickenpox, are given less than four weeks apart, the vaccine given second should be repeated. If Varicella vaccine is NOT administered on the same day as MMR, a minimum of 28 days must separate the two vaccines.
- If a child/student inadvertently received zoster vaccine rather than varicella vaccine, the dose of Zoster vaccine can be counted as one dose of Varicella vaccine.
- If the first dose was given *before* the student's first birthday, it is not a valid dose and must be repeated.
- The four-day "grace period" does not apply to the 28-day interval between two live vaccines not administered at the same visit.
- In 2015-2016 school year, two doses of Varicella vaccine became required for seventh grade and kindergarten school entry.
- If MMRV was given instead of MMR, minimum interval between doses is three months but if the second dose of MMRV was given at least four weeks after the first dose, it can be accepted as valid. MMRV is approved for children 12 months through 12 years.

Varicella (Chickenpox)

Recommended Immunization Schedule

Birth	2 months	4 months	6 months	12 months	15 months	18 months	19-23 months	4-6 years	11-12 years
				VAR #1				VAR #2	

Shaded boxes indicate the vaccine can be given during shown age range.

INDIVIDUAL VACCINE REQUIREMENTS



Haemophilus influenzae type b (Hib)

A child less than five years of age attending an early childhood program must be immunized with Haemophilus influenzae type b (Hib) vaccine as appropriate for age.

Hib is not recommended after a child's fifth birthday and, therefore, is not a requirement for entry into kindergarten.

Recommended Schedule: The number of doses in the *primary series* depends on the type of vaccine used. Merck (PedvaxHIB) vaccines require a two-dose primary series (Table, Row 1), while other brands require a three-dose primary series (Table, Row 2). If more than one brand of vaccine is used for the primary series, a three-dose primary series is required. The minimum interval between Hib doses in the primary series is four weeks. (Infants 2 through 6 months of age should receive a 3-dose series of ActHIB, Hiberix, or Pentacel or a 2-dose series of PedvaxHIB. The first dose can be administered as early as age 6 weeks. Hib-containing vaccine should not be given before 6 weeks of age. Doses given before 12 months of age should be separated by at least 4 weeks. A booster dose (which will be dose 3 or 4 depending on vaccine type used in primary series) of any Hib-containing vaccine is recommended at age 12 through 15 months and at least 8 weeks after the most recent Hib dose.)

A booster dose is recommended at 12-15 months of age regardless of which vaccine brand is used for the primary series. The booster dose must be administered a minimum of eight weeks following the previous dose **and after 12 months of age.**

Infants 2-6 months of age should receive a 3-dose series of ActHIB, Hiberix, Pentacel, or a 2-dose series of PedvaxHIB. The first dose can be administered as early as age 6 weeks. Hib-containing vaccine should not be given before 6 weeks of age. Doses given before 12 months of age should be separated by at least 4 weeks. A booster dose (which will be dose 3 or 4 depending on vaccine type used in primary series) of any Hib-containing vaccine is required at age 12-15 months and at least 8 weeks after the most recent Hib dose.

If a healthy child receives a dose of Hib vaccine at 15 months of age or older, he or she does not need any further doses regardless of the number of doses received before 15 months of age. Some high-risk children between the ages of 5 months and 59 months will be recommended for two doses of Hib vaccine based on previous history of incomplete vaccination.

NOTE: Comvax - a Hib/Hepatitis B combination vaccine was discontinued in 2014.

Routine vaccination

ActHIB, Hiberix, or Pentacel: 4-dose series at 2, 4, 6, 12–15 months

PedvaxHIB: 3-dose series at 2, 4, 12–15 months

For catch-up guidance for healthy children 4 months through 4 years of age for Haemophilus influenza type B vaccines: ActHIB, Pentacel, Hiberix, unknown, or PedvaxHIB, see the next few pages.

Haemophilus influenzae type B (Hib)

Recommended Immunization Schedule

Birth	2 months	4 months	6 months	12 months	15 months	18 months	19-23 months	4-6 years	11-12 years
	Merck Hib #1	Merck Hib #2		Merck Hib #3 Booster					
	Other Hib #1	Other Hib #2	Other Hib #3	Other Hib #4 Booster					

Shaded boxes indicate the vaccine can be given during shown age range.

INDIVIDUAL VACCINE REQUIREMENTS

Catch-Up Guidance for Healthy¹ Children 4 Months through 4 Years of Age

Haemophilus Influenzae type B Vaccines: ActHIB, Pentacel, Hiberix, or Unknown

Table #1- The table below provides guidance for children whose vaccinations have been delayed. Start with the child's age and information on previous doses (previous doses must be documented and must meet minimum age requirements and minimum intervals between doses).

IF current age is	AND # of previous doses is	AND		THEN	Next dose due
4 through 6 months	Unknown or 0	→		Give Dose 1 today	Give Dose 2 at least 4 weeks after Dose 1
	1	It has been at least 4 weeks since Dose 1		Give Dose 2 today	Give Dose 3 at least 4 weeks after Dose 2
		It has not been 4 weeks since Dose 1		No dose today	Give Dose 2 at least 4 weeks after Dose 1
	2	It has been at least 4 weeks since Dose 2		Give Dose 3 today	Give Dose 4 (Final Dose) at 12 months of age or older
		It has not been 4 weeks since Dose 2		No dose today	Give Dose 3 at least 4 weeks after Dose 2
	7 through 11 months	Unknown or 0	→	→	Give Dose 1 today
1		It has been at least 4 weeks since Dose 1	→	Give Dose 2 today	IF Dose 1 was given before 7 months of age, give Dose 3 at least 4 weeks after Dose 2
					IF Dose 1 was given at 7 months of age or older, give Dose 3 (Final Dose) at least 8 weeks after Dose 2 and no earlier than 12 months of age or older
		It has not been 4 weeks since Dose 1	→	No dose today	Give Dose 2 at least 4 weeks after Dose 1
2		Dose 1 was given before 7 months of age	It has been at least 4 weeks since Dose 2	Give Dose 3 today	Give Dose 4 (Final Dose) at least 8 weeks after Dose 3 and no earlier than 12 months of age or older
			It has not been 4 weeks since Dose 2	No dose today	Give Dose 3 at least 4 weeks after Dose 2
		Dose 1 was given at 7 months of age or older	→	No dose today	Give Dose 3 (Final Dose) at least 8 weeks after Dose 2, and no earlier than 12 months of age or older

INDIVIDUAL VACCINE REQUIREMENTS

Catch-Up Guidance for Healthy¹ Children 4 Months through 4 Years of Age Haemophilus Influenzae type B Vaccines: ActHIB, Pentacel, Hiberix, or Unknown

IF current age is	AND # of previous doses is	AND	AND	AND	THEN	Next Dose Due	
12 through 14 months	Unknown or 0	→	→	→	Give Dose 1 today	Give Dose 2 (Final Dose) at least 8 weeks after Dose 1	
	1	Dose 1 was given before 12 months of age	It has been at least 4 weeks since Dose 1	→	Give Dose 2 today	Give Dose 3 (Final Dose) at least 8 weeks after Dose 2	
			It has not been 4 weeks since Dose 1	→	No dose today	Give Dose 2 at least 4 weeks after Dose 1	
		Dose 1 was given at 12 months of age or older	It has been at least 8 weeks since Dose 1	→	Give Dose 2 (Final Dose) today	No additional doses needed	
			It has not been 8 weeks since Dose 1	→	No dose today	Give Dose 2 (Final Dose) at least 8 weeks after Dose 1	
	2	Dose 1 was given before 12 months of age	It has been at least 8 weeks since Dose 2	→	Give Dose 3 (Final Dose) today	No additional doses needed	
			It has not been 8 weeks since Dose 2	→	No dose today	Give Dose 3 (Final Dose) at least 8 weeks after Dose 2	
		Dose 1 was given at 12 months of age or older	→	→	No dose today	No additional doses needed	
	3	All doses were given before 12 months of age	→	It has been at least 8 weeks since Dose 3	→	Give Dose 4 (Final Dose) today	No additional doses needed
				It has not been 8 weeks since Dose 3	→	No dose today	Give Dose 4 (Final Dose) at least 8 weeks after Dose 3
		At least one dose was given at 12 months of age or older	→	→	No dose today	No additional doses needed	

INDIVIDUAL VACCINE REQUIREMENTS

Catch-Up Guidance for Healthy¹ Children 4 Months through 4 Years of Age Haemophilus Influenzae type B Vaccines: ActHIB, Pentacel, Hiberix, or Unknown

IF current age is	AND # of previous doses is	AND	AND	AND	THEN	Next Dose Due	
15 through 59 months	Unknown or 0	→	→	→	Give Dose 1 (Final Dose) today	No additional doses needed	
	1	Dose 1 was given before 12 months of age	→	→	Give Dose 2 (Final Dose) today	No additional doses needed	
		Dose 1 was given at 12 through 14 months of age	It has been at least 8 weeks since Dose 1	→	Give Dose 2 (Final Dose) today	No additional doses needed	
			It has not been 8 weeks since Dose 1	→	No dose today	Give Dose 2 (Final Dose) at least 8 weeks after Dose 1	
		Dose 1 was given at 15 months of age or older	→	→	No dose today	No additional doses needed	
	2	Dose 1 was given before 12 months of age	Dose 2 was given before 15 months of age	→	→	Give Dose 3 (Final Dose) today	No additional doses needed
			It has not been 8 weeks since Dose 2	→	No dose today	Give Dose 3 (Final Dose) at least 8 weeks after Dose 2	
		Dose 2 was given at 15 months of age or older	→	→	No dose today	No additional doses needed	
		Dose 1 was given at 12 months of age or older	→	→	No dose today	No additional doses needed	

INDIVIDUAL VACCINE REQUIREMENTS

Catch-Up Guidance for Healthy¹ Children 4 Months through 4 Years of Age Haemophilus Influenzae type B Vaccines: ActHIB, Pentacel, Hiberix, or Unknown

IF current age is	AND # of previous doses is	AND	AND	AND	THEN	Next Dose Due
15 through 59 months	3	Dose 3 was given before 15 months of age	All doses were given before 12 months of age	→	Give Dose 4 (Final Dose) today	No additional doses needed
			At least one dose was given at 12 months of age or older	→	No dose today	No additional doses needed
		Dose 3 was given at 15 months of age or older	→	→	No dose today	No additional doses needed

1 Refer to notes of the Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger–United States, 2020, for immunization guidance for children at increased risk for Haemophilus influenzae type b disease. Reference: Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger–United States, 2020. www.cdc.gov/vaccines/schedules/downloads/child/0-18yrs-child-combined-schedule.pdf

INDIVIDUAL VACCINE REQUIREMENTS

Catch-Up Guidance for Healthy¹ Children 4 Months through 4 Years of Age Haemophilus Influenzae type B Vaccines: PedvaxHIB vaccine only

Table #2- The table below provides guidance for children whose vaccinations have been delayed. Start with the child's age and information on previous doses (previous doses must be documented and must meet minimum age requirements and minimum intervals between doses).

IF current age is	AND # of previous doses is	AND	AND	THEN	Next Dose Due
4 through 6 months	0	→	→	Give Dose 1 today	Give Dose 2 at least 4 weeks after Dose 1
	1	→	It has been at least 4 weeks since Dose 1	Give Dose 2 today	Give Dose 3 (Final Dose) at 12 months of age or older
		→	It has not been 4 weeks since Dose 1	No dose today	Give Dose 2 at least 4 weeks after Dose 1
7 through 11 months	0	→	→	Give Dose 1 today	Give Dose 2 at least 4 weeks after Dose 1
	1	→	It has been at least 4 weeks since Dose 1	Give Dose 2 today	Give Dose 3 (Final Dose) at least 8 weeks after Dose 2 and at 12 months of age or older
		→	It has not been 4 weeks since Dose 1	No dose today	Give Dose 2 at least 4 weeks after Dose 1
12 through 14 months	0	→	→	Give Dose 1 today	Give Dose 2 (Final Dose) at least 8 weeks after Dose 1
	1	Dose 1 was given before 12 months of age	It has been at least 4 weeks since Dose 1	Give Dose 2 today	Give Dose 3 (Final Dose) at least 8 weeks after Dose 2
			It has not been 4 weeks since Dose 1	No dose today	Give Dose 2 at least 4 weeks after Dose 1
		Dose 1 was given at 12 months of age or older	It has been at least 8 weeks since Dose 1	Give Dose 2 (Final Dose) today	No additional doses needed
			It has not been 8 weeks since Dose 1	No dose today	Give Dose 2 (Final Dose) at least 8 weeks after Dose 1
	2	Dose 1 was given before 12 months of age	It has been at least 8 weeks since Dose 2	Give Dose 3 (Final Dose) today	No additional doses needed
			It has not been 8 weeks since Dose 2	No dose today	Give Dose 3 (Final Dose) at least 8 weeks after Dose 2
Dose 1 was given at 12 months of age or older		→	No dose today	No additional doses needed	

INDIVIDUAL VACCINE REQUIREMENTS

Catch-Up Guidance for Healthy¹ Children 4 Months through 4 Years of Age Haemophilus Influenzae type B Vaccines: PedvaxHIB vaccine only

IF current age is	AND # of previous doses is	AND	AND	AND	THEN	Next Dose Due
15 through 59 months	0	→	→	→	Give Dose 1 (Final Dose) today	No additional doses needed
	1	Dose 1 was given before 12 months of age	→	→	Give Dose 2 (Final Dose) today	No additional doses needed
		Dose 1 was given at 12 through 14 months of age	It has been at least 8 weeks since Dose 1	→	Give Dose 2 (Final Dose) today	No additional doses needed
			It has not been 8 weeks since Dose 1	→	No dose today	Give Dose 2 (Final Dose) at least 8 weeks after Dose 1
		Dose 1 was given at 15 months of age or older	→	→	No dose today	No additional doses needed
	2	Dose 1 was given before 12 months of age	Dose 2 was given before 15 months of age	It has been at least 8 weeks since Dose 2	Give Dose 3 (Final Dose) today	No additional doses needed
				It has not been 8 weeks since Dose 2	No dose today	Give Dose 3 (Final Dose) at least 8 weeks after Dose 2
			Dose 2 was given at 15 months of age or older	→	No dose today	No additional doses needed
		Dose 1 was given at 12 months or older	→	→	No dose today	No additional doses needed

¹ Refer to notes of the Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger—United States, 2020, for immunization guidance for children at increased risk for Haemophilus influenzae type b disease. Reference: Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger—United States, 2020. www.cdc.gov/vaccines/schedules/downloads/child/0-18yrs-child-combined-schedule.pdf

INDIVIDUAL VACCINE REQUIREMENTS



Pneumococcal

A child less than five years of age attending an early childhood program must be immunized for Pneumococcal vaccine as appropriate for age.

Pneumococcal vaccine is not recommended after a child's fifth birthday and, therefore, is not a requirement for entry into kindergarten.

Recommended Schedule: Pneumococcal vaccine is recommended for routine administration at ages two, four and six months of age with a booster dose at 12-15 months. Catch-up immunization is recommended for children who may have started late or fell behind schedule, using fewer doses depending on their age (see tables on page 8). The minimum interval between doses administered to children <12 months of age is four weeks. The minimum interval between doses administered at ≥12 months of age is eight weeks. The booster dose of PCV vaccine, following the primary series, should be administered no earlier than 12 months of age **and** at least eight weeks after the previous dose.

NOTE: One supplemental dose of PCV 13 vaccine is required for healthy children 14-59 months of age who have received four doses of PCV 7 or another age-appropriate, complete PCV7 schedule. Children who have underlying medical conditions, a single supplemental PCV13 is required through 71 months of age.

For catch-up guidance for health children 4 months through 4 years of age for pneumococcal conjugate vaccine (PCV), see the next few pages

Pneumococcal Conjugate (PCV)

Recommended Immunization Schedule

Birth	2 months	4 months	6 months	12 months	15 months	18 months	19-23 months	4-6 years	11-12 years
	PCV #1	PCV #2	PCV #3	PCV Booster					

 Shaded boxes indicate the vaccine can be given during age range shown.

INDIVIDUAL VACCINE REQUIREMENTS

Catch-Up Guidance for Healthy Children 4 months through 4 Years of Age

Pneumococcal Conjugate Vaccine: PCV

Table #1 – The table below provides guidance for children whose vaccinations have been delayed. Start with the child’s age and information on previous doses (previous doses must be documented and must meet minimum age requirements and minimum intervals between doses).

IF current age is	AND # of previous doses is	AND		THEN	Next dose due
4 through 6 months	0 or unknown	→	→	Give Dose 1 today	Give Dose 2 at least 4 weeks after Dose 1
	1	→	It has been at least 4 weeks since Dose 1	Give Dose 2 today	Give Dose 3 at least 4 weeks after Dose 2
		→	It has not been at least 4 weeks since Dose 1	No dose today	Give Dose 2 at least 4 weeks after Dose 1
	2	→	It has been at least 4 weeks since Dose 2	Give Dose 3 today	Give Dose 4 (Final Dose) at 12 months of age or older
		→	It has not been at least 4 weeks since Dose 2	No dose today	Give Dose 3 at least 4 weeks after Dose 2
	7 through 11 months	0	→	→	Give Dose 1 today
1		Dose 1 was given before 7 months of age	It has been at least 4 weeks since Dose 1	Give Dose 2 today	Give Dose 3 (Final Dose) at least 8 weeks after Dose 2 and at 12 months of age or older
			It has not been 4 weeks since Dose 1	No dose today	Give Dose 2 at least 4 weeks after Dose 1
		Dose 1 was given at 7 months or older	It has been at least 4 weeks since Dose 1	Give Dose 2 today	Give Dose 3 (Final Dose) at least 8 weeks after Dose 2 and at 12 months of age or older
			It has not been 4 weeks since Dose 1	No dose today	Give Dose 2 at least 4 weeks after Dose 1
2		Dose 2 was given before 7 months of age	It has been at least 4 weeks since Dose 2	Give Dose 3 today	Give Dose 4 (Final Dose) at least 8 weeks after Dose 3 and at 12 months of age or older
			It has not been 4 weeks since Dose 2	No dose today	Give Dose 3 at least 4 weeks after Dose 2
		Dose 2 was given at 7 months or older	→	No dose today	Give Dose 3 (Final Dose) at least 8 weeks after Dose 2 and at 12 months of age or older

¹Refer to the notes of the Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger—United States, 2020, for immunization guidance for children at increased risk for pneumococcal disease.

Reference: Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger—United States, 2020. www.cdc.gov/vaccines/schedules/downloads/child/0-18yrs-child-combined-schedule.pdf.

INDIVIDUAL VACCINE REQUIREMENTS

Catch-Up Guidance for Healthy Children 4 months through 4 Years of Age Pneumococcal Conjugate Vaccine: PCV

IF current age is	AND # of previous doses is	AND	AND	THEN	Next dose due
12 through 23 months	0 or unknown	→	→	Give Dose 1 today	Give Dose 2 (Final Dose) at least 8 weeks after Dose 1
	1	Dose 1 was given before 12 months of age	It has been at least 4 weeks since Dose 1	Give Dose 2 today	Give Dose 3 (Final Dose) at least 8 weeks after Dose 2
			It has not been 4 weeks since Dose 1	No dose today	Give Dose 2 at least 4 weeks after Dose 1
		Dose 1 was given at 12 months of age or older	It has been at least 8 weeks since Dose 1	Give Dose 2 (Final Dose) today	No additional doses needed
			It has not been 8 weeks since Dose 1	No dose today	Give Dose 2 (Final Dose) at least 8 weeks after Dose 1
	2	Both doses were given before 12 months of age	It has been at least 8 weeks since Dose 2	Give Dose 3 (Final Dose) today	No additional doses needed
			It has not been 8 weeks since Dose 2	No dose today	Give Dose 3 (Final Dose) at least 8 weeks after Dose 2
		At least one dose was given at 12 months or older	It has been at least 8 weeks since Dose 2	Give Dose 3 (Final Dose) today	No additional doses needed
			It has not been 8 weeks since Dose 2	No dose today	Give Dose 3 (Final Dose) at least 8 weeks after Dose 2
		Both doses were given at 12 months or older ²	→	No dose today	No additional doses needed
		3	All doses were given before 12 months of age	It has been at least 8 weeks since Dose 3	Give Dose 4 (Final Dose) today
	It has not been 8 weeks since Dose 3			No dose today	Give Dose 4 (Final Dose) at least 8 weeks after Dose 3
	1 or more doses were given at 12 months of age or older		→	No dose today	No additional doses needed

¹Refer to the notes of the Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger—United States, 2020, for immunization guidance for children at increased risk for pneumococcal disease.

² Separated by at least 8 weeks.

Reference: Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger—United States, 2020. www.cdc.gov/vaccines/schedules/downloads/child/0-18yrs-child-combined-schedule.pdf.

INDIVIDUAL VACCINE REQUIREMENTS

Catch-Up Guidance for Healthy Children 4 months through 4 Years of Age

Pneumococcal Conjugate Vaccine: PCV

IF current age is	AND # of previous doses is	AND	AND	AND	THEN	Next dose due		
24 through 59 months	0	→	→	→	Give Dose 1 today	No additional doses needed		
	1	Dose 1 was given before 1 st birthday	→	→	→	Give Dose 2 (Final Dose) today	No additional doses needed	
		Dose 1 was given after 1 st birthday	Dose 1 was given before 2 nd birthday	→	→	It has been at least 8 weeks since Dose 1	Give Dose 2 (Final Dose) today	No additional doses needed
			It has not been at least 8 weeks since Dose 1				No dose today	Give Dose 2 (Final Dose) at least 8 weeks after Dose 1
		Dose 1 was given after 2 nd birthday	→	→	→	No dose today	No additional doses needed	
	2	Dose 1 was given before 12 months of age	Dose 2 was given before 1 st birthday	→	→	→	Give Dose 3 (Final Dose) today	No additional doses needed
			Dose 2 was given before 2 nd birthday	→	→	→	Give Dose 3 (Final Dose) today	No additional doses needed
			Dose 2 was given after 2 nd birthday	→	→	→	No dose today	No additional doses needed
		Dose 1 was given after 12 months of age	→	→	→	→	No dose today	No additional doses needed
		3	All 3 doses were given before 12 months of age	→	→	→	→	Give Dose 4 (Final Dose) today
	1 or more doses were given at 12 months or older		→	→	→	→	No dose today	No additional doses needed

¹Refer to the notes of the Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger—United States, 2020, for immunization guidance for children at increased risk for pneumococcal disease. Reference: Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger—United States, 2020. www.cdc.gov/vaccines/schedules/downloads/child/0-18yrs-child-combined-schedule.pdf.

INDIVIDUAL VACCINE REQUIREMENTS



Hepatitis A

A student must be immunized with Hepatitis A vaccine for entering a Utah school or early childhood program.

School entry: Two doses of Hepatitis A vaccine are required for kindergarten entry. The first dose must be administered **on** or **after** a student's first birthday. The second dose must be administered a minimum of six months after the first dose.

Early childhood program entry: A child one year of age or older attending an early childhood program must be immunized for Hepatitis A. The first dose must be administered **on** or **after** a child's first birthday. The second dose must be administered a minimum of six months after the first dose.

Hepatitis A

Recommended Immunization Schedule

Birth	2 months	4 months	6 months	12 months	15 months	18 months	19-23 months	4-6 years	11-12 years
				Hepatitis A #1 & 2					

 Shaded boxes indicate the vaccine can be given during shown age range.

INDIVIDUAL VACCINE REQUIREMENTS



Hepatitis B

A student must be immunized for Hepatitis B for entering a Utah school or early childhood program.

Kindergarten entry: Three doses of Hepatitis B vaccine are required for kindergarten entry. The first two doses must be administered a minimum of four weeks apart. The final (third or fourth) dose must be administered according to the following three conditions. All three conditions **MUST** be met.

- (a) The student (child) is/was a minimum of 24 weeks of age;
- (b) The minimum interval between dose two and three must be at least eight weeks; and
- (c) The minimum interval between dose one and dose three (final dose) must be at least 16 weeks.

NOTES:

- **Condition (a) must be met before (b) and (c).**
- For students aged 11-15 years, two doses meet the requirement (separated by at least four months) if adult Hepatitis B vaccine Recombivax HB was used.
- A total of four doses of Hepatitis B vaccine is recommended when a combination vaccine containing Hepatitis B is administered after the birth dose.

Seventh grade entry: A student must be immunized for Hepatitis B for seventh grade entry. Immunizations previously administered according to the above schedule satisfy this requirement.

Early childhood program entry: Children enrolled in early childhood programs must be immunized for Hepatitis B vaccine according to their appropriate age. The number of doses required varies by a child's age and how long ago they were vaccinated.

Hepatitis B Recommended Immunization Schedule									
Birth	2 months	4 months	6 months	12 months	15 months	18 months	19-23 months	4-6 years	11-12 years
Hepatitis B #1									
	Hepatitis B #2		Hepatitis B #3						

Shaded boxes indicate the vaccine can be given during shown age range.

INDIVIDUAL VACCINE REQUIREMENTS



Meningococcal

A student must be immunized with a dose of Meningococcal Conjugate vaccine for 7th grade entry.

School entry: One dose of Meningococcal Conjugate vaccine is required for 7th grade entry.

NOTE: Only Meningococcal Conjugate vaccine given on or after 10 years of age is acceptable for 7th grade school entry.

Meningococcal Conjugate Recommended Immunization Schedule

Birth	2 months	4 months	6 months	12 months	15 months	18 months	19-23 months	4-6 years	11-12 years
									Meningococcal



Tetanus-diphtheria-acellular pertussis (Tdap)

A student must be immunized with a dose of Tdap vaccine for 7th grade entry.

Tetanus-diphtheria-acellular pertussis (Tdap) Recommended Immunization Schedule

Birth	2 months	4 months	6 months	12 months	15 months	18 months	19-23 months	4-6 years	11-12 years
									Tdap

Shaded boxes indicate the vaccine can be given during shown age range.

SECTION 2 SUMMARY OF REQUIREMENTS



SCHOOL ENTRY REQUIREMENTS FOR GRADES K-12

The following vaccines are required for students entering kindergarten:

- 5 DTaP/DT*
- 4 Polio**
- 2 Measles, Mumps, Rubella (MMR)
- 3 Hepatitis B
- 2 Hepatitis A
- 2 Varicella (Chickenpox)

*Proof of immunity to disease (s) can be accepted in place of vaccination only if a document is presented to the school from a healthcare provider stating the student previously contracted the disease.

The following vaccines are required for students entering seventh grade:

- 1 Tdap
- 3 Hepatitis B
- 2 Varicella (Chickenpox)
- 1 Meningococcal Conjugate- **Only Meningococcal Conjugate vaccine given on or after 10 years of age is acceptable for 7th grade school entry.**

*Proof of immunity to disease (s) can be accepted in place of vaccination only if a document from a healthcare provider stating the student previously contracted the disease is presented to the school.

Kindergarten through grade 12: ALL students kindergarten through grade 12 are required to have two doses of the MMR vaccine.

In 2015-2016 school year, two doses of Varicella vaccine became required for seventh grade and kindergarten school entry.

***DTaP/DT- Only four doses are required if fourth dose was administered on or after the fourth birthday.**

****Polio - Only three doses are required if third dose was administered on or after the fourth birthday.**

SUMMARY OF REQUIREMENTS



PROGRESSIVE GRADE REQUIREMENTS FOR SCHOOLS ONLY

Beginning with the 1999-2000 school year, Hepatitis B became a requirement for kindergarten entry. Beginning with the 2002-2003 school year, Hepatitis A and Varicella became requirements for kindergarten entry. Beginning with the 2006-2007 school year, Hepatitis B, Tetanus/Diphtheria booster (Td), and Varicella became requirements for seventh grade entry. Beginning with the 2007-2008 school year, Tetanus/Diphtheria/Pertussis (Tdap) became a requirement for the seventh grade booster dose. Beginning with the 2015-2016 school year one dose of Meningococcal conjugate vaccine became a requirement for the seventh grade entry and two doses of Varicella vaccine became a requirement for seventh grade entry and kindergarten entry. Please refer to the chart below to determine which grades are required to have these immunizations.

All grade requirements are progressive, meaning that if a vaccine is required for kindergarten entry this year, it is required for kindergarten and first grade the following year, kindergarten, first, and second grades the next year, and so on.

Remember these requirements are based upon a particular grade cohort or group. If a child repeats a grade, the child is subject to the requirements of the new grade, even if the child's birth date is not in the range for requirement.

Hepatitis A, Hepatitis B, Varicella, MMR, Polio, DTaP*/Td

School Year	Grades Required
2020-2021	K-12th

*DTaP vaccine is required for kindergarten entry. Students 7 years or older who have not received any of the components of DTaP vaccine, or whose vaccination history is unknown, should receive 3 doses of Td or Tdap. Tdap for dose #1 followed by Td or Tdap for next 2 doses.

Varicella (Chickenpox)

School Year	Grades Required
2020-2021	Kindergarten-5th
2020-2021	7th-12th

*STUDENTS IN ALL OTHER GRADES ARE REQUIRED TO HAVE ONE DOSE OF THE VARICELLA (CHICKENPOX) VACCINE

Tdap

School Year	Grades Required
2020-2021	7th-12th

Meningococcal Conjugate

School Year	Grades Required
2020-2021	7th-12th

SUMMARY OF REQUIREMENTS



EARLY CHILDHOOD PROGRAM REQUIREMENTS

As of July 1, 2008, children enrolled in early childhood programs must be immunized appropriately for age with the following immunizations:

- Diphtheria, Tetanus, Pertussis (DTaP)
- Measles, Mumps, Rubella (MMR)
- Polio
- Haemophilus influenzae type b (Hib)
- Hepatitis A
- Hepatitis B
- Varicella (Chickenpox)
- Pneumococcal

*Proof of immunity to disease(s) can be accepted in place of vaccination only if a document from a healthcare provider stating the student previously contracted the disease is presented to the facility.



MINIMUM AGE AND MINIMUM INTERVALS

The timing and spacing of vaccine doses are two of the most important issues in the appropriate use of vaccines. Using an accelerated vaccine schedule may be necessary for children who have fallen behind schedule and need to be brought up-to-date quickly. Accelerated schedules should not be used routinely.

Vaccine doses should not be administered at intervals less than the minimum interval or earlier than the minimum ages listed in the following table.

SUMMARY OF REQUIREMENTS



MINIMUM AGE AND MINIMUM INTERVALS

VACCINE	Minimum AGE Dose 1	Minimum INTERVAL Dose 1 to 2	Minimum INTERVAL Dose 2 to 3	Minimum INTERVAL Dose 3 to 4	Minimum INTERVAL Dose 4 to 5
DTaP/DTP/DT	6 weeks	4 weeks	4 weeks	6 months <i>NOTE: For auditing purposes only — dose 4 need not be repeated if given at least 4 months after dose 3.</i>	6 months
Polio	6 weeks	4 weeks	4 weeks	6 months (final dose must be given on or after the fourth birthday AND 6 months from the previous dose)	
MMR	12 months	4 weeks	If the first dose of MMR is given <u>before</u> the first birthday, it must be repeated.		
Hepatitis B	birth	4 weeks	8 weeks (child must be at least 24 weeks of age)	There must be 16 weeks between dose 1 and 3.	
Hib	6 weeks	4 weeks If first dose given at <12 months 8 weeks (as final dose) If first dose given at 12-14 months No further doses needed If first dose given at ≥15 months	4 weeks If current age <12 months 8 weeks (as final dose) If current age ≥12 months and second dose given at <15 months No further doses needed If previous dose given at ≥15 months	8 weeks (as final dose) This dose only necessary for children aged 12 months - 5 years who received 3 doses before 12 months. Last dose should not be given earlier than 12 months and a minimum of 8 weeks after previous dose.	<i>NOTE: Schedule may vary according to child's current age and previous number of doses received.</i>
Varicella (Chickenpox)	12 months	3 months (Children >13 years of age need 2 doses, 4 weeks apart.)	If the first dose of Varicella is given <u>before</u> the first birthday, it must be repeated.		
Hepatitis A	12 months	6 months			
Pneumococcal Conjugate (PCV)	6 weeks	4 weeks If first dose given at <12 months 8 weeks (as final dose) If first dose given at ≥12 months or current age 24-59 months No further doses needed for healthy children if first dose given at ≥24 months	4 weeks If current age <12 months 8 weeks (as final dose) If current age ≥12 months No further doses needed for healthy children if previous dose given at ≥24 months	8 weeks (as final dose) This dose necessary for children age 12 months - 5 years who received 3 doses before age 12 months.	<i>NOTE: One supplemental dose of Prevnar 13 vaccine is recommended for healthy children 14-59 months of age who have completed the 4-dose series with Prevnar 7 AND for children with underlying medical conditions through 71 months of age. Schedule may vary according to child's current age and previous number of doses received.</i>
Tetanus/Diphtheria/ Pertussis (Tdap)	A single dose of Tdap is recommended at 11-12 years of age, regardless of interval since the last tetanus/diphtheria-containing vaccine. Td or Tdap boosters should be administered every ten years thereafter.				
Meningococcal Conjugate	11-12 years	8 weeks			

SECTION 3 ANNUAL REPORTS



DUE DATES

Each year, the Utah Department of Health collaborates with the Utah State Board of Education (USBE) as required by Utah Statutory Code 53G-9-305(2)(b) to collect immunization data on currently enrolled students from all public, private, and parochial schools. Each school is required to submit data regarding the immunization status of all children currently enrolled. These reports reflect the current requirements in accordance with CDC guidelines. **All reports must be completed online.** The Utah Department of Health will prescribe the information needed for each of the listed reports and instructions for completion.

THE DUE DATES ARE AS FOLLOWS:

NOVEMBER 30 OF EACH YEAR:

- (a) *KINDERGARTEN SUMMARY REPORT* – statistical report of the immunization status of all kindergarten children in any school setting (public, private, charter, or parochial).
- (b) *SECOND DOSE MMR REPORT* – statistical report of the two-dose Measles, Mumps, and Rubella immunization status of all students kindergarten through grade 12.
- (c) *SEVENTH GRADE SUMMARY REPORT* – statistical report of the Hepatitis B, Tdap, Meningococcal, and Varicella status of all seventh grade students in any setting (public, private, charter, or parochial).
- (d) *EARLY CHILDHOOD PROGRAM REPORT* – statistical report of the immunization status of all children in an early childhood program (nursery or preschools, licensed child care centers, child care facility, family home care, and Head Start Programs).

OTHER REQUIREMENTS:

- (a) *YEAR-END REPORTS – DUE JUNE 15th of each year* – public and charter schools that report students as “conditional admission” or “out-of-compliance” on the November report will be required to submit a year-end report. This report will track those students to determine if they were immunized by the end of the school year. The Utah Immunization Program will collect the information and submit it to the Utah State Board of Education (USBE) to determine weighted pupil unit funds for each public school district in accordance with USBE policies and Utah Statutory Code (Section 53G-9-302).
- (b) *AUDITS* – Periodic audits of schools and/or early childhood programs may be conducted by local or state health department representatives for record review to ensure children meet the immunization requirements. The goal of these audits is to assure adequate protection of Utah’s children while improving immunization procedures. A major emphasis of these visits is to provide assistance in solving any problems.

SECTION 3 ANNUAL REPORTS



DEFINITIONS

The following are **definitions** which are used in the **Annual Reports**.

UP-TO-DATE (UTD) FOR SCHOOL ATTENDANCE - any student who has received the appropriate number of doses for each required vaccine. Proof of immunity is acceptable if student/child is claiming immunity against a disease for which vaccination is required because the student previously contracted the disease. The student must submit a document signed by a healthcare provider to the school/early childhood program as proof of immunity.

CONDITIONAL ENROLLMENT- A student who has not provided a school/early childhood program with a complete immunization record at the time of enrollment may attend school/early childhood program on a conditional enrollment. Conditional enrollment is a period where the student's immunization record is under review by the school/early childhood program or for 21 calendar days after the day a school/early childhood program provides a written notice to a student's legally responsible individual, in person or by mail. The notice describes the identified deficiencies or states that the school has not received an immunization record for the student and requests the required immunizations to be provided to school/early childhood program within the conditional enrollment period to avoid exclusion.

Students who do not comply at the end of the conditional enrollment period must be excluded from attending the school/early childhood program until they provide proper documentation of immunization records to school.

EXTENDED CONDITIONAL ENROLLMENT- At the end of the conditional enrollment period, a school principal or administrator can grant an additional extension of the conditional enrollment in the following situations, if the extension is necessary to complete all required vaccination doses:

- When more time is medically recommended to complete all required vaccination doses, and
- School principal or administrator and a school nurse, a health official, or a health official designee agree that an additional extension will likely lead to compliance with school immunization record requirements during the additional extension period.

UP-TO-DATE (UTD) FOR EARLY CHILDHOOD PROGRAM ATTENDANCE - any child who has received appropriate number of doses for each required vaccine appropriate for his/her age. Proof of immunity is acceptable if student/child is claiming immunity against a disease for which vaccination is required because the student previously contracted the disease. The student must submit a document signed by a healthcare provider to the school/early childhood program as proof of immunity.

EXEMPTION - a relief from the statutory immunization requirements by reason of medical, religious, or personal reasons.

SECTION 3 ANNUAL REPORTS



DEFINITIONS

The following are **definitions** that are used in the **Annual Reports**.

OUT-OF-COMPLIANCE – At the end of the conditional enrollment period, the school/early childhood program must exclude the student who does not comply with school immunization record requirements from attending school/early childhood program until the student complies with the school immunization requirements, EXCEPT if a student has been granted:

- (1) an additional extension of the conditional enrollment period by a school principal or administrator, for a time period medically recommended to complete all required vaccination doses, or
- (2) an additional extension of the conditional enrollment in cases of extenuating circumstances if a school principal or administrator and a school nurse, a health official, or a health official designee agree that an additional extension will likely lead to compliance with school immunization record requirements during the additional extension period.

A student missing any of the following school immunization record requirements is considered out of compliance:

- (a) if the school has not received an immunization record (no immunization record) from the legally responsible individual of the student, the student's former school, or a statewide registry that shows the student has received each vaccination required by the department, or
- (b) If the student did not receive each vaccination required by the department, or
- (c) for any required vaccination that the student did not receive and claimed immunity, the student did not submit a document signed by a healthcare provider to the school as proof of immunity (history of disease) against the disease for which the vaccination is required, or
- (d) legally responsible individual of the student claimed the student had an exemption from one or more of the required vaccinations but the student has not submitted an exemption form to school, or
- (e) the student has received fewer than the required number of doses, and is one month past due for subsequent immunizations, or
- (f) the student has received one or more doses at less than the minimum interval or less than the minimum age, or
- (g) the student does not comply with the immunization requirements for military children under Section 53E-3-905.

SECTION 4 APPENDICES

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Utah Statutory Code – Title 53G – Chapter 9 – Part 3 Immunization Requirements
Utah Immunization Rule for Students (R396-100)

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Frequently Asked Questions
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APPENDIX C - Page 57

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English Exclusion Notice for Inadequate Immunizations
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Common Vaccine Names

APPENDIX E - Page 65

Sample Utah Immunization Program Forms
Sample Exemption Form
Sample Utah School Immunization Record (USIR) card

APPENDIX F - Page 70

Utah School and Child care Employee Immunization Recommendations

APPENDIX G - Page 71

Tips for Talking to Parents About Vaccines
How Do I Fill Out The Utah School Immunization Record (USIR)

APPENDIX A – UTAH IMMUNIZATION STATUTES AND RULES

UTAH STATUTORY CODE

Utah Code – Statutes and Constitution

Title 53 G – Public Education System – Local Administration

Chapter 9 – Health and Welfare

Part 3 -- Immunization Requirements

53G-9-301. Definitions.

As used in this part:

- (1) "Department" means the Department of Health, created in Section 26-1-4.
- (2) "Health official" means an individual designated by a local health department from within the local health department to consult and counsel parents and licensed health care providers, in accordance with Subsection 53G-9-304(2)(a).
- (3) "Health official designee" means a licensed health care provider designated by a local health department, in accordance with Subsection 53G-9-304(2)(b), to consult with parents, licensed health care professionals, and school officials.
- (4) "Immunization" or "immunize" means a process through which an individual develops an immunity to a disease, through vaccination or natural exposure to the disease.
- (5) "Immunization record" means a record relating to a student that includes:
 - (a) information regarding each required vaccination that the student has received, including the date each vaccine was administered, verified by:
 - (i) a licensed health care provider;
 - (ii) an authorized representative of a local health department;
 - (iii) an authorized representative of the department;
 - (iv) a registered nurse; or
 - (v) a pharmacist;
 - (b) information regarding each disease against which the student has been immunized by previously contracting the disease; and
 - (c) an exemption form identifying each required vaccination from which the student is exempt, including all required supporting documentation described in Section 53G-9-303.
- (6) "Legally responsible individual" means:
 - (a) a student's parent;
 - (b) the student's legal guardian;
 - (c) an adult brother or sister of a student who has no legal guardian; or
 - (d) the student, if the student:
 - (i) is an adult; or
 - (ii) is a minor who may consent to treatment under Section 26-10-9.
- (7) "Licensed healthcare provider" means a healthcare provider who is licensed under Title 58, Occupations and Professions, as:
 - (a) a medical doctor;
 - (b) an osteopathic doctor;
 - (c) a physician assistant; or
 - (d) an advanced practice registered nurse.

APPENDIX A – UTAH IMMUNIZATION STATUTES AND RULES

- (8) "Local education agency" or "LEA" means:
- (a) a school district;
 - (b) a charter school; or
 - (c) the Utah Schools for the Deaf and the Blind.
- (9) "Local health department" means the same as that term is defined in Section 26A-1-102.
- (10) "Required vaccines" means vaccines required by department rule described in Section 53G-9-305.
- (11) "School" means any public or private:
- (a) elementary or secondary school through grade 12;
 - (b) preschool;
 - (c) child care program, as that term is defined in Section 26-39-102;
 - (d) nursery school; or
 - (e) kindergarten.
- (12) "Student" means an individual who attends a school.
- (13) "Vaccinating" or "vaccination" means the administration of a vaccine.
- (14) "Vaccination exemption form" means a form, described in Section 53G-9-304, that documents and verifies that a student is exempt from the requirement to receive one or more required vaccines.
- (15) "Vaccine" means the substance licensed for use by the United States Food and Drug Administration that is injected into or otherwise administered to an individual to immunize the individual against a communicable disease.

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53G-9-302. Immunization required-- Exception-- Weighted pupil unit funding.

- (1) A student may not attend a school unless:
- (a) the school receives an immunization record from the legally responsible individual of the student, the student's former school, or a statewide registry that shows:
 - (i) that the student has received each vaccination required by the department under Section 53G-9-305; or
 - (ii) for any required vaccination that the student has not received, that the student:
 - (A) has immunity against the disease for which the vaccination is required, because the student previously contracted the disease as documented by a health care provider, as that term is defined in Section 78B-3-103; or
 - (B) is exempt from receiving the vaccination under Section 53G-9-303;
 - (b) the student qualifies for conditional enrollment under Section 53G-9-308; or
 - (c) the student:
 - (i) is a student, as defined in Section 53E-3-903; and
 - (ii) complies with the immunization requirements for military children under Section 53E-3-905.
- (2) An LEA may not receive weighted pupil unit money for a student who is not permitted to attend school under Subsection (1).

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APPENDIX A – UTAH IMMUNIZATION STATUTES AND RULES

53G-9-303. Grounds for exemption from required vaccines -- Renewal.

- (1) A student is exempt from the requirement to receive a vaccine required under Section 53G-9-305 if the student qualifies for a medical or personal exemption from the vaccination under Subsection (2) or (3).
- (2) A student qualifies for a medical exemption from a vaccination required under Section 53G-9-305 if the student's legally responsible individual provides to the student's school:
 - (a) a completed vaccination exemption form; and
 - (b) a written notice signed by a licensed health care provider stating that, due to the physical condition of the student, administration of the vaccine would endanger the student's life or health.
- (3) A student qualifies for a personal exemption from a vaccination required under Section 53G-9-305 if the student's legally responsible individual provides to the student's school a completed vaccination exemption form, stating that the student is exempt from the vaccination because of a personal or religious belief.
- (4)
 - (a) A vaccination exemption form submitted under this section is valid for as long as the student remains at the school to which the form first is presented.
 - (b) If the student changes schools before the student is old enough to enroll in kindergarten, the vaccination exemption form accepted as valid at the student's previous school is valid until the earlier of the day on which:
 - (i) the student enrolls in kindergarten; or
 - (ii) the student turns six years old.
 - (c) If the student changes schools after the student is old enough to enroll in kindergarten but before the student is eligible to enroll in grade 7, the vaccination exemption form accepted as valid at the student's previous school is valid until the earlier of the day on which:
 - (i) the student enrolls in grade 7; or
 - (ii) the student turns 12 years old.
 - (d) If the student changes schools after the student is old enough to enroll in grade 7, the vaccination exemption form accepted as valid at the student's previous school is valid until the student completes grade 12.
 - (e) Notwithstanding Subsections (4)(b) and (c), a vaccination exemption form obtained through completion of the online education module created in Section 26-7-9 is valid for at least two years.

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APPENDIX A – UTAH IMMUNIZATION STATUTES AND RULES

53G-9-304. Vaccination exemption form.

- (1) The department shall:
 - (a) develop a vaccination exemption form that includes only the following information:
 - (i) identifying information regarding:
 - (A) the student to whom an exemption applies; and
 - (B) the legally responsible individual who claims the exemption for the student and signs the vaccination exemption form;
 - (ii) an indication regarding the vaccines to which the exemption relates;
 - (iii) a statement that the claimed exemption is for:
 - (A) a medical reason; or
 - (B) a personal or religious belief; and
 - (iv) an explanation of the requirements, in the event of an outbreak of a disease for which a required vaccine exists, for a student who:
 - (A) has not received the required vaccine; and
 - (B) is not otherwise immune from the disease; and
 - (b) provide the vaccination exemption form created in this Subsection (1) to local health departments.
 - (2) (a) Each local health department shall designate one or more individuals from within the local health department as a health official to consult, regarding the requirements of this part, with:
 - (i) parents, upon the request of parents;
 - (ii) school principals and administrators; and
 - (iii) licensed health care providers.
 - (b) A local health department may designate a licensed health care provider as a health official designee to provide the services described in Subsection (2)(a).
 - (3) (a) To receive a vaccination exemption form described in Subsection (1), a legally responsible individual shall complete the online education module described in Section 26-7-9, permitting an individual to:
 - (i) complete any requirements online; and
 - (ii) download and print the vaccine exemption form immediately upon completion of the requirements.
 - (b) A legally responsible individual may decline to take the online education module and obtain a vaccination exemption form from a local health department if the individual:
 - (i) requests and receives an in-person consultation at a local health department from a health official or a health official designee regarding the requirements of this part; and
 - (ii) pays any fees established under Subsection (4)(b).
 - (4) (a) Neither the department nor any other person may charge a fee for the exemption form offered through the online education module in Subsection (3)(a).
 - (b) A local health department may establish a fee of up to \$25 to cover the costs of providing an in-person consultation.

APPENDIX A – UTAH IMMUNIZATION STATUTES AND RULES

53G-9-305. Regulations of department.

- (1) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the department shall make rules regarding:
 - (a) which vaccines are required as a condition of attending school;
 - (b) the manner and frequency of the vaccinations; and
 - (c) the vaccination exemption form described in Section 53G-9-304.
- (2) The department shall ensure that the rules described in Subsection (1):
 - (a) conform to recognized standard medical practices; and
 - (b) require schools to report to the department statistical information and names of students who are not in compliance with Section 53G-9-302.

2018

53G-9-306. Immunization record part of student's record -- School review process at enrollment -- Transfer.

- (1) Each school:
 - (a) shall request an immunization record for each student at the time the student enrolls in the school;
 - (b) may not charge a fee related to receiving or reviewing an immunization record or a vaccination exemption form; and
 - (c) shall retain an immunization record for each enrolled student as part of the student's permanent school record.
- (2)
 - (a) Within five business days after the day on which a student enrolls in a school, an individual designated by the school principal or administrator shall:
 - (i) determine whether the school has received an immunization record for the student;
 - (ii) review the student's immunization record to determine whether the record complies with Subsection 53G-9-302 (1); and
 - (iii) identify any deficiencies in the student's immunization record.
 - (b) If the school has not received a student's immunization record or there are deficiencies in the immunization record, the school shall:
 - (i) place the student on conditional enrollment, in accordance with Section 53G-9-308; and
 - (ii) within five days after the day on which the school places the student on conditional enrollment, provide the written notice described in Subsection 53G-9-308 (2).
- (3) A school from which a student transfers shall provide the student's immunization record to the student's new school upon request of the student's legally responsible individual.

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APPENDIX A – UTAH IMMUNIZATION STATUTES AND RULES

53G-9-308. Conditional enrollment -- Suspension for noncompliance -- Procedure.

- (1) A student for whom a school has not received a complete immunization record may attend the school on a conditional enrollment:
 - (a) during the period in which the student's immunization record is under review by the school; or
 - (b) for 21 calendar days after the day on which the school provides the notice described in Subsection (2).
- (2)(a) Within five days after the day on which a school places a student on conditional enrollment, the school shall provide written notice to the student's legally responsible individual, in person or by mail, that:
 - (i) the school has placed the student on conditional enrollment for failure to comply with the requirements of Subsection 53G-9-302(1);
 - (ii) describes the identified deficiencies in the student's immunization record or states that the school has not received an immunization record for the student;
 - (iii) gives notice that the student will not be allowed to attend school unless the legally responsible individual cures the deficiencies, or provides an immunization record that complies with Subsection 53G-9-302(1), within the conditional enrollment period described in Subsection (1)(b); and
 - (iv) describes the process for obtaining a required vaccination.
- (b) A school shall remove the conditional enrollment status from a student after the school receives an immunization record for the student that complies with Subsection 53G-9-302(1).
- (c) Except as provided in Subsection (2)(d), at the end of the conditional enrollment period, a school shall prohibit a student who does not comply with Subsection 53G-9-302(1) from attending the school until the student complies with Subsection 53G-9-302(1).
- (d) A school principal or administrator:
 - (i) shall grant an additional extension of the conditional enrollment period, if the extension is necessary to complete all required vaccination dosages, for a time period medically recommended to complete all required vaccination dosages; and
 - (ii) may grant an additional extension of the conditional enrollment period in cases of extenuating circumstances, if the school principal or administrator and a school nurse, a health official, or a health official designee agree that an additional extension will likely lead to compliance with Subsection 53G-9-302(1) during the additional extension period.

2018

53G-9-309. School record of students' immunization status -- Confidentiality.

- (1) Each school shall maintain a current list of all enrolled students, noting each student:
 - (a) for whom the school has received a valid and complete immunization record;
 - (b) who is exempt from receiving a required vaccine; and
 - (c) who is allowed to attend school under Section 53G-9-308.
- (2) Each school shall ensure that the list described in Subsection (1) specifically identifies each disease against which a student is not immunized.
- (3) Upon the request of an official from a local health department in the case of a disease outbreak, a school principal or administrator shall:

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- (a) notify the legally responsible individual of any student who is not immune to the outbreak disease, providing information regarding steps the legally responsible individual may take to protect students;
 - (b) identify each student who is not immune to the outbreak disease; and
 - (c) for a period determined by the local health department not to exceed the duration of the disease outbreak, do one of the following at the discretion of the school principal or administrator after obtaining approval from the local health department:
 - (i) provide a separate educational environment for the students described in Subsection (3)(b) that ensures the protection of the students described in Subsection (3)(b) as well as the protection of the remainder of the student body; or
 - (ii) prevent each student described in Subsection (3)(b) from attending school.
- (4) A name appearing on the list described in Subsection (1) is subject to confidentiality requirements described in Section 26-1-17.5 and Section 53E-9-202.

2018

Title 53E - Public Education System -- State Administration
Chapter 3 - State Board of Education Organization, Powers, and Duties
Part 9 - Interstate Compact on Educational Opportunity for Military Children
Section 905 - Article IV -- Educational records and enrollment -- Immunizations -- Grade level entrance.

Effective 1/24/2018 **53E-3-905. Article IV — Educational records and enrollment — Immunizations — Grade level entrance.**

- (1) Unofficial or "hand-carried" education records. In the event that official education records cannot be released to the parents for the purpose of transfer, the custodian of the records in the sending state shall prepare and furnish to the parent a complete set of unofficial educational records containing uniform information as determined by the Interstate Commission. Upon receipt of the unofficial education records by a school in the receiving state, the school shall enroll and appropriately place the student based on the information provided in the unofficial records pending validation by the official records, as quickly as possible.
- (2) Official education records or transcripts. Simultaneous with the enrollment and conditional placement of the student, the school in the receiving state shall request the student's official education record from the school in the sending state. Upon receipt of this request, the school in the sending state will process and furnish the official education records to the school in the receiving state within 10 days or within such time as is reasonably determined under the rules promulgated by the Interstate Commission.
- (3) Immunizations. Compacting states shall give 30 days from the date of enrollment or within such time as is reasonably determined under the rules promulgated by the Interstate Commission, for students to obtain any immunization required by the receiving state. For a series of immunizations, initial vaccinations must be obtained within 30 days or within such time as is reasonably determined under the rules promulgated by the Interstate Commission.
- (4) Kindergarten and First grade entrance age. Students shall be allowed to continue their enrollment at grade level in the receiving state commensurate with their grade level, including Kindergarten, from a local education agency in the sending state at the time of transition, regardless of age. A student that has satisfactorily completed the prerequisite grade level in the local education agency in the sending state shall be eligible for enrollment in the next highest grade level in the receiving state, regardless of age. Students transferring after the start of the school year in the receiving state shall enter the school in the receiving state on their validated level from an accredited school in the sending state.

Renumbered and Amended by Chapter 1, 2018 General Session

R396-100. Immunization Rule for Students.

R396-100-1. Purpose and Authority.

- (1) This rule implements the immunization requirements of Title 53A, Chapter 11, Part 3. It establishes minimum immunization requirements for attendance at a public, private, or parochial kindergarten, elementary, or secondary school through grade 12, nursery school, licensed day care center, child care facility, family home care, or Head Start program in this state. It establishes:
 - (a) required doses and frequency of vaccine administration;
 - (b) reporting of statistical data; and
 - (c) time periods for conditional enrollment.
- (2) This rule is required by Section 53A-11-303 and authorized by Section 53A-11-306.

R396-100-2. Definitions.

As used in this rule:

“Department” means the Utah Department of Health.

“Early Childhood Program” means a nursery or preschool, licensed day care center, child care facility, family care home, or Head Start program.

“Exemption” means a relief from the statutory immunization requirements by reason of qualifying under Sections 53A-11-302 and 302.5.

“Parent” means a biological or adoptive parent who has legal custody of a child; a legal guardian, or the student, if of legal age.

“School” means a public, private, or parochial kindergarten, elementary, or secondary school through grade 12.

“School entry” means a student, at any grade, entering a Utah school or an early childhood program for the first time.

“Student” means an individual enrolled or attempting to enroll in a school or early childhood program.

R396-100-3. Required Immunizations.

- (1) A student born before July 1, 1993 must meet the minimum immunization requirements of the ACIP prior to school entry for the following antigens: Diphtheria, Tetanus, Pertussis, Polio, Measles, Mumps, and Rubella.
- (2) A student born after July 1, 1993 must meet the minimum immunization requirements of the ACIP prior to school entry for the following antigens: Diphtheria, Tetanus, Pertussis, Polio, Measles, Mumps, Rubella, and Hepatitis B.
- (3) A student born after July 1, 1993 must also meet the minimum immunization requirements of the ACIP prior to entry into the seventh grade for the following antigens: Tetanus, Diphtheria, Pertussis, Varicella, and Meningococcal.
- (4) A student born after July 1, 1996 must meet the minimum immunization requirements of the ACIP prior to school entry for the following antigens: Diphtheria, Tetanus, Pertussis, Polio, Measles, Mumps, Rubella, Hepatitis B, Hepatitis A, and Varicella.

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- (5) To attend a Utah early childhood program, a student must meet the minimum immunization requirements of the ACIP for the following antigens: Diphtheria, Tetanus, Pertussis, Polio, Measles, Mumps, Rubella, Haemophilus Influenza Type b, Hepatitis A, Hepatitis B, Pneumococcal, and Varicella prior to school entry.
- (6) The vaccinations must be administered according to the recommendations of the United States Public Health Service's Advisory Committee on Immunization Practices (ACIP) as listed below which are incorporated by reference into this rule:
- (a) General Recommendations on Immunization: MMWR, December 1, 2006/Vol. 55/No. RR-15;
 - (b) Immunization of Adolescents: MMWR, November 22, 1996/Vol. 45/No. RR-13;
 - (c) Combination Vaccines for Childhood Immunization: MMWR, May 14, 1999/Vol. 48/No. RR-5;
 - (d) Use of Diphtheria Toxoid-Tetanus Toxoid-Acellular Pertussis Vaccine as a Five-Dose Series: Supplemental Recommendations of the Advisory Committee on Immunization Practices: MMWR November 17, 2000/Vol. 49/No. RR-13;
 - (e) Updated Recommendations for Use of Tetanus Toxoid, Reduced Diphtheria Toxoid and Acellular Pertussis (Tdap) Vaccine from the Advisory Committee on Immunization Practices, 2010: MMWR, January 14, 2011/Vol. 60/No. 1;
 - (f) A Comprehensive Strategy to Eliminate Transmission of Hepatitis B Virus Infection in the United States: MMWR, December 23, 2005/Vol. 54/No. RR-6
 - (g) Haemophilus b Conjugate Vaccines for Prevention of Haemophilus influenzae Type b Disease Among Infants and Children Two Months of Age and Older: MMWR, January 11, 1991/Vol. 40/No. RR-1;
 - (h) Recommendations for Use of Haemophilus b Conjugate Vaccines and a Combined Diphtheria, Tetanus, and Pertussis, and Haemophilus b Vaccine: MMWR, September 17, 1993/Vol. 42/No. RR-13;
 - (i) Updated Recommendations of the Advisory Committee on Immunization Practices (ACIP) for the Control and Elimination of Mumps: MMWR, June 9, 2006/Vol. 55/No. RR-22;
 - (j) Updated Recommendations of the Advisory Committee on Immunization Practices (ACIP) Regarding Routine Poliovirus Vaccination: MMWR, August 7, 2009/Vol. 58/No. 30;
 - (k) Prevention of Varicella: MMWR, June 22, 2007/Vol. 56/No. RR-4;
 - (l) Prevention of Hepatitis A Through Active or Passive Immunization: MMWR, May 29, 2006/Vol. 55/No. RR-7;
 - (m) Licensure of a 13-Valent Pneumococcal Conjugate Vaccine (PCV13) and Recommendations for Use Among Children—Advisory Committee on Immunization Practices, (ACIP), 2010: MMWR March 12, 2010/Vol. 59/No. 09; and
 - (n) Prevention and Control of Meningococcal Disease: Recommendations of the Advisory Committee on Immunization Practices (ACIP): March 22, 2013/62(RR02);1-22.

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R396-100-4. Official Utah School Immunization Record (USIR).

- (1) Schools and early childhood programs shall use the official Utah School Immunization Record (USIR) form as the record of each student's immunizations. The Department shall provide copies of the USIR to schools, early childhood programs, physicians, and local health departments upon each of their requests.
- (2) Each school or early childhood program shall accept any immunization record provided by a licensed physician, registered nurse, or public health official as certification of immunization. It shall transfer this information to the USIR with the following information:
 - (a) name of the student;
 - (b) student's date of birth;
 - (c) vaccine administered; and
 - (d) the month, day, and year each dose of vaccine was administered.
- (3) Each school and early childhood program shall maintain a file of the USIR for each student in all grades and an exemption form for each student claiming an exemption.
 - (a) The school and early childhood programs shall maintain up-to-date records of the immunization status for all students in all grades such that it can quickly exclude all non-immunized students if an outbreak occurs.
 - (b) If a student withdraws, transfers, is promoted or otherwise leaves school, the school or early childhood program shall either:
 - (i) return the USIR and any exemption form to the parent of a student; or
 - (ii) transfer the USIR and any exemption form with the student's official school record to the new school or early childhood program.
- (4) A representative of the Department or the local health department may examine, audit, and verify immunization records maintained by any school or early childhood program.
- (5) Schools and early childhood programs may meet the record keeping requirements of this section by keeping its official school immunization records in the Utah Statewide Immunization Information System (USIIS).

R396-100-5. Exemptions.

A parent claiming an exemption to immunization for medical, religious or personal reasons, as allowed by Section 53A-11-302, shall provide to the student's school or early childhood program the required completed forms. The school or early childhood program shall attach the forms to the student's USIR.

R396-100-6. Reporting Requirements.

- (1) Each school and early childhood program shall report the following to the Department in the form or format prescribed by the Department:
 - (a) by November 30 of each year, a statistical report of the immunization status of students enrolled in a licensed day care center, Head Start program, and kindergartens;
 - (b) by November 30 of each year, a statistical report of the two-dose measles, mumps, and rubella immunization status of all kindergarten through twelfth grade students;
 - (c) by November 30 of each year, a statistical report of tetanus, diphtheria, pertussis, hepatitis B, varicella, and the two-dose measles, mumps, and rubella immunization status of all seventh grade students; and

APPENDIX A – UTAH IMMUNIZATION STATUTES AND RULES

- (d) by June 15 of each year, a statistical follow-up report of those students not appropriately immunized from the November 30 report in all public schools, kindergarten through twelfth grade.
- (2) The information that the Department requires in the reports shall be in accordance with the Centers for Disease Control and Prevention guidelines.

R396-100-7. Conditional Enrollment and Exclusion.

A school or early childhood program may conditionally enroll a student who is not appropriately immunized as required in this rule. To be conditionally enrolled, a student must have received at least one dose of each required vaccine and be on schedule for subsequent immunizations. If subsequent immunizations are one calendar month past due, the school or early childhood program must immediately exclude the student from the school or early childhood program.

- (1) A school or early childhood program with conditionally enrolled students shall routinely review every 30 days the immunization status of all conditionally enrolled students until each student has completed the subsequent doses and provided written documentation to the school or early childhood program.
- (2) Once the student has met the requirements of this rule, the school or early childhood program shall take the student off conditional status.

R396-100-8. Exclusions of Students Who Are Under Exemption and Conditionally Enrolled Status.

- (1) A local or state health department representative may exclude a student who has claimed an exemption to all vaccines or to one vaccine or who is conditionally enrolled from school attendance if there is good cause to believe that the student has a vaccine preventable disease, or
 - (a) has been exposed to a vaccine preventable disease; or
 - (b) will be exposed to a vaccine-preventable disease as a result of school attendance.
- (2) An excluded student may not attend school until the local health officer is satisfied that a student is no longer at risk of contracting or transmitting a vaccine-preventable disease.

R396-100-9. Penalties.

Enforcement provisions and penalties for the violation or for the enforcement of public health rules, including this Immunization Rule for Students, are prescribed under Section 26-23-6.

KEY: Immunization, Rules and Procedures

Date of Enactment or Last Substantive Amendment: December 5, 2014

Notice of Continuation: June 7, 2018

Authorizing, Implemented, or Interpreted Law: 53A-11-303; 53A-11-306

APPENDIX B – FREQUENTLY ASKED QUESTIONS



ADMISSION/ENTRY

1. What records are required for school or early childhood program entry?

All children enrolled in a school or early childhood program, nursery school, or preschool MUST have written proof to verify the student's immunizations, exemption, or proof of immunity (history of disease).

Immunization records of students must show:

- (1) information regarding each required vaccination that the student has received, including the date each vaccine was administered verified by a licensed healthcare provider, registered nurse, an authorized representative of a local health department, an authorized representative of the department, or a pharmacist;
- (2) information regarding each disease against which the student has been immunized by previously contracting the disease (healthcare provider document required if the student has immunity against the disease for any required vaccination that the student has not received because the student previously contracted the disease); and
- (3) a Utah vaccination exemption form identifying each required vaccination from which the student is exempt (for medical exemption, students must provide a completed vaccination exemption form AND a written statement signed by a licensed healthcare provider stating that, due to the physical condition of the student, administration of the vaccine would endanger the student's life or health).

NOTE: Every Utah early childhood program and school student file MUST have a Utah School Immunization Record (USIR) on site per UT Admin Code R396-100-4 with all fields completed. If the USIR is kept in an electronic form, it must be up-to-date with the most current immunization information, include any required documents (exemption, proof of immunity, and have all required signatures).

2. How can a student be admitted/enrolled in a school or early childhood program conditionally?

A student who has not provided a school/early childhood program with a complete immunization record at the time of enrollment can attend the school or early childhood program on a conditional enrollment. Conditional enrollment is a period where the student's immunization record is under review by the school or for 21 calendar days after the day a school/early childhood program provides a written notice to a student's legally responsible individual, in-person or by mail. The notice describes the identified deficiencies or states that the school/early childhood program has not received an immunization record for the student and requests the required immunizations to be provided to school within the conditional enrollment period to avoid exclusion.

Students who do not comply at the end of the conditional enrollment period, must be excluded from attending the school/early childhood program until they provide proper documentation of immunization records to the school/early childhood program.

3. Are transfer students required to provide immunization documentation at the time of enrollment to a new school?

Yes. All children transferring from one Utah school to another or from schools outside Utah to a Utah school are required to provide the new school with the appropriate immunization information. Please exercise sound judgment when working with other schools to ensure immunization records are transferred in a timely manner.

APPENDIX B – FREQUENTLY ASKED QUESTIONS



ADMISSION/ENTRY

4. What about homeless students?

Homeless students are like any other student in your school. See the McKinney-Vento Homeless Assistance Act (re-authorized Dec. 2015):

- The school selected must immediately enroll even if unable to produce normally required records for enrollment or while obtaining school records from previous school. 42 U.S.C. § 11432(g)(3)(C)(i)
- Enrolling schools shall contact the school last attended by the student immediately to obtain relevant academic and other records. 42 U.S.C. § 11432(g)(3)(C)(ii)
- If a child or youth experiencing homelessness needs to obtain immunization or other required health records, the enrolling school will immediately refer the parent, guardian, or unaccompanied youth to the local liaison, who will assist in obtaining necessary immunizations or screenings, or immunization or other required health records. 42 U.S.C. § 11432(g)(3)(C)(iii)

Please work closely with your school district's liaison and use your best judgment to ensure these students receive the education they are entitled to and to receive immunizations they need to be protected from vaccine-preventable diseases. Collaboration will continue with the Utah State Office of Education to ensure school districts do not have weighted pupil units withheld for homeless students if there have been concerted efforts to obtain immunizations or immunization records for them. Many of these homeless students have no insurance, and are eligible to receive low- or no-cost immunizations through local health departments using vaccine provided by the Vaccines for Children (VFC) Program. For information on the Utah VFC Program call (801) 538-9450.

5. What is the school/early childhood program immunization record review process at enrollment?

Each school/early childhood program:

- (a) Must request an immunization record for each student at the time the student enrolls in the school/early childhood program.
- (b) Must retain an immunization record for each enrolled student as part of the student's permanent school record.

Within five business days after the day a student enrolls in a school/early childhood program, an individual designated by the school principal or administrator:

- (a) must determine whether the school has received an immunization record for the student;
- (b) must review each student's immunization record to determine whether the record complies with the required immunizations. The record must show the student: 1) has received each vaccination required by the Utah Department of Health under Section 53G-9-305; 2) has immunity against the disease as documented by a healthcare provider for any required vaccination that the student has not received because the student previously contracted the disease; 3) is exempt from receiving the vaccination under Section 53G-9-303; 4) qualifies for conditional enrollment under Section 53G-9-308; or 5) complies with the immunization requirements for military children under Section 53E-3-905.
- (c) Identify any deficiencies in the student's/child's immunization record.
- (d) Place the student/child lacking immunization records or having deficiencies in their immunization records on conditional enrollment.

Within five days after the day the school/early childhood program places the student on conditional enrollment, provide the written notice to the child legally responsible individual via mail or in person.

Students/children can attend school/early childhood program during the conditional enrollment period (21 calendar day). A school/early childhood program from which a student transfers must provide the student's immunization record to the student's/child's new school/early childhood program upon request of the student's/child's legally responsible individual.

APPENDIX B – FREQUENTLY ASKED QUESTIONS

6. What is conditional enrollment and what is the conditional enrollment process?

A student who has not provided a school with a complete immunization record at the time of enrollment can attend school/early childhood program on a conditional enrollment status. Conditional enrollment is a period where the student's immunization record is under review by the school or for 21 calendar days after the day a school/early childhood program provides a written notice to a student's legally responsible individual, in-person or by mail. The notice describes the identified deficiencies or states that the school/early childhood program has not received an immunization record for the student and requests the required immunizations to be provided to school/early childhood program within the conditional enrollment period to avoid exclusion.

Students who do not comply at the end of the conditional enrollment period must be excluded from attending the school/early childhood program until they provide proper documentation of immunization records to school/early childhood program.

During the conditional enrollment the student's/child's legally responsible individual must get the student/child vaccinated, show a record of past vaccination, show a healthcare provider statement as proof of immunity if the child has history of disease for any of the required vaccines, or exempt the student/child for the missing vaccine. Students/children can attend school/early childhood program during the conditional enrollment period.

Conditional enrollment process:

- Starting the day of enrollment, the school/early childhood program has up to five business days to review the immunization record.
- After the above review, if deficiencies in the immunization record exist, the school/early childhood program has five additional days to provide **written notice** to the student's/child's legally responsible individual in person or by mail which:
 - identifies, and requests the required immunizations.
 - provides a written 21-calendar day notice for the immunization records to be provided to avoid exclusion.
- Students who do not comply at the end of the conditional enrollment period must be excluded from attending the school/early childhood program until they provide proper documentation of immunization records to school/early childhood program.

7. Can schools/early childhood programs extend the conditional enrollment period?

Yes, At the end of the conditional enrollment period, a school principal or administrator may grant an additional extension of the conditional enrollment, if:

- (1) the extension is medically necessary to complete all required vaccination doses; and
- (2) the school principal or administrator and a school nurse, a health official, or a health official designee agree that an additional extension will likely lead to compliance with school immunization record requirements during the additional extension period.

APPENDIX B – FREQUENTLY ASKED QUESTIONS

8. What is the process for claiming an exemption from the required vaccines?

Students/children claiming an exemption from the required vaccinations must have their legally responsible individual complete an on-line educational module (free of charge), or in-person consultation (fee of up to \$25) at a local health department, AND provide a copy of the completed form to the school/early childhood program official. *Completion of the online educational module or in-person consultation at a local health department must be completed for all types of exemptions.*

- Utah allows for three types of exemptions: medical, personal, or religious.
- The legally responsible individual who claims the exemption for the student/child must complete the online education module, free of charge at immunize.utah.gov AND present a copy of the vaccination exemption form to the school/early childhood program.
- If the legally responsible individual who claims the exemption for the student/child declines to take the online education module, he/she can obtain a vaccination exemption form from a local health department and receive an in-person consultation. There is a fee of up to \$25 to cover the costs of providing an in-person consultation.
- For a **medical exemption** from required immunizations, the student's/child's legally responsible individual must provide to the student's/child's school/early childhood program a completed Utah vaccination exemption form **AND** a written statement signed by a licensed healthcare provider stating that, due to the physical condition of the student/child, administration of the vaccine would endanger the student's/child's life or health.
- For **personal/religious** exemption from the required vaccinations, the student's/child's legally responsible individual must provide to the student's/child's school/early childhood program a completed Utah vaccination exemption form, stating that the student/child is exempt from vaccination because of a personal or religious belief.
- A copy of the vaccination exemption form must be attached to the Utah School Immunization Record (USIR) and filed in the student's cumulative folder. A written statement from a licensed healthcare provider must also be attached to the USIR if a medical exemption is claimed.

9. When should students/children renew their exemption forms?

When the student is eligible to enroll in kindergarten or the student turns six years old. Also when the student enrolls in 7th grade or the student turns 12 years old.

- Utah vaccination exemption forms provided to a preschool or early childhood program do not need to be renewed as long as the child is in preschool or any early childhood program - even if the child changes preschools or early childhood programs. However, if a child changes schools and is old enough to enroll in kindergarten or the child turns six years old, the child must renew his/her vaccination exemption form. In other words - children must renew their vaccination exemption forms for kindergarten entry.
- Once an exemption form is received at any point from grade 7 on, the form is valid until the student graduates from high school - even if the student changes schools. No need for exemption renewal.
- Exemption forms obtained through the completion of the online education module are valid for no less than two years. For example, if a student obtains an exemption form in 6th grade, that student does not need to renew his/her exemption form for 7th grade entry.

10. **Some parents or schools have the signed outdated Utah School Immunization Record card for history of chickenpox disease for their students. Since the Utah School Immunization Record card was signed by these parents prior to July 1, 2018, can school/child care facilities accept them as proof of immunity now that the Rule has changed?**

Yes. Schools/child care facilities can accept the old signed Utah School Immunization Record cards as proof of immunity for chickenpox disease only.

APPENDIX B – FREQUENTLY ASKED QUESTIONS

11. What if a student/child has previously been diagnosed by a physician with a vaccine-preventable disease?

If the student/child has immunity against the disease for which the vaccination is required, *because the student has previously contracted the disease*, a letter from a healthcare provider must be provided to the school/early childhood program verifying the diagnosis. Schools/early childhood programs must attach the immunity document from the healthcare provider to the Utah School Immunization Record.

12. Are schools/early childhood programs required to maintain a current list of all students' immunization status?

Yes. Each school/early childhood program must maintain a current list of all enrolled students, including:

- List of students the school has received a valid and complete immunization record;
- List of students who are exempt from receiving a required vaccine;
- List of students who are allowed to attend school/early childhood program under conditional enrollment status; and
- List that specifically identifies each disease against which a student is not immunized.

Upon the request of an official from a local health department in the event of a disease outbreak, a school principal or administrator must:

- (a) notify the legally responsible of any student who is not immune to the outbreak disease, providing information regarding steps the legally responsible individual may take to protect students;
- (b) identify each student who is not immune to the outbreak disease; and
- (c) for a period determined by the local health department not to exceed the duration of the disease outbreak, do one of the following at the discretion of the school principal or administrator after obtaining approval from the local health department:
 - (i) provide a separate educational environment for non-immune students, that ensures the protection of the non immune students as well as the protection of the remainder of the student body; or
 - (ii) prevent each student who is not immune to the outbreak disease from attending school.

A name appearing on the list of all the enrolled students is subject to confidentiality requirements described in Section 26-1-17.5 and Section 53E-9-202.

13. What is the definition of legally responsible individual?

Legally responsible individual is defined as a parent or parents, a legal guardian, or adult sibling of a student/child who has no legal guardian.

APPENDIX B – FREQUENTLY ASKED QUESTIONS



EXEMPTIONS

1. Are there any allowable exemptions?

Yes. The Utah Immunization Rule for Students allows an exemption to be claimed for medical, religious, or personal reasons. Exemptions are allowable for enrollment use in early childhood programs or public, private, charter, and parochial schools for kindergarten through twelfth grade.

2. Are exempted children to be excluded from school in the event of an outbreak?

Yes. In the event of an outbreak, children who are conditionally enrolled, extended conditionally enrolled, out of compliance, or those who have claimed an exemption and have not received the immunization for which there is an outbreak should be encouraged to complete immunizations or should be excluded from school/early childhood program.

3. We have some students that their exemption form states they are exempt from all the required vaccines. These students have been receiving vaccines since they submitted their exemption form to school and are current with some of the school immunization requirements. Therefore, they are technically no longer exempt from all the required vaccines but are still exempt from some. What is the best thing for schools to do in this scenario?

For vaccine-preventable outbreak investigation of exempt students, accurate reporting, and auditing purposes, it is better for parents of these students to update the exemption form to reflect the current immunization or exemption status of these students.



IMMUNIZATION RECORD REVIEW AND REPORTING

1. Can a school or early childhood program maintain immunization records in a computer database ONLY?

No. According to the Utah Immunization Rule for Students (R396-100-4), the Utah School Immunization Record (USIR), is the official school immunization record for all students who are enrolled in any early childhood program, public, private, charter, or parochial school. This USIR card should be used to verify a student's immunization status. The Utah Statewide Immunization Information System (USIIS) provides a way for schools and other facilities to have access to immunization records statewide and to track and record immunizations. A school or early childhood program may enroll to use USIIS and print out the USIR for the student's file from USIIS. Unless a school or early childhood program enrolls and uses USIIS, a USIR card shall be completed and placed in the student's cumulative file. If a school has a database, it may be used to track student follow-up and may generate reports—if it is done correctly. However, a USIR card must be in each student's cumulative file as a backup. A print out from the database is not acceptable. For questions about USIIS or to enroll your school or program in USIIS, contact the Utah Immunization Program at (801) 538-9450.

2. Where can I get USIR cards?

You can now print the USIR card from our Program website at immunize.utah.gov/order-educational-materials.

3. What about the USIR card filling?

Schools must use the most current version of the USIR card (07/2020) for students entering kindergarten, 7th grade and students transferring from another state. If an existing student has an older version of the USIR and the student is required to have a vaccine that is not on the USIR on file, schools must use the most current USIR (07/2020) and transfer all the old information onto the most current version of USIR or staple the new USIR to the old one.

APPENDIX B – FREQUENTLY ASKED QUESTIONS

Schools must also attach the following information to the current USIR form: immunity verification statement, Utah vaccination exemption form, or previous USIR card that has parent signature for chickenpox verification.

4. A child received vaccinations in another country. Can those records be accepted?

They can be accepted IF the same dosing schedule that is used in the U.S. was used. Often, foreign countries use a different schedule than in the U.S. The Utah Immunization Rule is based on the schedule that is used in the U.S.

5. Is a school-age student attending an early childhood program required to have an immunization record on file at that facility?

Yes. A current immunization record must be maintained on EVERY child attending an early childhood program.

6. Are schools required to maintain immunization records for preschool children?

Yes. Preschool children attending a public or private school must have an immunization record on file with the school.

7. A parent is adamant that his/her child has been vaccinated, but cannot provide written documentation. Can the child be admitted into school or an early childhood program?

Yes, the child can be “conditionally enrolled” and the facility has the responsibility to follow the requirements for conditionally enrolling the children.

8. A parent has a partial record and/or statement signed by a physician stating, “All doses received,” “Complete,” “Up To Date,” “Primary series complete,” or other similar statements. Can this be accepted as proof of immunization?

No. Statements regarding immunizations that do not contain complete dates for all doses received are NOT adequate for attendance. The parent should contact their healthcare provider and request a new record documenting all vaccinations and dates administered.

9. What is the four-day grace period?

The four-day grace period was implemented in the 2002 General Recommendations from the U.S. Advisory Committee on Immunization Practices. The four-day grace period should be used for auditing purposes only. It allows the record reviewer to give a four-day grace period if a dose of any vaccine was given too early. Four days is the limit. It should not be used to schedule succeeding doses of vaccine. It should be used with discretion and with the understanding it is for auditing purposes only. *The four-day “grace period” should not be applied to the 28-day interval between live vaccines not administered at the same visit.*

10. We occasionally encounter teen-agers who received 4 doses of IPV before their fourth birthday. Should we recommend a 5th dose of IPV for these children?

Generally, no. ACIP revised its recommendation for IPV in June 2009 to include a dose at 4 through 6 years regardless of the number of doses prior to age 4 years. However, ACIP did not recommend retroactive application of the new minimum age rule for the fourth dose. For children receiving their fourth dose prior to August 7, 2009, four doses separated by at least 4 weeks is sufficient, unless the teenager is traveling to a polio-endemic area (Reference: http://www.immunize.org/askexperts/experts_pol.asp).

APPENDIX B – FREQUENTLY ASKED QUESTIONS

11. Should special education students be included in annual immunization reports?

Students in special education programs should follow requirements for the grade they are in. If these students are not associated with a specific grade, they should follow the requirements for students who are about the same age.

Students over 18 years of age in a special education program who have not completed high school should follow the immunization requirements for students who are about the same age. All these students must be included in the annual immunization reports.

Schools should not include post high school students enrolled in special programs in the annual immunization reports.

12. The immunization record shows that some vaccines were given at intervals longer than those recommended. Do these vaccines need to be repeated?

No. All doses given at intervals *longer* than recommended are valid doses. A longer interval does not affect the effectiveness of a vaccine.

13. How does Utah determine the required immunization schedule?

Utah's Immunization Rule for Students is based upon the "Recommended Childhood Immunization Schedule" published by the Centers for Disease Control and Prevention (CDC). This schedule is developed from the recommendations of the National Advisory Committee on Immunization Practices (ACIP). The ACIP includes representatives from both the public health and the private medical sectors, including the American Academy of Pediatrics (AAP) and the American Academy of Family Physicians (AAFP). To establish Utah's requirements, the Utah Scientific Vaccine Advisory Committee evaluates the ACIP recommendations and determines their appropriateness/feasibility to Utah's unique situations and makes recommendations to the Utah Department of Health as to which immunizations should be required for school entry.

14. Why must vaccines be repeated if received before the minimum age or interval?

Children who receive vaccines before the minimum age or interval may not develop an adequate antibody response to the immunization. Therefore, even though a child physically received a "shot," it may have been ineffective in protecting the child against disease. By consistently maintaining the minimum age and interval requirement for all vaccines, children are more likely to develop adequate immunity. Refer to the minimum age and interval chart on page 28.

15. If a dose of DTaP or Tdap is inadvertently given to a child/student for whom the product is not indicated (e.g., wrong age group), how do we rectify the situation?

- Tdap given to a child younger than age seven years as either dose 1, 2, or 3, is NOT valid. Repeat with DTaP as soon as feasible.
- Tdap given to a child younger than age seven years as either dose 4 or 5 can be counted as valid for DTaP dose 4 or 5.
- **DTaP inadvertently administered at or after 7 years:**
 - Children age 7–9 years:** DTaP may count as part of catch-up series. Routine Tdap dose at age 11-12 years should be administered.
 - Children age 10-18 years:** Count dose of DTaP as the adolescent Tdap booster.
- **Tdap administered at 7-10 years of age:**
 - Children age 7-9 years** who receive Tdap should receive the routine Tdap dose at age 11-12 years.
 - Children age 10 years** who receive Tdap do not need to receive the routine Tdap dose at age 11-12 years.

*Fully vaccinated = 5 valid doses of DTaP or 4 valid doses of DTaP if dose 4 was administered at age 4 years or older.



COMPLIANCE ISSUES

1. What criteria are used to determine whether a student is in compliance with Utah's immunization requirements?

To determine if a student meets the requirements of the Utah Immunization Rule for Students, the following must be considered:

- (a) the student's age;
- (b) whether the student is in a school or early childhood program (requirements may differ depending on which facility the student is attending; i.e., Hib is not required for entry into kindergarten).
- (c) whether the student's immunization history indicates:
 - (i) verification by a a liscenced healthcare provider, registered nurse, an authorized representattive of a local health department, an authorized representative of the department, or a pharmacist.
 - (ii) month, day, and year each vaccine was administered.
 - (iii) sufficient spacing intervals between doses.
- (d) whether the student has claimed an exemption and submitted a copy to the school or early childhood program.
- (e) if the child has immunity from any required vaccines and submitted a statement from a licensed healthcare provider.

It is difficult to describe all possible situations that a school or early childhood program might encounter in its efforts to maintain compliance with the regulations and limit the spread of vaccine-preventable diseases. If you have specific questions that cannot be answered by this guidebook, please call the Utah Immunization Program for consultation.

2. Who is responsible for proper immunization compliance?

Legally Responsible Individual of the student/child:

- (a) is responsible for obtaining all age-appropriate immunizations for their children and providing valid immunization records to the school or early childhood program.

Principal/Early Childhood Program Official:

- (a) has the ultimate responsibility to ensure students attending school or early childhood programs are in compliance with Utah's immunization requirements; this includes assuring valid immunization records are complete and on file at the school or early childhood program and that follow-up for additional information (records or doses) is accomplished when necessary.
- (b) shall exclude students who are out-of-compliance after notifying the parent or guardian that the student is out-of-compliance and will be excluded from school.
- (c) is responsible to ensure the annual immunization reports are submitted to the Utah Department of Health. See Section 5 starting on page 56 for information regarding annual reports.

3. Can a school scan the Utah School Immunization Record (USIR), exemption form, and health care provider documentation for history of disease if the school only uses electronic student cumulative folder/school permanent record file?

Yes, maintaining an electronic/scanned copy of the USIR, student exemption form, and health care provider documentation for history of disease as part of the student's permanent cumulative record meets the Utah Statutory Code. This eliminates the need for a hard copy record to be kept on file because everything is electronic. If the USIR is kept in an electronic form, it must be up-to-date with the most current immunization information, including any required documents, and have all required signatures.

When a district uses electronic student cumulative folder all the following criteria must be met:

- School personnel signed USIR, exemption form, and health care provider documentation for history of disease must be checked for accuracy before scanning into the file;
- The electronic copy of the USIR, student exemption, and health care provider documentation for history of disease must be made available to the Utah Department of Health (UDOH) or local health departments as required for audit and to verify immunization records/exemptions/history of disease if an outbreak occurs for excluding all non-immunized students or exempt students; and
- The electronic copy of the USIR, student exemption form, and health care provider documentation for history of disease follows the student through his or her school career and must be sent to any transfer school upon the request of the student's legally responsible individual (53G-9-306).

APPENDIX B – FREQUENTLY ASKED QUESTIONS



RESOURCES

1. Where can I find more information about immunizations?

Contact the Utah Immunization Program or visit our website at immunize.utah.gov. This guidebook is available on the website. Please visit the website periodically to learn more about the latest on immunization issues.

Utah Immunization Program

Phone: (801) 538-9450 or Fax (801)538-9440 Immunization Hotline: 1-800-275-0659

Address:

Utah Immunization Program

288 North 1460 West

P.O. Box 142012

Salt Lake City, Utah 84114-2012

2. What other sources of information are available on the internet?

There are many sources for great information on the internet. See the following list for some examples.

American Academy of Pediatrics (AAP) – Policy statements, student, community information, “Red Book” order information. www.aap.org

Bill & Melinda Gates Children’s Vaccine Program – A non-profit organization which focuses on children in developing countries, but information is also applicable in the United States.

www.gatesfoundation.org

Centers for Disease Control and Prevention (CDC) – Several websites and phone numbers with timely and accurate information for students, parents, the community, and school nurses.

CDC Home Page – www.cdc.gov

In the News (announcements, hot topics, etc.)

Health information

Publications, software, and products

Electronic Emerging Infectious Disease Journal

CDC Prevention Guidelines

Advisory Committee on Immunization Practices (ACIP) - vaccine recommendations, access to individual state immunization program home pages

International Travel – online health information and recommended immunizations by geographic areas; the latest news on international disease outbreaks. The most recent “*Health Information for International Travel*” (the Yellow Book). www.cdc.gov/travel

APPENDIX B – FREQUENTLY ASKED QUESTIONS

National Center for Immunization and Respiratory Diseases (NCIRD) (Formerly the National Immunization Program) – Upcoming events, announcements, publications, including *Epidemiology and Prevention of Vaccine-Preventable Diseases*” (the Pink Book), Vaccine Information Statements (VIS), Clinic Assessment Software Application (CASA), Vaccine Safety Information.

www.cdc.gov/vaccines

Hepatitis Branch – www.cdc.gov/hepatitis

Spanish Language – www.cdc.gov/spanish

Morbidity and Mortality Weekly Report (MMWR) – Free subscription via email. www.cdc.gov/mmwr

Children’s Hospital of Philadelphia (CHOP) – Vaccine Education Center; great resources for families and professionals www.vaccine.chop.edu

Immunization Action Coalition (IAC) – Dependable source on a variety of immunization issues

Home Page – www.immunize.org

General Resources – www.immunize.org/resources

IAC Express – Free email news services express@immunize.org

Vaccine Information Statements (VIS) – English and many other languages

www.immunize.org/vis

National Alliance for Hispanic Health – Immunizations for All Ages Programs; a great Hispanic immunization resource for schedules, news briefs, videos. www.hispanichealth.org or call 202-387-5000.

The Food and Drug Administration (FDA) – Vaccine Adverse Events Reporting System (VAERS) This site explains this safety system and provides vaccine information. www.vaers.hhs.gov

FDA Information – 1-888-FDA-INFO (1-888-463-6332)

The National Network for Immunization Information – www.immunizationinfo.org

The Vaccine Page – www.vaccines.org

Toll Free Numbers

CDC Immunization Information – 1-800-CDC-INFO (1-800-232-4636)

FDA Information – 1-888-FDA-INFO (1-888-463-6332)

APPENDIX C – COMMUNICATION WITH PARENTS



The following pages are sample letters that may be used to notify parents of immunization requirements. These letters may be modified by adding local letterhead, clinic hours, phone numbers, etc.

- (1) Early Childhood Program Immunization Requirements**
- (2) English “Exclusion Notice” for Inadequate Immunizations**
- (3) Spanish “Exclusion Notice” for Inadequate Immunizations**
- (4) English “21-Day Conditional Enrollment Notice”**
- (5) Spanish “21-Day Conditional Enrollment Notice”**



Early Childhood Program Immunization Requirements

Date:

Dear Parent/Guardian:

Utah law requires children attending this Early Childhood Program or facility be appropriately immunized for their age against the following vaccine-preventable diseases:

Diphtheria	Measles
Pertussis	Mumps
Tetanus	Rubella
Polio	Haemophilus influenzae type b (Hib)
Hepatitis A	Pneumococcal
Hepatitis B	Varicella (Chickenpox)

It is your responsibility to have your child immunized and to provide this facility with a medically verified, date- and dose-specific immunization record for all required immunizations he/she has received. This is required for admission to this facility.

Factors regarding when your child gets which doses of vaccine include:

- current age of child;
- when he/she began the immunization series; and
- grade, if he/she attends school.

For specific information on which immunizations your child should receive, please consult with your child's healthcare provider.

Sincerely,



Exclusion Notice For Inadequate Immunizations

Date:

Dear Parent/Guardian:

A recent review of immunization records shows that your child, (NAME), is currently not in compliance with Utah's School Immunization Law for Students (53G-9-302). Therefore, under Utah Statutory Code 53G-9-308, your child will be excluded from attending school on mm/dd/yyyy. We regret that we have taken this action but state law requires that children must be appropriately immunized in order to attend a Utah school or early childhood program. Our facility supports this policy. Please obtain complete dates for the indicated immunizations and provide a record to us. If your child is not immunized due to medical, religious, or personal reasons, you are required to provide us the appropriate exemption form. If your child has immunity against the disease for which the vaccination is required because your child previously contracted the disease, you need to provide us a document from a healthcare provider verifying that. Your child can not attend school until we have this information.

Vaccine	Dose in Question (circle dose number)	Reason (see codes to right)
DTaP/DT/Td*	1 2 3 4 5	
Tdap*	1	
Polio	1 2 3 4	
MMR (Measles, Mumps, Rubella)	1 2	
Hepatitis B	1 2 3	
Haemophilus influenzae type b (Hib)	1 2 3 4	
Varicella (Chickenpox)	1 2	
Hepatitis A	1 2	
Pneumococcal (PCV)	1 2 3 4 5	
Meningococcal Conjugate	1	

- A. Dates or doses are missing or incomplete.
- B. Previous dose(s) was/were given too close together.
- C. Previous dose(s) was/were given at too young an age.

*D = Diphtheria
*T = Tetanus
*P = Pertussis

If you have questions or need additional information, please call (TELEPHONE NUMBER).

Sincerely,

Name

Title



Notificación de Exclusión por Inmunizaciones Inadecuadas

(DATE)

Estimados Padres/Guardianes:

Una revisión reciente de los registros de vacunación muestra que su hijo, (NAME), actualmente no cumple con la Ley de Inmunización Escolar para Estudiantes del estado de Utah (53G-9-302). Por lo tanto, bajo el Código Estatutario de Utah 53G-9-308, su hijo no podrá seguir asistiendo a la escuela a partir de (mm/dd/yyyy). Lamentamos tener que haber tomado esta medida, pero la Ley Estatal exige que los niños y niñas tengan las vacunas adecuadas para poder asistir a una escuela o un programa para la primera infancia en el estado de Utah. Nuestra institución apoya esta política. Por favor obtenga las fechas completas para las vacunas indicadas y provéanos con un registro. Si su hijo/a no está vacunado por razones médicas, religiosas o personales, tiene que proveernos del formulario de exención correspondiente. Si su hijo/a tiene inmunidad contra la enfermedad para la cual se requiere la vacuna debido a que su hijo/a contrajo previamente dicha enfermedad, tiene que proveernos un documento de un proveedor de atención médica que así lo verifique. Su hijo/a no puede asistir a la escuela hasta que tengamos esta información.

LAS CAJETILLAS MARCADAS ABAJO INDICAN LAS DOSIS QUE SE REQUIEREN PARA EL REGISTRO DE SU NIÑO/A.

Vacuna	Dosis faltante (haga un círculo alrededor del número de la dosis faltante)					Razón (vea códigos en columna derecha)
DTaP/DT/Td *	1	2	3	4	5	
TDap (Refuerzo)*			1			
Polio	1	2	3	4		
MMR (Sarampión, Paperas, Rubéola)		1	2			
Hepatitis B	1	2	3			
Haemophilus Influenzae Tipo b (Hib)	1	2	3	4		
Varicela		1	2			
Hepatitis A		1	2			
Pneumocócica (PCV)	1	2	3	4	5	
Meningocócica			1			

- A. Las fechas y dosis faltan o están incompletas.
- B. Las dosis previas fueron hechas con muy poco tiempo de por medio.
- C. Las dosis previas fueron hechas a una edad demasiado temprana.

*D = Difteria
 *T = Tétano
 *P = Pertussis

Si tiene preguntas o requiere información adicional, sírvase llamar (TELEPHONE NUMBER).

Sinceramente,

Name

Title



21-Day Conditional Enrollment Notice

Date:

To the legally responsible individual of _____.

The purpose of this letter is to inform you that in review of your student/child immunization record we have noticed that we did not receive all or some of the required immunization records for school/early childhood program entry. This information is required by the Utah Statutory Code 53G-9-302. Therefore, we have placed your student/child on a conditional enrollment status in accordance with Utah Statutory Code 53G-9-308. This means that you have 21 calendar days to bring proof of immunizations, an exemption form, or proof of immunity from diseases that vaccines are required for to the school/early childhood program your student/child attends. Please provide this information to us by _____. Your student/child is allowed to attend school/early childhood program during the **21-day** calendar day conditional enrollment period.

Your child is missing the following immunization (s):

- DTaP (D=Diphtheria, Tetanus, and Pertussis)
- Tdap
- Polio
- MMR (Measles, Mumps, Rubella)
- Hepatitis A
- Hepatitis B
- Haemophilus influenzae type b (Hib)
- Varicella (chickenpox)
- Pneumococcal
- Meningococcal Conjugate
- No immunization record

Possible places to take your child to receive the missing required immunization (s): his/her healthcare provider, your local health department immunization clinic, or your local pharmacy.

If you want to obtain a vaccination exemption form, you must either complete the on-line Utah exemption module at immunize.utah.gov and print the vaccination exemption form after completion, or visit your local health department to obtain an exemption form for your child. You may have to pay a fee, if you choose to complete the exemption form in person from a local health department. A copy of the exemption form must be presented to the school/early childhood program. For a medical exemption from vaccination, you must present to the school a completed vaccination exemption form **and** a written notice signed by a licensed healthcare provider stating that due to the physical condition of the student, administration of the vaccine would endanger the student's life or health.

If your child has immunity against the disease for which the vaccination is required because your child previously contracted the disease, you need to provide the school/daycare a document from a healthcare provider verifying that.

If we don't receive the above information from you by the date indicated previously, we will be forced to exclude your child from attendance in school/early childhood program under the Utah Statutory Code 53G-9-308.

If you have any questions or concerns, please contact us at (TELEPHONE NUMBER).

Sincerely,

Name

Title (Principal/director/Nurse/secretary designated by the school or early childhood program Principal/director)



Aviso de Matriculación Condicional de 21 Días

Fecha:

Para el individuo legalmente responsable de _____,
El propósito de esta carta es para informarle que al revisar el registro de inmunizaciones de su estudiante/niño hemos notado que no recibimos algunos o todos los registros de inmunización requeridos para que su estudiante/niño pueda ingresar a la escuela/guardería. Esta información es requerida por el Código Estatutario del estado de Utah 53G-9-302. Por lo tanto, hemos colocado a su estudiante/niño en un estado de matriculación condicional de acuerdo con el Código Estatutario 53G-9-308 del estado de Utah. Esto significa que tiene 21 días calendarios para presentar prueba de inmunización, un formulario de exención o prueba de inmunidad contra las enfermedades que son requeridas para que su hijo/a pueda asistir a la escuela/guardería. Por favor proporcione esta información no más tardar del _____. Su estudiante/niño puede asistir a la escuela/guardería durante el período de 21 días calendarios de matriculación.

A su hijo le faltan las siguientes inmunizaciones:

- DTaP (D=Difteria, Tetano y Pertusis)
- Tdap
- Polio
- MMR (Sarampión, Paperas, Rubeola)
- Hepatitis A
- Hepatitis B
- Haemophilus influenzae tipo b (Hib)
- Varicela
- Pneumococcal
- Meningococcal Conjugate
- No tiene registro de inmunizaciones

Lugares a donde puede llevar a su hijo para que reciba las inmunizaciones requeridas faltantes: su proveedor de atención médica, su clínica de inmunización del departamento de salud local o su farmacia local.

Si desea obtener un formulario de exención de vacunación, debe completar el módulo de exención en la página web immunize.utah.gov e imprimir el formulario de exención de vacunación después de completarlo el modulo, o visitar su departamento de salud local para obtener un formulario de exención para tu niño. Es posible que tenga que pagar una tarifa si elige completar el formulario de exención en persona en un departamento de salud local. Deberá presentar una copia del formulario de exención a la escuela/guardería. Para una exención médica de vacunación, deberá presentar a la escuela un formulario de exención de vacunación completado y una notificación firmada por un proveedor de servicios de salud con licencia que indique que debido a la condición física del estudiante, la administración de la vacuna puede representar un riesgo para la vida o salud del estudiante.

Si su hijo tiene inmunidad contra la enfermedad para la cual se requiere la vacuna debido a que su hijo contrajo previamente la enfermedad, debe proporcionar a la escuela/guardería un documento emitido por su proveedor de atención médica que así lo certifique.

Si no recibimos la información solicitada en la fecha indicada anteriormente, nos veremos obligados a excluir a su hijo de asistir a la escuela o guardería de acuerdo con el Código Estatutario del estado de Utah 53G-9-308. Si tiene alguna pregunta o inquietud, contáctenos al (NÚMERO DE TELÉFONO).

Sinceramente,

Nombre

Cargo (Director/enfermera/secretaria designada por el director de la escuela o guardería)

APPENDIX D – COMMON VACCINE NAMES



The following table is provided as a reference for school and early childhood program personnel, as well as health care professionals who evaluate immunization records. To lessen any confusion, **providers documenting current vaccines should use generic names** (i.e., DTaP, MMR, Hepatitis B) instead of brand names.

Not every vaccine in this table is required for entry in a Utah school or early childhood program. To verify whether a vaccine is required, see pages 27-29 for the summary of requirements.

Some vaccines listed are not currently in use, but were used in the past. These vaccines are included to assist in evaluating immunization records for compliance.

This list does not include vaccine brands available in other countries. For a complete list of U.S. and Foreign Vaccines, reference the “Epidemiology and Prevention of Vaccine-Preventable Diseases” (Pink Book).

APPENDIX D – COMMON VACCINE NAMES

Vaccine/Combination Vaccine (by Generic Name or Trade Name)	Vaccine Components
ACEL-IMUNE®	Diphtheria/Tetanus/acellular Pertussis
ActHIB®	Haemophilus influenzae type b
Adacel®	Tetanus/Diphtheria/acellular Pertussis
BOOSTRIX®	Tetanus/Diphtheria/acellular Pertussis
COMVAX®	Hepatitis B/Haemophilus influenzae type b
DT	Diphtheria/Tetanus
DTaP	Diphtheria/Tetanus/acellular Pertussis
DTP	Diphtheria/Tetanus/whole cell Pertussis
DAPTACEL®	Diphtheria/Tetanus/acellular Pertussis
Engerix-B®	Hepatitis B
GARDASIL®	Human Papillomavirus
HAVRIX®	Hepatitis A
HibTITER®	Haemophilus influenzae type b
HPV	Human Papillomavirus
INFANRIX®	Diphtheria/Tetanus/acellular Pertussis
IPV / IPOL®	Polio (Inactivated Polio Vaccine)
KINRIX®	Diphtheria/Tetanus/acellular Pertussis, Inactivated Polio Vaccine
Menactra®	Meningococcal Conjugate Vaccine (also called MCV4)
Menomune®	Meningococcal Polysaccharide Vaccine (also called MPSV)
MR	Measles/Rubella
MMR	Measles/Mumps/Rubella
M-M-R II®	Measles/Mumps/Rubella
OPV / ORIMUNE®	Polio (Oral Polio Vaccine)
PEDIARIX™	Diphtheria/Tetanus/acellular Pertussis, Hepatitis B, Inactivated Polio
PedvaxHIB®	Haemophilus influenzae type b
Pentacel®	Diphtheria/Tetanus/acellular Pertussis, Inactivated Polio, Haemophilus influenzae type b
Pneumovax®	Pneumococcal Conjugate Vaccine (also called PPV23)
Prevnar®	Pneumococcal Conjugate Vaccine (also called PCV7)
ProHIBIT™	Haemophilus influenzae type b (only for children ≥ 18 months of age)
ProQuad®	Measles, Mumps, Rubella, Varicella
RECOMBIVAX HB®	Hepatitis B
RotaTeq®	Rotavirus
ROTARIX®	Rotavirus
Td	Tetanus/ Diphtheria (for ≥ 7 years of age)
TETRAMUNE®	Diphtheria/Tetanus/whole cell Pertussis/Haemophilus influenzae type b
TriHIBIT®	Diphtheria/Tetanus/acellular Pertussis/Haemophilus influenzae type b
Tripedia®	Diphtheria/Tetanus/acellular Pertussis
TWINRIX®	Hepatitis A/Hepatitis B
VAQTA®	Hepatitis A
VARIVAX®	Varicella (Chickenpox)



SAMPLE FORMS

The following pages are sample forms which the Utah Immunization Program provides.

- (1) Sample Exemption Form**
- (2) Sample Utah School Immunization Record (USIR) card.**

APPENDIX E – UTAH IMMUNIZATION PROGRAM SAMPLE FORMS

Below is a sample of the vaccination exemption form after completion of the online education module. This vaccination exemption form is also provided to parents who receive an in-person consultation at a local department.

**ACKNOWLEDGMENT OF COMPLETION
VACCINATION EDUCATION**

_____ HAS COMPLETED THE VACCINATION EDUCATION

STUDENT NAME _____

SCHOOL _____

DATE OF BIRTH _____ **DATE COMPLETED** _____

Select an Exemption Reason: Exemptions:

<input type="checkbox"/> Personal	<input type="checkbox"/> Tdap	<input type="checkbox"/> Hib	<input type="checkbox"/> Hep A
<input type="checkbox"/> Medical	<input type="checkbox"/> Hep B	<input type="checkbox"/> Pneumococcal	<input type="checkbox"/> Hep B
<input type="checkbox"/> Religious	<input type="checkbox"/> Polio	<input type="checkbox"/> MMR	<input type="checkbox"/> Meningococcal
		<input type="checkbox"/> Varicella (chickenpox)	

 **UTAH DEPARTMENT OF HEALTH**
Immunization Program

APPENDIX E – UTAH IMMUNIZATION PROGRAM SAMPLE FORMS

Below is a sample of the vaccination exemption form after completion of the online education module. This exemption form is no longer used but schools and early childhood programs must accept it from parents if a parent presents it to them. See the following page for the sample of the most current exemption form.

CERTIFICATE OF VACCINATION EDUCATION

_____ HAS COMPLETED THE VACCINATION EDUCATION

STUDENT NAME _____ DATE OF BIRTH _____

SCHOOL _____ DATE COMPLETED _____

Select an Exemption Reason:

<input type="checkbox"/> Personal	<input type="checkbox"/> DTaP	<input type="checkbox"/> Hib	<input type="checkbox"/> Hep A
<input type="checkbox"/> Medical	<input type="checkbox"/> Tdap	<input type="checkbox"/> Pneumococcal	<input type="checkbox"/> Hep B
<input type="checkbox"/> Religious	<input type="checkbox"/> Polio	<input type="checkbox"/> MMR	<input type="checkbox"/> Meningococcal
	<input type="checkbox"/> Rotavirus	<input type="checkbox"/> Varicella (chickenpox)	

UTAH DEPARTMENT OF HEALTH
Immunization Program

Below is a sample of the vaccination exemption form completed at a local health department. This exemption form is no longer used but schools and early childhood programs must accept it from parents if a parent presents it to them. See the following page for the most current form.

CERTIFICATE OF VACCINATION EDUCATION

_____ HAS COMPLETED THE VACCINATION EDUCATION

STUDENT NAME _____ DATE OF BIRTH _____

SCHOOL _____ DATE COMPLETED _____

AUTHORIZED DOH SIGNATURE _____

Select an Exemption Reason:

<input type="checkbox"/> Personal	<input type="checkbox"/> All	<input type="checkbox"/> Hib	<input type="checkbox"/> Hep A
<input type="checkbox"/> Medical	<input type="checkbox"/> DTaP	<input type="checkbox"/> Pneumococcal	<input type="checkbox"/> Hep B
<input type="checkbox"/> Religious	<input type="checkbox"/> Tdap	<input type="checkbox"/> MMR	<input type="checkbox"/> Meningococcal
	<input type="checkbox"/> Polio	<input type="checkbox"/> Varicella (chickenpox)	<input type="checkbox"/> Rotavirus

UTAH DEPARTMENT OF HEALTH
Immunization Program

APPENDIX E – UTAH IMMUNIZATION PROGRAM SAMPLE FORMS



UTAH SCHOOL IMMUNIZATION RECORD

This record is part of the student's permanent school record (cumulative folder) as defined in Section 53G-9-306 of the Utah Statutory Code and shall transfer with that school record upon request of the student's legally responsible individual. See back for instructions on how to fill out this form.

Student Name _____ **Gender** Male Female **Date of Birth** _____
Name of Parent/Guardian _____
USIS ID _____ **PIN** _____ **Student ID Number** _____

Student Information

Vaccine Information

VACCINE	1 st	2 nd	3 rd	4 th	5 th	Status	Due Date	Exemption
	Record the month, day, & year for each vaccine dose was given.							
DTaP, DTP, DT, Td, Tdap <small>(D-Diphtheria, T-Tetanus, P-Pertussis, aP-acellular Pertussis)</small>								
Tdap								
Polio (IPV or OPV)								
Haemophilus influenzae type b (Hib)								
Pneumococcal								
Measles, Mumps, and Rubella (MMR) <small>1st dose must be received on or after the 1st birthday</small>								
Hepatitis B (HBV)								
Varicella (Chickenpox) <small>1st dose must be received on or after the 1st birthday.</small>								
Hepatitis A (HAV) <small>1st dose must be received on or after the 1st birthday.</small>								
Meningococcal Conjugate (ACWY)								

Immunization record received for this student is from: A statewide registry
 Student's former school
 Legally responsible individual of the student

Authorized Signature: _____ **Date:** _____

Above signature is the signature of the school or health personnel who verified the Utah School Immunization Record (USIR) against the source record(s).

Utah Department of Health
 Division of Disease Control & Prevention
 Immunization Program
immunize.utah.gov
 (801)-538-9450

Rev. 07/2020

Instructions on how to complete the Utah School Immunization Record

All schools and early childhood programs must have a Utah School Immunization Record (USIR) for each enrolled student. The USIR must be completed by hand or printed from the Utah Statewide Immunization Information System (USIIS). For detailed information on the required immunizations and minimum intervals between vaccine doses, refer to the Utah Immunization Guidebook at immunize.utah.gov.

Instructions for Participating USIIS Users

The following fields will be automatically filled in on the USIR when printed by a participating USIIS User:

- **Student Information:** Student Name, Gender, Date of Birth, Name of Parent/Guardian (if entered on the Demographics page), USIIS ID, and PIN (a number that is given to an individual or a dependent's legal guardian, to obtain access to their immunization records in USIIS). The Student ID will only print when printed from a school that is enrolled in USIIS and has the students linked to that specific school.
 - **Vaccine Information:** Dates of vaccines given (1st, 2nd, 3rd, 4th, 5th), Status, and Due Date.
- Completing the Form:** Verify information is correct, print form, and fill in any of the necessary missing information below by hand.
- **Immunization Record Received For This Student:** Mark "A statewide registry". If you used any other records for verification or missing information also mark "Student's former school" and/or "Legally responsible individual of the student".
 - **Proof of Immunity (history of disease):** Mark the status column if the student is claiming immunity against a disease for which vaccination is required because the student previously contracted the disease. A document that includes each antigen being claimed as immune (e.g., varicella, measles, rubella) and signed by a healthcare provider as proof of immunity must be attached to the USIR.
 - **Exemption:** Fill in the exemption column with the type of exemption (religious, personal, or medical) if the student has an exemption. Attach a copy of the exemption form to the back of the USIR. For a medical exemption, a written notice signed by a licensed healthcare provider must also be attached to the USIR.
 - **Authorized Signature/Date:** Sign and date – this is the signature of the school or health personnel who verified the USIR against the source record(s).

Instructions for Non-Participating USIIS Users

- **Student Information:** Fill in the Student Name, Gender, Date of Birth, and Name of Parent/Guardian.
- **NOTE – The USIIS ID, PIN, and Student ID are not required fields to be completed by facilities that are not enrolled in USIIS.**
- **Vaccine Information:** Fill in the dates (month, day, and year in the appropriate column i.e., 1st, 2nd, 3rd, 4th, 5th) for each of the required vaccines the student has received. Ensure these dates have been verified by a licensed healthcare professional, registered nurse, authorized representative of a local health department, and/or pharmacist that is on the immunization record(s) you received for that student.
- **NOTE – Status is only required to be completed if the student has a past history of disease such as chickenpox. Due Date is not a required field to be completed by facilities that are not enrolled in USIIS.**
- **Immunization Record Received For This Student:** Mark the source of the record(s) used to complete this document.
- **Proof of Immunity (history of disease):** Mark the status column if the student is claiming immunity against a disease for which vaccination is required because the student previously contracted the disease. A document that includes each antigen being claimed as immune (e.g., varicella, measles, rubella) and signed by a healthcare provider as proof of immunity must be attached to the USIR.
- **Exemption:** Fill in the exemption column with the type of exemption (religious, personal, or medical) if the student has an exemption. Attach a copy of the exemption form to the back of the USIR. For a medical exemption, a written notice signed by a licensed health care provider must also be attached to the USIR.
- **Authorized Signature/Date:** Sign and date – this is the signature of the school or health personnel who verified the USIR against the source record(s).

For further information, visit the Utah Immunization website at immunize.utah.gov or 801-538-9450.

APPENDIX F - UTAH SCHOOL AND CHILDCARE EMPLOYEE IMMUNIZATION RECOMMENDATIONS

Educational institutions and childcare facilities are potential high-risk areas for transmission of vaccine-preventable diseases. While immunization is an important health requirement for students in Utah schools and childcare facilities, it is equally important for staff in these settings to be protected against vaccine-preventable diseases. Employee immunization can decrease the number of days teachers, staff and students miss due to illness. Absence due to sickness causes disruption in class schedules resulting in missed educational learning opportunities. Most importantly, teachers, staff and students who come to school sick can spread disease, suffer pain, and discomfort. Additionally, vaccine-preventable disease outbreaks in school and childcare settings can result in enormous costs for staff, students, parents, employers and public health.

The Utah Department of Health recommends that prior to employment in Utah schools and licensed childcare facilities, all full- and part-time employees, including teachers, substitute teachers, student teachers, and staff, show proof of vaccination against: Measles, Mumps, Rubella, Hepatitis B, Tetanus, Diphtheria, Pertussis, Influenza, Varicella, and Hepatitis A. This recommendation is in accordance with the recommendations of the Centers for Disease Control and Prevention (CDC) and the Advisory Committee on Immunization Practices (ACIP).

*School districts and childcare facilities are encouraged to keep employee vaccination records on file.

Recommended Immunizations For Teachers and Childcare Staff¹		
Vaccine	Persons Born Before 1957	Persons Born In or After 1957
MMR ² (Measles, Mumps, Rubella)	1 dose for women of childbearing age and for all adults <u>not</u> born in the U.S.	2 doses of MMR, at least 1 month apart
Varicella (Chickenpox) ³	2 doses	
Hepatitis A	2 doses	
Hepatitis B	2 or 3 doses depending on the brand	
Td/Tdap ⁴ (Tetanus, Diphtheria, Pertussis [Whooping Cough])	1 dose of Tdap, then Td or Tdap booster every 10 years	
Influenza	Annual influenza vaccine is recommended for everyone 6 months of age and older	

¹ All full- and part-time teachers, student teachers, substitute teachers and staff.

² Proof of immunity to Measles, Mumps **and** Rubella is recommended for staff of licensed group and family childcare centers. MMR vaccine is recommended for teachers and staff in other school settings.

³ Varicella vaccine is recommended for those who do not have documentation of age-appropriate immunization, a reliable history of varicella disease (physician diagnosis or personal recall) or serologic evidence of immunity.

⁴ All adults should receive a single dose of Tdap, especially those who have close contact with infants less than 12 months of age (e.g., childcare staff). There is no minimum interval between Tdap and a previous dose of Td.

*The Utah Statewide Immunization Information System (USIIS) is a statewide information immunization system that contains immunization histories for Utah residents of all ages. Many school districts and childcare facilities are enrolled in USIIS. Employers can input and maintain their staff immunization status through USIIS. For more information on how to enroll in USIIS, please contact the Utah Immunization Program at 801-538-9450.

February 2020

APPENDIX G – TIPS FOR TALKING TO PARENTS ABOUT VACCINES

A NOTE ON VACCINES FROM YOUR CHILDCARE PROVIDER, PEDIATRICIANS, AND THE UTAH DEPARTMENT OF HEALTH

We value the health and safety of your children. As a state-licensed childcare program, we support and must adhere to state immunization requirements for all children enrolled in our program to ensure their health and safety. It is critical for children attending childcare to receive all recommended vaccines to protect themselves and the other children in our program who are too young to be fully immunized.

Why immunizations are so important for children in childcare settings

- Children younger than five years of age are especially at risk for getting infections because their immune systems have not yet built up the defenses to fight infection. Immunizations help children build up these defenses.
- Many childcare programs include children less than one year of age. These children are at highest risk for getting vaccine-preventable infections because they are still receiving important immunizations. For example, children aren't fully protected against pertussis (whooping cough) until they are six months old. If infants less than six months of age are exposed to someone with whooping cough, they are at high risk for becoming infected and having serious illness or even death.

Rules and recommendations

- Utah requires your childcare provider to have *written proof* of each child's vaccines. A parent may get an exemption for their child to not be vaccinated. Your childcare provider must also have *written proof* (a legally valid exemption form) for all exemptions.
- Disease outbreaks sometimes occur in childcare programs. If there is even one case of a vaccine-preventable disease at your child's child care program, children for which the facility does not have *written proof* of the child's up-to-date status will be excluded from childcare until the child is vaccinated or risk of the disease has passed (sometimes up to 21 days).

Vaccine safety and effectiveness

- All vaccines undergo long and careful review.
- Vaccines do not cause autism. Many independent studies have convincingly shown that there is no link between autism and vaccines.
- No vaccine, or *any* medication or treatment, is completely risk-free. Common side effects (tenderness and redness) are mild, but serious side effects (such as allergic reactions) are very rare.
- When parents choose not to vaccinate their child, they are trading the small risk of side effects from the vaccine for the risk of getting a vaccine-preventable disease. Vaccines keep disease away; when we stop giving them, diseases that can be prevented by vaccines return.
- While some diseases, like measles are not common in Utah, they are only a plane ride away.

More information

- Free or low-cost vaccines are available for those who qualify through the Utah Vaccines for Children (VFC) Program <https://immunize.utah.gov/vaccines-for-children-program/>
- For more information on vaccines and the diseases they prevent, contact your healthcare provider or the Utah Immunization Program at 1-800-275-0659 or visit immunize.utah.gov.

02/2020



APPENDIX G – HOW DO I FILL OUT THE UTAH SCHOOL IMMUNIZATION RECORD (USIR)?

How do I fill out the Utah School Immunization Record (USIR)?

Did you know...?

School & childcare student files must have a USIR.

Every Utah school and early childhood program student file **MUST** have a USIR (UT Admin Code R396-100-4). If the USIR is kept in an electronic form it must be up-to-date with the most current immunization information, any required documents (see 3 & 4 below), and have all the required signatures.

A list of students' immunization statuses must be kept.

You must maintain a current list of all enrolled students' immunization statuses including students conditionally enrolled, extended conditionally enrolled, out of compliance, with a history of disease, and students who are exempt from receiving the required vaccines (UT Admin Code R396-100-4 [3a]).

Participating USIIS users can print out auto-filled USIRs.

Two of the main sections, 'Student Information' and 'Vaccine Information' will be automatically filled in on the USIR when printed by a participating USIIS user. To access forms on USIIS go to apps.usiis.org and click on USIIS Immunize. To print out blank forms go to immunize.utah.gov/order-educational-materials.

For compliance ensure all required fields in sections 1-5 are complete.

1. Student Information: Every USIR needs to have the student's name, gender, date of birth, and name of a parent/guardian to be considered a complete record. Write in any information that is missing.

**NOTE - USIIS ID, PIN, and Student ID Number are not required fields for facilities not enrolled in USIIS.*

2. Vaccine Information: All required immunizations must be included on the USIR. If there are missing doses on the USIR, but proof of the shots are in the student's file, their USIR will still be considered noncompliant for documentation. The USIR is the official school record. Immunization histories, yellow cards, and other doctor forms are supportive documents.

**NOTE - Due Date is not a required field for facilities not enrolled in USIIS and Status is only a required field if they are claiming an immunity (see 4 below).*

UTAH SCHOOL IMMUNIZATION RECORD

This record is part of the student's permanent school record (cumulative folder) as defined in Section 53G-9-309 of the Utah Statutory Code and shall transfer with that school record upon request of the student's legally responsible individual. See back for instructions on how to fill out this form.

1 Student Information

Student Name _____ Gender Male Female Date of Birth _____
 Name of Parent/Guardian _____
 USIIS ID _____ PIN _____ Student ID Number _____

Vaccine Information

VACCINE	Record the month, day, & year for each vaccine dose was given					Status	Due Date	Exemption
	1 st	2 nd	3 rd	4 th	5 th			
DTap, DTP, DT, Td, Tdap (Diphtheria, Tetanus, Polio, Pertussis)								
Tdap								
Polio (IPV or OPV)								
Haemophilus influenzae type b (Hib)								
Pneumococcal								
Measles, Mumps, and Rubella (MMR) (1 st dose must be recorded on or after the 1 st birthday)								
Hepatitis B (HBV)								
Varicella (Chickenpox) (1 st dose must be recorded on or after the 1 st birthday)								
Hepatitis A (HAV) (1 st dose must be recorded on or after the 1 st birthday)								
Meningococcal Conjugate (ACWY)								

Immunization record received for this student is from **5**

A statewide registry
 Student's former school
 Legally responsible individual of the student

Authorized Signature _____ Date _____ **6**

Above signature is the signature of the school or health personnel who verified the Utah School Immunization Record (USIR) against the source records.

Utah Department of Health
 Division of Disease Control & Prevention
 Immunization Program
immunize.utah.gov
 (801) 538-9450
 Rev 07/2020

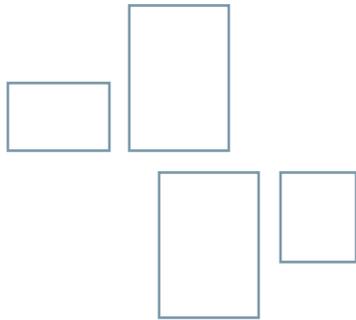
3. Exemptions: Fill in the exemption column with the type of exemption "Religious, Personal, or Medical" if the student has an exemption. The completion of the online immunization education module at immunize.utah.gov or an in-person consultation at a local health department must be done for ALL types of exemptions. Attach a copy of the exemption form to the back of the USIR. For a medical exemption, a written notice signed by a licensed health care provider must also be attached. For more specifics on exemptions refer the Utah Immunization Guidebook at immunize.utah.gov.

4. Proof of Immunity: Fill in the status column with "Immunity" for a claim that a child has immunity against a disease which requires vaccination due to previously contracting the disease. Attach the required document signed by a health care provider to the USIR. For more specifics on proof of immunity refer the Utah Immunization Guidebook at immunize.utah.gov.

5. Record Source, Signature & Date: Every USIR needs to be signed and dated. This is the signature of the school personnel or health personnel who verified the USIR against the record source. Indicate whether the immunization record information was obtained from a statewide registry (e.g., USIIS), the student's former school, and/or the legally responsible individual of the student such as a parents. A USIR without a signature, date, and/or record source is considered an incomplete record.

6. USIR Version: The USIR is periodically updated. At enrollment each student in Kindergarten and 7th grade or any existing student that receives a required vaccine not on their older USIR version must have the most current USIR version. The latest version can be found on the Utah Immunization Program website at immunize.utah.gov/order-educational-materials. Auto filled forms from USIIS (available to USIIS users) will be the most current version.

For more information, visit immunize.utah.gov or call 801-538-9450.



P.O. Box 142012 | 288 North 1460 West | Salt Lake City, UT 84114-2012
1-800-275-0659 or 801-538-9450 | immunize.utah.gov

Acuity

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	
Number of IHP/EAP in place (multiply by 1)		Multiply by 1	
Total Health Conditions Score (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	
	Total	Elementary Formula	Secondary Formula			Score	
B. Enrollment		1-500	1	1-1000		1	
		501-1000	2	1001-2000		2	
		1001-1250	3	2001-3000		3	
		1251+	4	3001+		4	
	Total	Elementary Formula	Secondary Formula			Score	
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	
	Total	Elementary Formula	Secondary Formula			Score	
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	
	Total	Elementary Formula	Secondary Formula			Score	
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	
	Total	Elementary Formula	Secondary Formula			Score	
F. Additional Programs (SpEd self-contained, PK, etc.)			1-2	1	5-6	3	
			3-4	2	7-8	4	
	Total	Elementary Formula	Secondary Formula			Score	
G. Grade Level			Elem	5	High	0	
			Jr/Mid	2	Specialty	5	
TOTAL ACUITY SCORE							
Acuity Score	FTE		Days per Week				
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 1st 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



Preamble: Acknowledging the diversity of the laws and conditions under which school nurses practice, NASN believes in a commonality of moral and ethical conduct.

1. Client Care

The school nurse is an advocate for students, families and members of the school community. To that end, school nurses facilitate positive responses to normal development, promote health and safety, intervene with actual and potential health problems, provide case management services, and actively collaborate with others to build student and family capacity for adaptation, self-management, self-advocacy, and learning. Each individual's inherent right to be treated with dignity and confidentiality is respected. All clients are treated equally regardless of race, gender, socio-economic status, culture, age, sexual orientation, disability or religion.

Interpretive Statements

- A. School nurses deliver care in a manner that promotes and preserves student and family autonomy, dignity and rights.
- B. School nursing services support and promote individuals' and families' ability to achieve the highest quality of life as understood by each individual and family.
- C. School nurses deliver care in a nonjudgmental and nondiscriminatory manner that is sensitive to student diversity in the school community.
- D. School nurses maintain student confidentiality within the legal, regulatory and ethical parameters of health and education.

2. Professional Competency

The school nurse maintains the highest level of competency by enhancing professional knowledge and skills, and by collaborating with peers, other health professionals and community agencies while adhering to the Standards of School Nursing Practice.

Interpretive Statements

- A. The profession of nursing is obligated to provide competent nursing care. The school nurse must be aware of the need for continued professional learning and must assume personal responsibility for currency of knowledge and skills.
- B. School nurses must evaluate their own nursing practice in relation to professional practice standards and relevant statutes, regulations and policies.
- C. It is necessary for school nurses to have knowledge relevant to the current scope of practice. Since individual competencies vary, nurses consult with peers and other health professionals with expertise and recognized competencies in various fields of practice. When in the client's best interest, the school nurse refers clients to other health professionals and community health agencies.
- D. Nurses are accountable for judgements made and actions taken in the course of nursing practice. Professional Standards of School Nursing Practice reflect a practice rounded in ethical commitment. The school nurse is responsible for establishing and maintaining a practice based on these standards.

3. Professional Responsibilities

The school nurse participates in the profession's efforts to advance the standards of practice, expand the body of knowledge through nursing research and improve conditions of employment.

Interpretive Statements

A. The school nurse is obligated to demonstrate adherence to the profession's standards by monitoring these standards in daily practice, participating in the profession's efforts to improve school health services and promoting student health and academic success.

B. The school nurse utilizes available research in developing the health programs and individual plans of care and interventions.

C. The school nurse participates in and promotes research activities as a means of advancing school health services and the health of students. This is done as appropriate to the nurse's education, position and practice environment and in adherence to the ethics that govern research, specifically:

1) Right to privacy and confidentiality,

2) Voluntary and informed consent and

3) Awareness of and participation in the mechanisms available to address violations of the rights of human subjects.

D. The school nurse recognizes that conditions of employment impact the quality of client care and is cognizant of the need to work with others to improve these conditions.