Health Guidelines for North Dakota Schools *2022*

NORTH Dakota
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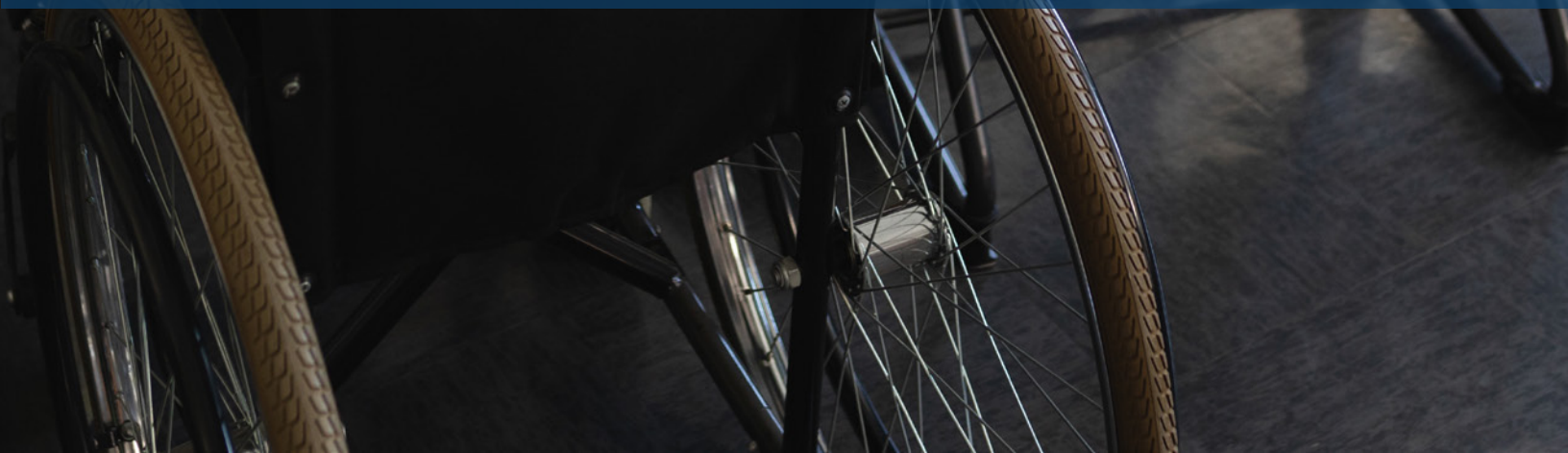

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We want to thank Bismarck and Fargo Public Schools, along with Bismarck-Burleigh Public Health and Fargo Cass Public Health, for providing copies of their forms.

FORMS PROVIDED IN THIS SECTION:

- Authorization for Administration of Specialized Health care Procedures (Fargo Public Schools)
- Individualized Health care Plan/Health Management Plan, General (Custer Public Health)
- Medication Record Administration (Fargo Public Schools)
- Prescription and Authorization for Medication Administration (Fargo Public Schools)
- Request and Authorization for Self-Administration of Medication (Fargo Public Schools)
- Staff Training Record

LINKS TO FORMS AVAILABLE ONLINE:

- Anaphylaxis Action Plan
  foodallergy.org/living-food-allergies/food-allergy-essentials/food-allergy-anaphylaxis-emergency-care-plan
- Asthma Action Plan
  aafa.org/asthma-treatment-action-plan
- Diabetes Care Plan (American Diabetes Association)
  diabetes.org/sites/default/files/2022-02/DMMP-final-2-3-22.pdf
- Immunization Record Request Form
  hhs.nd.gov/public-health-information/diseases-conditions-and-immunization/immunizations/immunization-record
- North Dakota High School Activities Association Physical Form
  ndhsaa.com/ndhsaa-physical
- Seizure Action Plan (Epilepsy Foundation)
  epilepsy.com/tools-resources/forms-resources/seizure-forms

LINKS TO RESOURCES AVAILABLE ONLINE:

- Head Lice – A Lousy Problem booklet
  hhs.nd.gov/public-health-information/diseases-conditions-and-immunization/head-lice
- Health Care Coverage Options brochure
  hhs.nd.gov/health/children/special-health-services
- North Dakota Health and Human Services Disease Control
  hhs.nd.gov/health/diseases-conditions-and-immunization
- North Dakota School Nurses Organization
  ndsno.com/
- North Dakota Health and Human Services Immunization Program
  hhs.nd.gov/public-health-information/diseases-conditions-and-immunization/immunizations

Note: Remember to check websites periodically to ensure that you have the most updated versions of the information.

REFERENCES

Intent of this Manual

This manual has been developed to provide the school health caregiver with general information and resources about meeting the basic healthcare needs of students in the schools. Please remember that these are only guidelines and are not intended to replace caregiver judgment or to substitute for school policy or the advice of a health care provider. Always consult a school administrator, the student's parents/legal guardians and/or a health care provider for questions regarding the care of the student. If a situation appears serious or life-threatening, always follow school policy regarding notifications or calling for emergency assistance.

One reason this manual was created is to help address the shortage of school nurses in North Dakota. This shortage requires that many people working within school systems provide for the health care needs of students and others. At times, students may have complex conditions and may require special care. This manual will help address those complex needs, as well as provide information and resources about common health care needs.

Definition of School Health

School health services are designed to promote the health and well-being of students and staff, identify, and prevent health-related problems and injuries and ensure care. This includes preventative services, educational services, emergency care, screening recommendations, referrals, and management of acute and chronic health conditions.

How To Use this Manual

This manual can be used by all staff members who provide health care in the school and is intended as a quick reference to procedures and policies that can be adopted as needed. This manual contains:

- **Table of Contents** – Each section listed in the Table of Contents is marked with a corresponding tab.
- **Flowcharts** – The flowcharts give step-by-step instructions to administer each procedure. The flowcharts have starting and ending points and offer directions at each level.
- **Narrative** – The narrative offers more detailed information and provides resources. Where appropriate, websites are provided to ensure access to the most current, up-to-date information.
- **Forms** – The Forms section includes samples of forms, listed in alphabetical order, that can be adapted as necessary to meet the needs of your school.

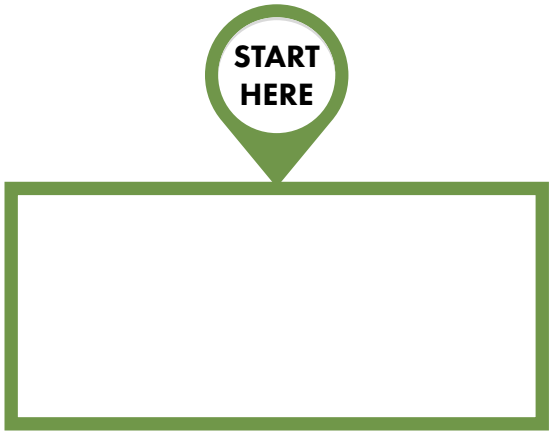
Staff Training

Information in this manual is condensed for quick reference of each topic. Individuals performing procedures require formal training by the student's parent/guardian, or preferably by a health care provider. Simply reading this manual does not qualify staff to perform procedures. The training should be repeated as needed. All staff training should be recorded and kept on record. A copy of a staff training record is in the Forms section.

An Individualized Health care Plan (IHP) and/or Emergency Care Plan (ECP) should be in place for students with special health care needs. In addition to the Special Health care Needs section of this manual, more information on the IHPs and ECPs can be found under various topics and in the Forms section.

It is recommended that a variety of staff be trained in cardiopulmonary resuscitation (CPR) and first aid. To find a class in your community, contact your local hospital or chapters of the American Heart Association or Red Cross.

Flow Chart Symbols



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Response to a question or action based on an answer
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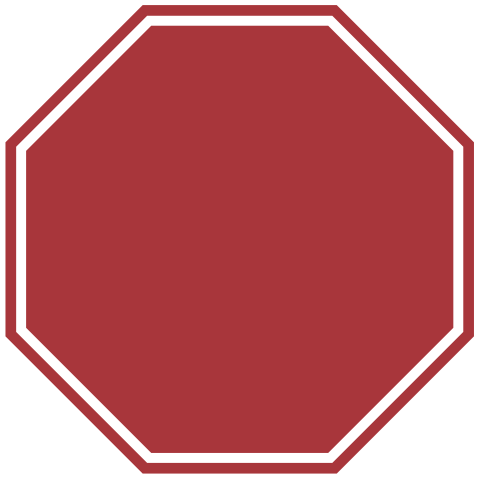

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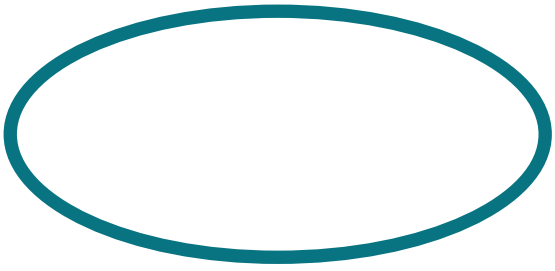

Special issues or concerns to note
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Basic First Aid Supplies

The following are recommended first aid supplies. Some of the materials can be used several times; other supplies will need to be disposed of after each use and replaced. Inventory should be completed at least once a month and supplies replaced as needed. As with all other information found in this manual, this is only a guide; each school may require special items to meet the needs of students. Medications or supplies for a specific child should not be stored in the first aid kit. Gerneral first aid kits should be located in all buildings and kept in a cool, dry area. Make sure every staff member knows where kits are located. Portable kits are best since most accidents do not happen in relation to the location of emergency kits. Plastic tool or tackle boxes make good containers for first aid supplies because they are lightweight, sturdy, portable and close securely.

The following materials/supplies can be used more than one time:

1. Current American National Red Cross First Aid Manual or equivalent (American Heart Association)
2. American Academy of Pediatrics First Aid Chart (shop.aap.org/first-aid-choking-cpr-chart-100pk/)
3. Portable stretcher
4. Cot (mattress with waterproof cover)
5. Blankets, sheets, pillows, pillowcases with disposable covers
6. Washcloths or hand towels with portable basin
7. Covered waste receptacle with disposable liner
8. Thermometer with disposable covers
9. Sharps container (will need to replace when full) – Refer to the Disposal of Sharps section for more information.

The following are disposable supplies:

1. Sterile cotton-tipped applicators
2. Sterile adhesive compresses
3. Cotton balls
4. Sterile gauze squares (2", 4" and other sizes as needed)
5. Adhesive tape (at least 1" in width)
6. Sterile gauze bandages (1" and 2" widths)
7. Splints, both long and short
8. Disposable thermometer
9. Triangle bandage for a sling
10. Sterile tongue depressors
11. Safety pins
12. Liquid soap or hand sanitizer. Note that hand sanitizers are not effective if hands are visibly soiled or sticky. Refer to the Hand Washing section for more information.
13. Disposable paper towels and facial tissue
14. Eye droppers/eye wash
15. Non-latex disposable gloves (various sizes)
16. Pocket mask/face shield for CPR (child and adult sizes) – You may wish to issue these to all trained staff members.
17. Activated charcoal – **ONLY ADMINISTER AFTER CALLING THE POISON CONTROL CENTER**

*Poison Control number for North Dakota – 800.222.1222

Poison Control magnets and phone stickers are available through the North Dakota Department of Health and Human Services by calling 701.328.4536 or 800.472.2286 (toll-free) or by visiting online at ndpoison.org/

REMEMBER to inventory materials on a regular basis.
First aid kits are useful when full, but useless when not kept stocked.

Emergency phone numbers should be available in numerous locations throughout the school.

The Emergency Guidelines for North Dakota Schools manual has a template form for recording emergency contact information.

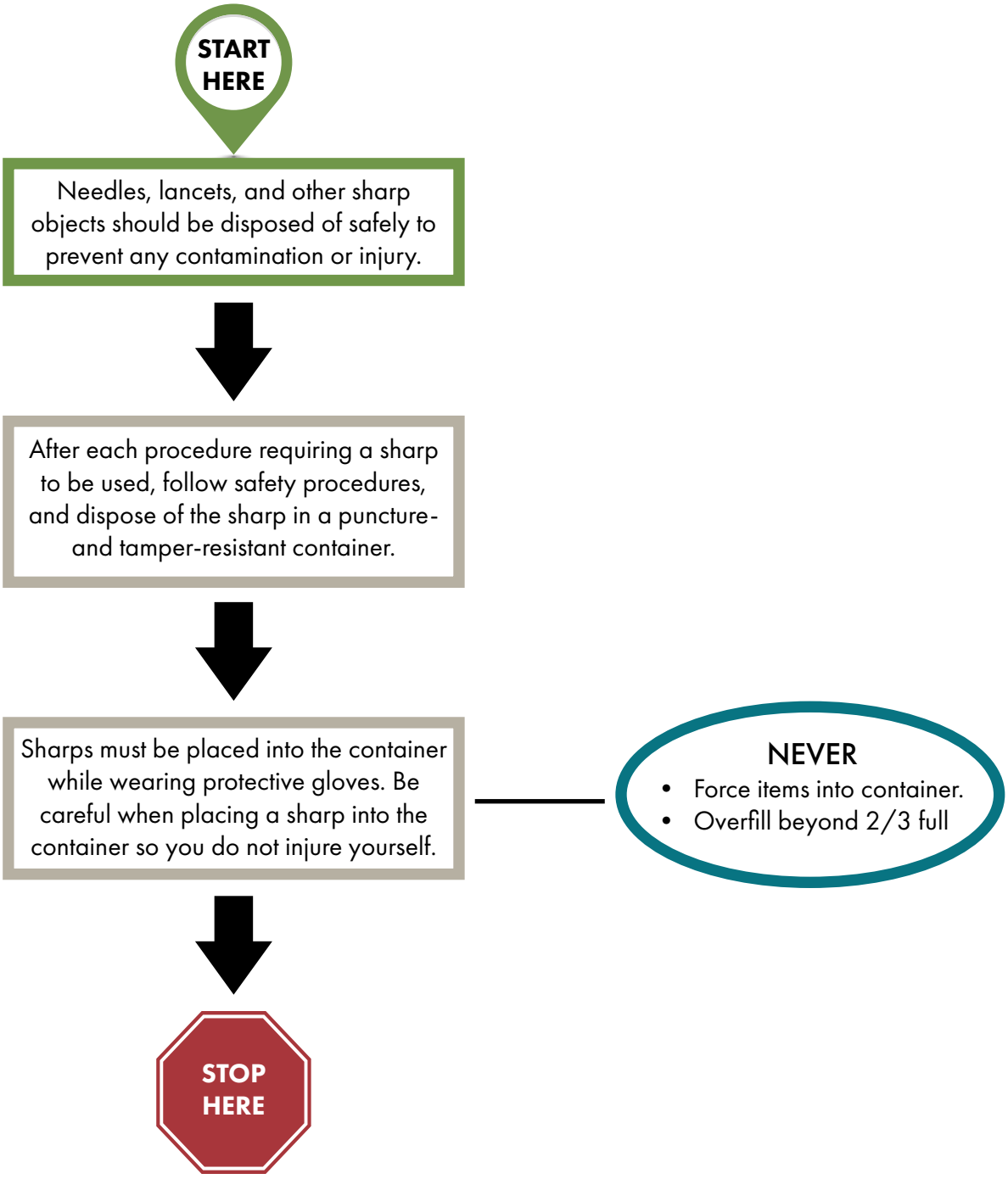
Emergency Medical Equipment

(Optional)

The following equipment may be added as your administration feels it is appropriate. Each type of equipment may be obtained from several sources. Each school will need to follow established procedures for obtaining equipment and supplies.

- **Air splint** – used to immobilize limbs for suspected sprains and breaks.
- **Automated electronic defibrillator (AED)** – used in cardiac emergencies when a person's heart goes into cardiac arrest or dangerous arrhythmia. Training should be provided about how to use an AED. Most CPR classes provide this training.
- **Blood pressure cuff** – used in taking blood pressure. Training about how to take blood pressure can be provided by local health units or health care providers.
- **Crutches** – kept for leg injuries on school grounds. They are adjustable and are relatively inexpensive.
- **Disposable syringes** – kept in case students who administer medications lose, misplace, or damage their supply.
- **Epi-pen** – a pre-measured dose (epinephrine) given to a person suffering from an anaphylactic reaction. This can be administered only with a physician's order.
- **Oxygen** – used for air intake during an emergency. Tanks are refillable and can be used if they are tested and certified as local regulations require. Oxygen requires tubing and facial masks, which are disposable. Follow the manufacturer's instructions for storage.
- **Personal protective equipment (PPE)** – includes gowns, face shields, gloves, sterile caps, and disposable coverings for large spills of body fluids or procedures that expose staff to contamination or infection. All material should be disposable to prevent any cross contamination.
- **Stethoscope** – used for listening to heartbeats, breathing, and monitoring blood pressure.
- **Wheelchair** – used to move students who become injured from one place to another. This does not have to be the latest model but must be mechanically sound and safe.

Disposal of Sharps



Disposal of Sharps

Overview

Needles, lancets, and other sharp objects should be disposed of safely to prevent any contamination or injury.

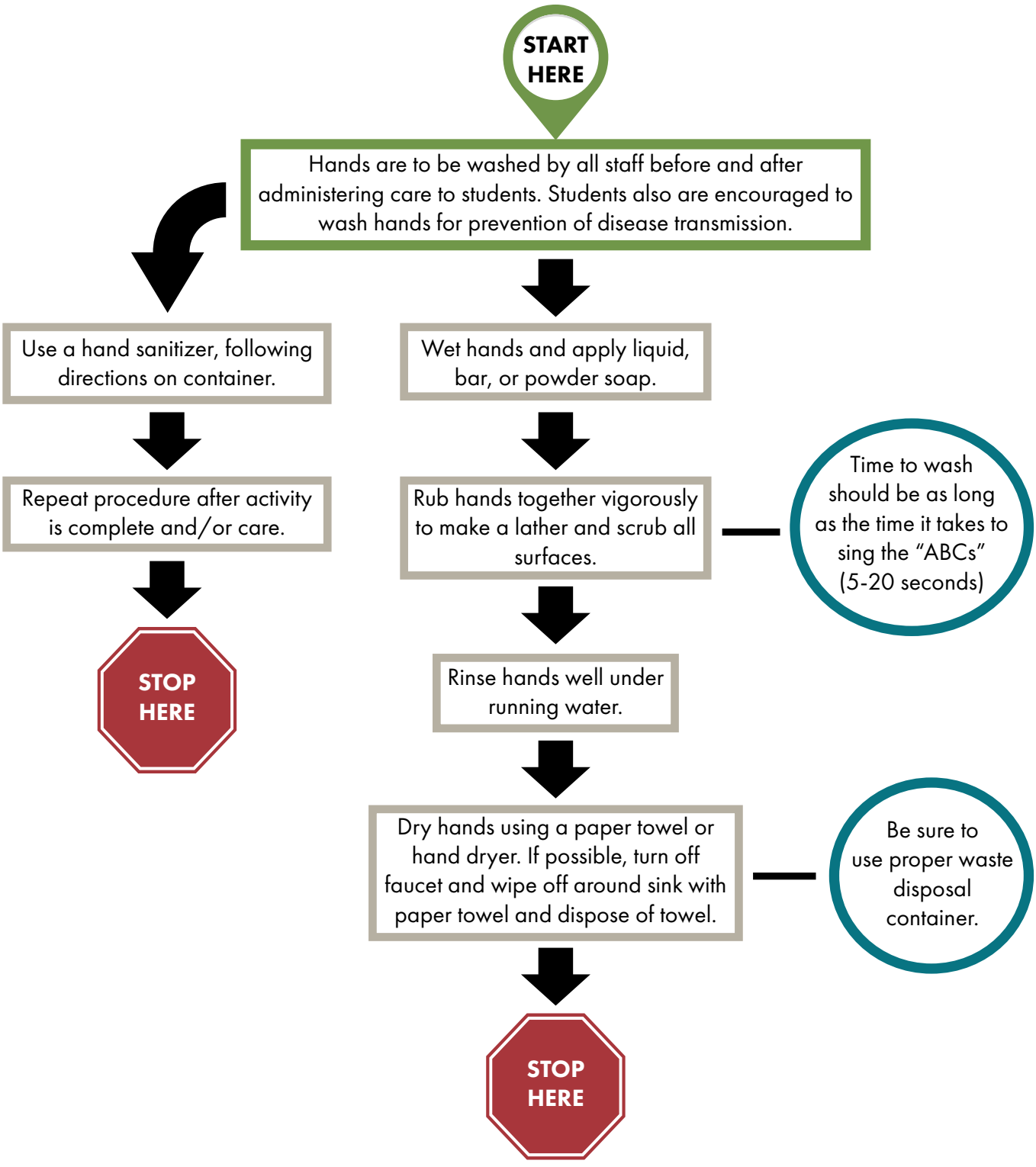
A sharps disposal device should be used by schools that regularly have need for the disposal of sharps. Check with your local pharmacy, health care entity, or local public health unit, or search the Internet using the keywords "sharp disposal devices" to purchase the device. The prices of these devices vary according to product types and manufacturers.

A hard plastic or metal container with a screw-on or tightly secured lid may be used by schools that infrequently have the need for the disposal of sharps. If these types of containers are used, a heavy plastic container with a narrow top is the safest. Soft drink containers are not appropriate for sharps disposal. Be sure to label the container "Sharps Disposal."

Procedure

- Always wear protective gloves during the procedure and handling of sharps.
- After use of sharp, place into a puncture- and tamper-resistant container marked for sharps. Take special care not to injure yourself when placing sharp into the container. If using a purchased disposal device, be sure to read the manufacturer's directions for use prior to using the device.
- Be sure that the container cover is secure after placing the sharp into the container to prevent any spills of items inside.
- When container is two-thirds full, seal the container and take to disposal site.
- If using a heavy plastic or metal container, be sure to reinforce the lid with heavy-duty tape before disposal. Purchased sharps disposal devices have self-locking lids.
- Contact North Dakota Health and Human Services (NDHHS), your local pharmacy, health care entity, or local public health unit to arrange for a disposal site.
- Obtain a new container and repeat steps.

Hand Washing



Sanitizers should be used when soap and water are not available, but you should wash with soap and water as soon as you can.

Hand Washing

Overview
Hand washing, when done correctly, is the best way to prevent spread of common infectious concerns.

Hand washing is to be done by all staff before and after contact with students when performing procedures.

Hand washing procedure:

1. Wet hands and apply liquid, bar, or powder soap.
2. Rub hands together vigorously to make a lather and scrub all surfaces. Scrub well for 20 seconds! It takes that long to dislodge and remove stubborn germs. To time yourself, sing the ABCs.
3. Rinse hands well under running water.
4. Dry hands using a paper towel or air dryer.
5. If possible, use a paper towel to turn off the faucet.

A waterless solution of 62 percent alcohol may be used to sanitize hands. Many products are currently available. They are effective at killing germs on the hands, if your hands are not visibly dirty or sticky. Sanitizers should be used when soap and water are not available, but you should wash with soap and water as soon as you can.

Teaching students how to correctly wash their hands, and when to wash their hands, will help prevent the spread of illness.

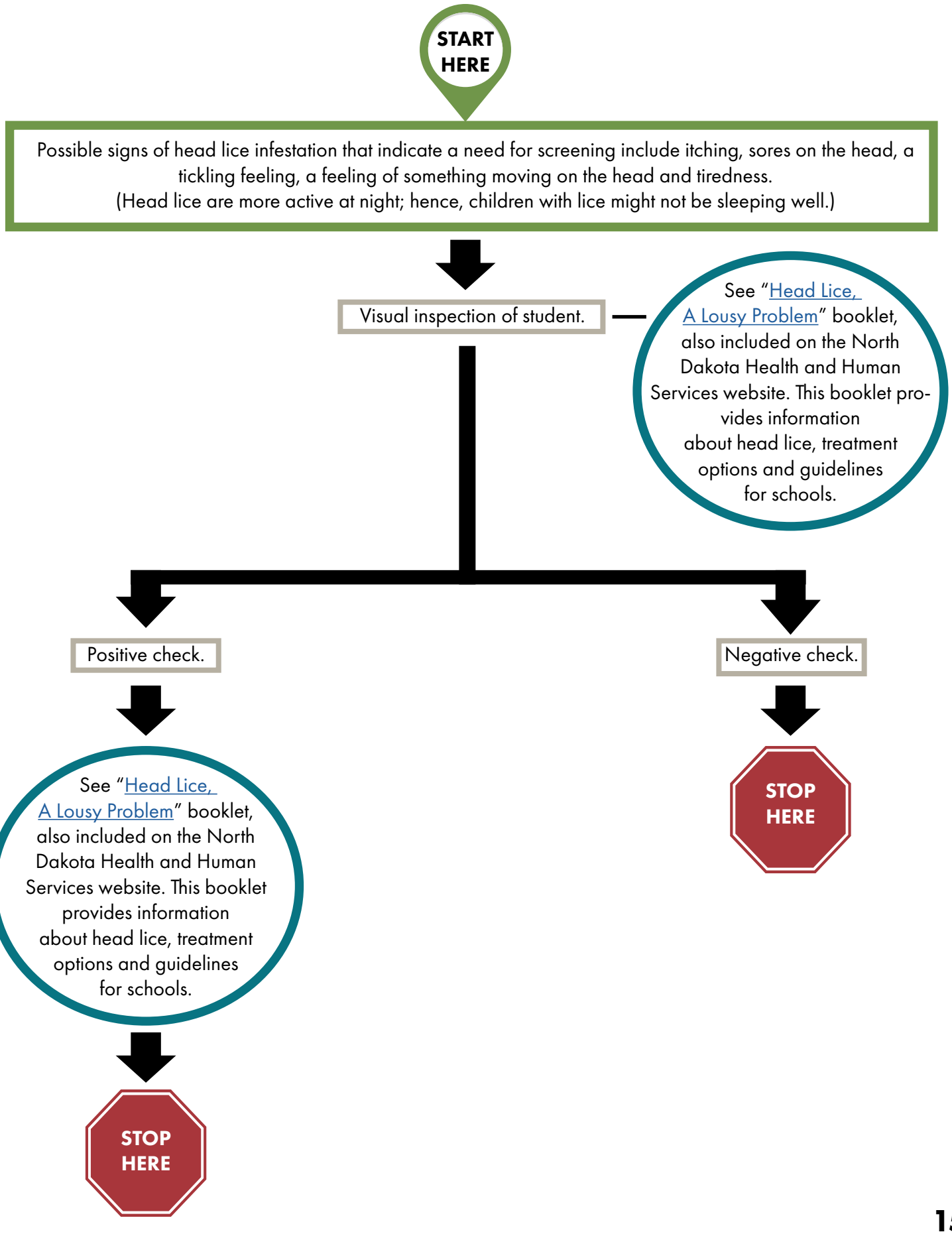
CDC Hand Hygiene Resources

Clean Hands Count for Healthcare Providers
cdc.gov/handhygiene/providers/index.html

Clean Hands Count for Patients
cdc.gov/handhygiene/patients/index.html

Clean Hands Save Lives
cdc.gov/handwashing/index.html

Head Lice Screening



Head Lice Screening

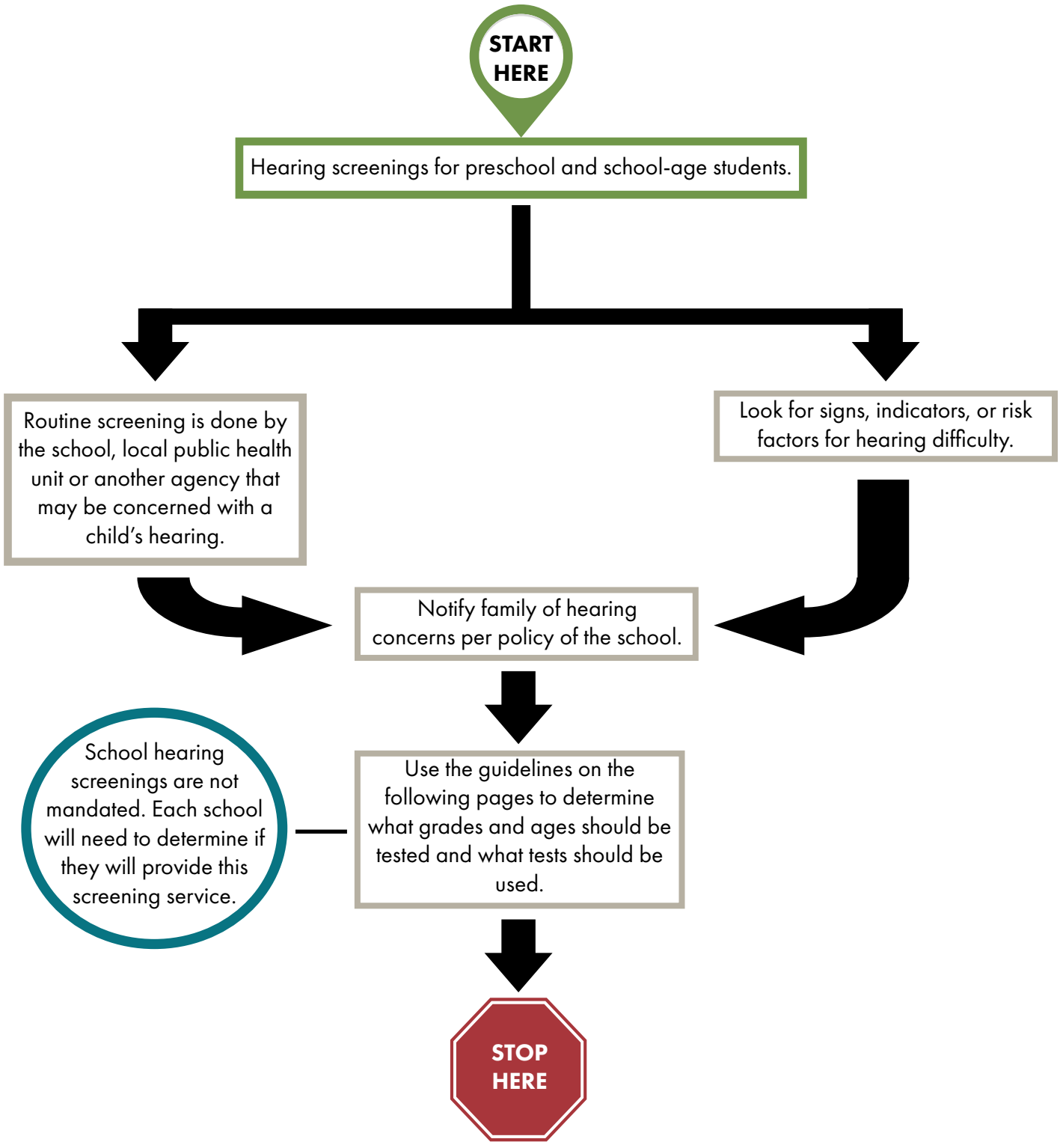
Overview

Please refer to the "Head Lice, A Lousy Problem" booklet that can be found online via the North Dakota Health and Human Services website:
hhs.nd.gov/public-health-information/diseases-conditions-and-immunization/head-lice

The booklet was developed to provide information about head lice, treatment options and guidelines appropriate for use in the home, child-care settings, schools, and communities. Within the professional literature, controversy exists about the treatment and management of head lice. The booklet is designed to provide a balanced review of the issues pertaining to the treatment and management of head lice.

The last two pages of the booklet contain two fact sheets: "Head Lice (Pediculosis)" and "Quick Guide for Removing Head Lice." These fact sheets may be reproduced and given to parents and others trying to get rid of head lice.

Hearing Screening



Hearing Screening

Overview

Hearing screenings are most often done outside of a school setting and are routinely performed at birth. It is important to know what to look for and what to recommend if you suspect issues involving your students.

Preschool (Ages 3 to 5)

The goal of screening preschool children for hearing loss is to identify children who may have hearing loss that interferes with communication, development, health, or future school performance. Some children may pass an initial hearing screening but still be at risk for hearing loss that fluctuates, is progressive or is acquired later in development. Screening should be provided by audiologists, speech-language pathologists and/or other personnel under the supervision of a certified audiologist.

Screening Techniques

Two screening methods are suggested as the most appropriate tools for preschool children who are functioning at a developmental age of 3 years: visual reinforcement audiometry (VRA), which can be done only in a sound room; and conditioned play audiometry (CPA). Both methods are behavioral techniques that require the involvement and cooperation of the child. With both methods, sounds of different frequencies are presented at a sound level that children with normal hearing can detect.

What Happens if a Preschool Child Does Not Pass the Screening?

1. The child will be screened using infant-toddler procedures or will be recommended for a more in-depth audiologic assessment.
2. If the child did not pass the screening, then referral for audiological assessment by a certified audiologist is recommended.

The hearing status of children referred after screening should be confirmed within one month, but no later than three months, after the initial screening.

School-Age (Ages 5 to 18)

School-age children should be screened for hearing loss as needed, requested, or mandated, or when conditions place them at risk for hearing disability. Screening for hearing loss identifies school-age children who may have a hearing impairment that may interfere with development, communication, health, and education. School-age children with even minimal hearing loss are at risk for academic and communication difficulties.

Periodic screenings are recommended because of the increased potential for hearing loss due to overexposure to high levels of noise. The importance of identifying children at risk for hearing impairment may affect their future educational, vocational, or social opportunities.

Hearing Screening

(continued)

Suggested Screening Times for School-Age Children:

1. On first entry into school
2. Every year from kindergarten through third grade
3. In seventh grade
4. In 11th grade
5. Upon entrance into special education
6. Upon grade repetition
7. Upon entering a new school system without evidence of having passed a previous hearing screening
8. Upon returning to school after serious illness

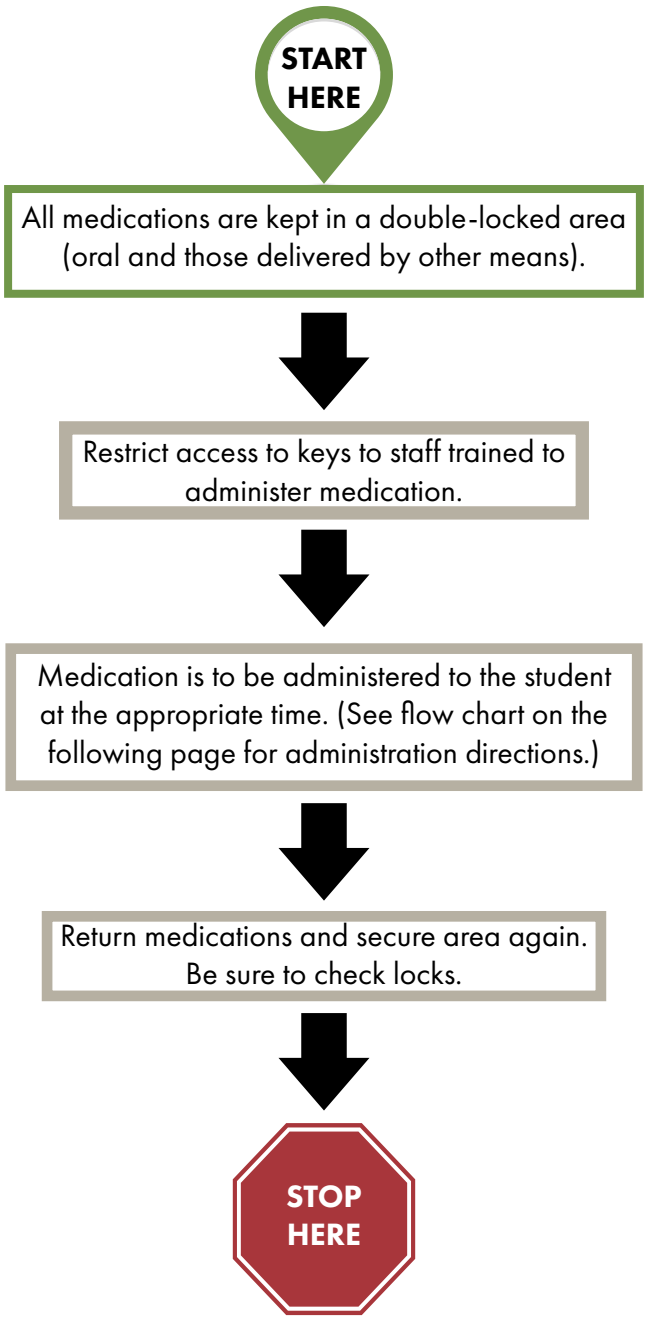
Screening Techniques

Screening practitioners should be limited to audiologists, speech-language pathologists, and support personnel under the supervision of a certified audiologist and/or the school nurse.

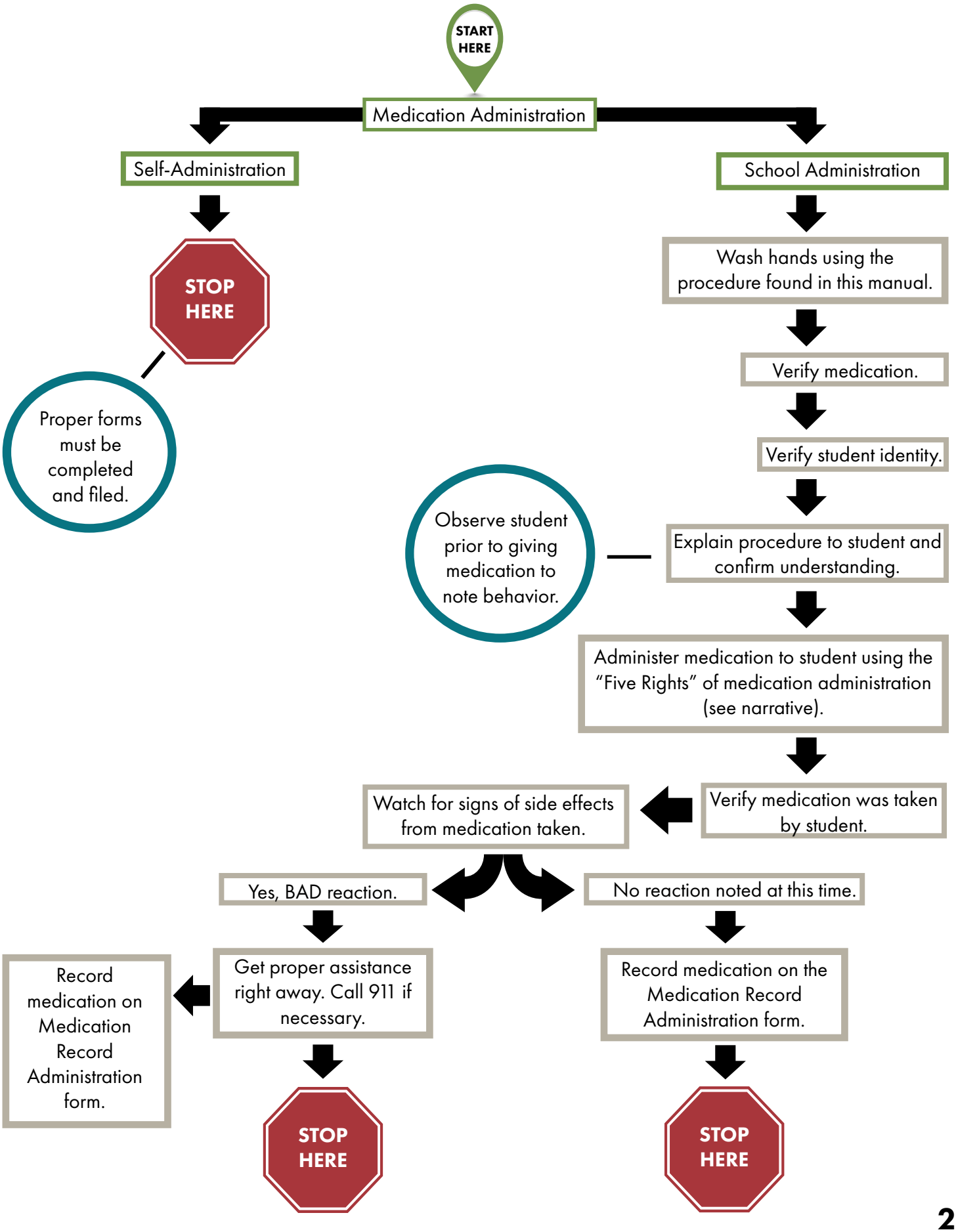
Risk Factors for More Frequent Screening:

1. Parent/legal guardian, health care provider, teacher or other school personnel have concerns regarding hearing, speech, language or learning abilities; for example, needing to repeat instructions to the student repeatedly so tasks can be completed.
2. There is family history of late-onset or delayed-onset hereditary hearing loss.
3. Otitis media with effusion (fluid in the middle ear) recurs.
4. There are skull or facial abnormalities, characteristics or other findings associated with a syndrome known to include hearing loss.
5. There is head trauma with loss of consciousness.
6. There is reported exposure to potentially damaging noise levels or to drugs that frequently cause hearing loss.
7. An individual contracts bacterial meningitis or mumps.

Medication Storage/Security



Medication Administration



Medication Storage, Security, and Administration

Overview

Medication administration is one of the most common health-related activities performed in schools. The safe and effective use of medications for the treatment of certain health conditions or illnesses has enabled many children to attend school and achieve academic success; however, medication can be one of the most dangerous items kept on school grounds. Medication taken properly is useful, but medication taken improperly can be dangerous and even deadly. For this reason, we suggest schools have a policy for medication storage, security, and administration. The school administrator is responsible for assigning the task of medication administration.

In most cases, nurses are not the people administering the medication; often this is handled by support staff having many other duties. In these cases, it is recommended that a nurse or other qualified health care provider provide training and education about how to administer medications correctly and safely. Be sure to record the training of staff on the staff training record. Refer to the Forms section of this manual for a sample of the Specialized Procedure Training – Medication Administration form. (Note to nurses: Providing training and education to school staff is not delegation.) Nurses may utilize the medication administration PowerPoint that the NDHHS created to help train unlicensed school staff, which can be found at hhs.nd.gov/school-healthschool-nursing

Nurses generally have many questions regarding medication administration in schools. The North Dakota Board of Nursing, the North Dakota School Nurses Organization, North Dakota Health and Human Services, and the North Dakota Department of Public Instruction have provided responses to some of the most frequently asked questions. You can also find medication administration resources on the NDHHS website:
hhs.nd.gov/school-healthschool-nursing

Medication in School

Parent/caregivers are encouraged to administer medications at home whenever possible. Medications should be administered at school only when necessary for the health and safety of students. Medication coming into school must be documented by school personnel. It does not matter if the medication is to be self-administered or given by school personnel or the manner of administration (oral, injection, inhaler, etc.). Any medication found in school without approval may be held and given back to the responsible adult in charge of the student. An authorization for medication administration form must be completed, signed by the legal guardian and filed at the school before the medication can be given. Refer to the Forms section of this manual for sample forms.

Security of Medication in School

In the case of self-administered medication, the student may keep the medication and be responsible for the proper handling of the medication and administration. For school-administered medication, the school should designate a location for medication to be kept in an office under double lock. Other areas may come into play in the case of medications that may need refrigeration. In this case, the school should make sure that area is secured in a similar fashion.

The person responsible for passing out the medication and the school administrator should have access to the keys and medications and be the only people with knowledge of the keys' location. The keys shall be always in a monitored area where school personnel can ensure the security of the keys. At the end of each school day, the keys will be secured to provide assurance that they will not fall into unauthorized hands.

Medication Storage, Security, and Administration

(continued)

Administering of Medications

1. Administering personnel will not allow any distractions in the administration area.
2. Before administering medication each time, check for the "Five Rights" (right medication, right dose, right route, right person, and right time). This can be done by looking on the bottle and checking with the student present and by matching bottle label with forms for administration of medication. All information must match.
3. Ask student for his or her name and double-check against another form of identification.
4. Explain procedure to the student and have him or her confirm understanding. Observe the student for present appearance and demeanor. Use this information to compare for signs of side effects that may occur after the medication is taken. School staff who have direct contact with the student after medication is taken should be aware that the student has received a medication so that they can observe for any possible side effects.
5. Administer the medication to the student and verify that the medication is taken. If taken orally, a simple method is to have the student open his/her mouth and check for any medication left in the mouth.
6. Watch for any immediate side effects and note if any. If none, go to step 7. If there are side effects, take the following steps:
   - Make all the appropriate contact calls.
   - Get medical attention for the student.
   - Once the student is safe, record all actions taken on the Medication Record Administration form and any other forms, as needed. Refer to the Forms section of this manual for a sample.
7. Record medication.
8. Excuse student and replace medication in locked area.
9. Secure keys.

Check and double-check steps as you go. Medication has a high liability and extra care is required.

Safeguards

- Never give a student someone else's medication.
- Do not use expired medication.
- Do not mix bottles of medication, even if they are the same.
- Never give a student a different dosage amount than what is indicated on the bottle, not even if a parent or caregiver instructs you to do so. The medication dosage given must match the label instructions on the bottle.
- Never give a medication unless it is properly packaged and labeled.

Field Trips

- If self-administered, follow the same school procedure.
- Any medication to be administered to a student while on a trip or during other activities will be kept in the possession of an adult with assigned duties to administer medications and who is accompanying the student on the trip or activity.
- All medication is to be clearly marked and in a sealed envelope with the student's name, name of medication and directions for administration.
- Upon return to school, the person administering the medication must record all information on the Medication Record Administration form for that student.

Medications Delivered by Other Than Oral Routes

Overview

Medications may often be administered by methods other than by mouth. The following is a listing of information in general terms for other routes of administration. As with oral medications, an authorization for medication administration form must be completed, signed by the legal guardian and on file at the school before the medication can be given.

As with oral medications not administered by a school nurse, it is recommended that a nurse or other qualified health care provider provide training and education about how to administer medications correctly and safely. Be sure to record the training of staff on the staff training record. Refer to the Forms section of this manual for a sample of the Specialized Procedure Training – Medication Administration form.

Topical Medications

1. Compare the medication package with the Medication Record Administration form to double-check the "Five Rights" (right medication, right dose, right route, right person, and right time).
2. Wash hands.
3. Using warm water, wash off the area where topical medication is to be applied.
4. Apply amount prescribed to specific area of skin, as directed, with tongue blade or gloves.
5. Close container and return medication to secure area.
6. Dispose of tongue blade or gloves appropriately.
7. Wash hands.
8. Document dose on Medication Record Administration form. Refer to the Forms section of this manual for a sample form.

Ear Drops

1. Compare the medication package with the Medication Record Administration form to double-check for the "Five Rights" (right medication, right dose, right route, right person, and right time).
2. Wash hands.
3. Obtain container and warm ear drops to near body temperature.
4. Gently shake the bottle for 10 seconds if drops are a cloudy suspension, then check bottle or dropper tip to ensure it is not dirty, chipped or cracked. Most drops will come in package with own dropper attached to top.
5. Draw medication into dropper, tilt affected ear up and place correct number of drops in each ear while tugging on outer ear to allow drops to run in.
6. Keep ear tilted several minutes or insert soft cotton plug as directed.
7. Replace cap and tighten immediately.
8. Return medication to secure area.
9. Wash hands to remove any medication.
10. Document dose on Medication Record Administration form. Refer to the Forms section of this manual for a sample form.

Eye Drops

1. Compare the medication package with the Medication Record Administration form to double-check for the "Five Rights" (right medication, right dose, right route, right person, and right time).
2. Wash hands.
3. Obtain container and check bottle or dropper top to ensure it is not dirty, chipped or cracked. Most drops will come in a bottle with dropper on top.
4. Tilt head back or have child look at the ceiling.

Medications Delivered by Other Than Oral Routes

(continued)

5. Pull down lower lid of correct eye with index finger to form a pocket.
6. Dispense correct number of drops without touching dropper to eye while holding hand against forehead to steady it.
7. Instruct child to close eye gently for two to three minutes.
8. Child or staff may wipe any spill from cheeks.
9. Replace cap and tighten immediately.
10. Return medication to secure area.
11. Wash hands to remove any medication.
12. Document dose on Medication Record Administration form. Refer to the Forms section of this manual for a sample form.

Opthalmic Eye Ointment

1. Compare the medication package with the Medication Record Administration form to double-check for the "Five Rights" (right medication, right dose, right route, right person, and right time).
2. Wash hands.
3. Check container to be sure it is not contaminated (i.e., cap off, tube punctured).
4. Take cap off tube.
5. Pull down lower lid of eye with finger.
6. Have student look upward.
7. Dispense a small ribbon of medicine according to directions on container (usually along the bottom of the lower lid).
8. Allow student to close eye. Student may experience blurred vision and will report a greasy feeling in eye for a short time.
9. Close container and return to secure area.
10. Wash hands before returning to work.
11. Record in the Medication Record Administration form. Refer to the Forms section of this manual for a sample form.

Inhaler Use

Please see the section labeled Proper Use of a Metered Dose Inhaler (MDI) on page 88.

In 2005, legislation was passed that enable students to possess and self-administer emergency asthma medication. Information regarding the requirements of this law – along with fact sheets, parent letters and forms – can be found at hhs.nd.gov/health/children/special-health-services. Please note that this law does not provide for carrying and administration of asthma inhalers that are used daily to control asthma. More information on inhaler use can be found in this manual under Special Situation, Asthma/Wheezing Concerns.

Auto-Injector (Epinephrine, Epi-Pen) for Allergic Emergencies

It is highly recommended that training about how to administer an auto-injector is received. Your local clinic, pharmacy or public health unit should be able to provide this training. Be sure to record the training of staff on the staff training record. Refer to the Forms section of this manual for a sample Specialized Procedure Training – Medication Administration form.

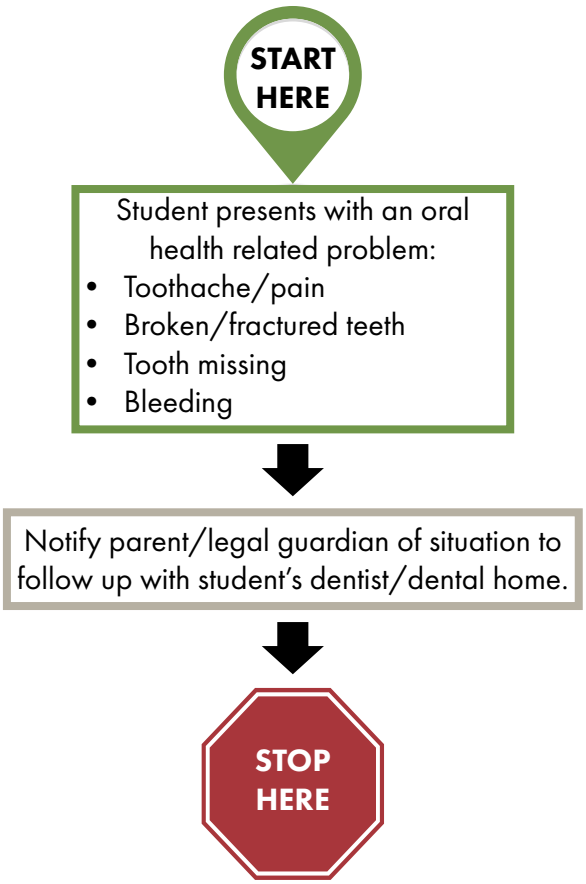
Medications Delivered by Other Than Oral Routes

(continued)

1. At first appearance of symptoms and signs of impending serious allergy reaction (facial swelling, hives, difficulty breathing) or as directed, be prepared to use epinephrine (adrenalin) by injection.
2. While preparing to use an injection, have someone call the emergency number (usually 911) for immediate transportation to the nearest health care facility or hospital emergency room.
3. Pull off safety cap if present.
4. Place tip of Epi-pen® or needle at right angle to the front of and just to the outside of the leg in the fleshiest part of the front of the thigh. Press into thigh hard (Epi-pen ®) or push plunger (Anakit®) to release medication and hold for a few seconds before removing the needle.
5. Massage area for 10 seconds.
6. Dispose of sharps appropriately.
7. Wash hands to remove any medication.
8. Document dose on Medication Record Administration form. Refer to the Forms section of this manual for a sample form.

In 2005, legislation was passed that enable students to possess and administer anaphylaxis medications (Epi-Pen). Information regarding the requirements of this law – along with fact sheets, parent letters and forms – can be found at hhs.nd.gov/health/children/special-health-services. More information relating to allergic reactions can be found in this manual under Special Situation, Allergic Reactions.

Oral Health Prevention Services



Oral Health Prevention Services

Overview

Oral health is an essential and integral component of overall health. Oral disease restricts activities at school, work, and home, and often significantly diminishes the quality of life. Schools can be very important in the education process of students. Integration of oral health into your classroom can be part of overall health care. Oral health training programs for health professionals and teachers are available on the North Dakota Health and Human Services website under the Oral Health Program: hhs.nd.gov/health/oral-health-program (under the Resources for Teachers link). In addition to the Resources for Teachers, there is a link for the Smiles for Life Training. Smiles for Life is a free online oral health training curriculum. Health care providers may take this training to develop knowledge about a variety of oral health care issues, including modules pertaining to Caries Risk Assessment and Fluoride Varnish application.

Prevention Programs:

SEAL!ND School-based Sealant Program

The North Dakota Health and Human Services' Oral Health Program has a school-based sealant and fluoride varnish program, SEAL!ND. Public health dental hygienists (employees of NDHHS) visit schools two times a year (fall and spring) and provide direct preventive services. Services include oral health education, a dental screening, dental sealant and fluoride varnish application and referral information if further dental care is recommended. A parent/guardian signed consent form is required to participate in the SEAL!ND program. An oral hygiene bag consisting of a result sheet (what the child had done), toothbrush, toothpaste and floss will be provided to each child that is seen. The Oral Health Program partners with private dentists and Federally Qualified Health Centers across North Dakota to expand the reach of the program.

Resources

Dental Coverage

- *Safety Net Dental Clinics* are programs that usually see patients who do not have other access to dental care. The patients typically are covered by Medicaid, or the clinic offers sliding fee schedules or reduced fees.

- *Bridging the Dental Gap* is a nonprofit community dental clinic serving low-income and uninsured individuals within Bismarck-Mandan and the surrounding area. (701.221.0518)

- *Family HealthCare Dental Clinic* is a federally qualified health center serving low-income and uninsured individuals within the Fargo/Red River Valley region. (701.271.3344)

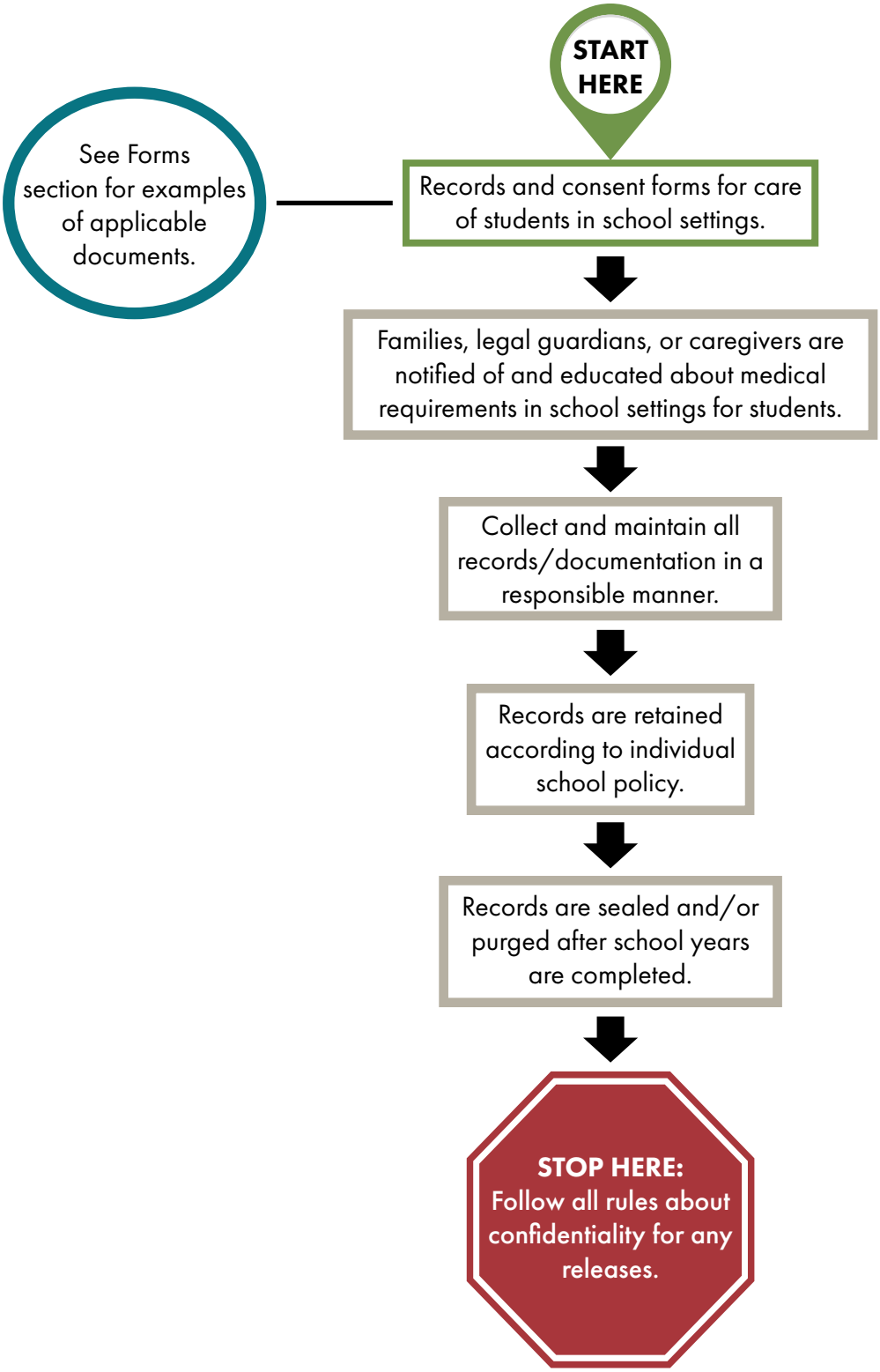
- *Red River Valley Dental Access Project* serves low-income, uninsured, and Medicaid-eligible individuals who have urgent dental pain and do not have access to a dentist in Fargo orMoorhead. (218.790.7790)

- *Spectra Health Dental Clinic* is a federally qualified health center serving low-income, uninsured, and insured individuals of all ages in the Northern Red River Valley. (701.757.2100)

- *Northland Community Health Centers Dental Clinic* is a federally qualified health center serving low-income, uninsured, and insured individuals of all ages in the rural areas. Minot (701.838.3051) Rolette (701.246.3391) Turtle Lake (701.448.9225)

- *North Dakota Donated Dental Services* is a network of volunteer dentists who provide dental care to the state's most vulnerable people: disabled, elderly or medically compromised individuals who cannot afford necessary treatment or get public aid. (701.729.2731)

Records and Authorizations



Records and Authorizations

It is strongly recommended that schools keep medical records and academic records separate to comply with privacy laws.

The employees of the school system, by nature of their position or occupation, are exposed to confidential information that should not be discussed outside the school system. Information concerning student performance and behavior can only be discussed with the student's parents or legal guardians and school personnel directly associated with the student. Such information may be discussed with other school employees only as it benefits either the individual student involved or the objectives of the school system.

A student's academic and medical records are private and are protected from unauthorized inspection or use. A cumulative record is maintained for each student from the time the student enters the district until the student withdraws or graduates. This record moves with the student from school to school. The Forms section of this manual contains examples of medical records.

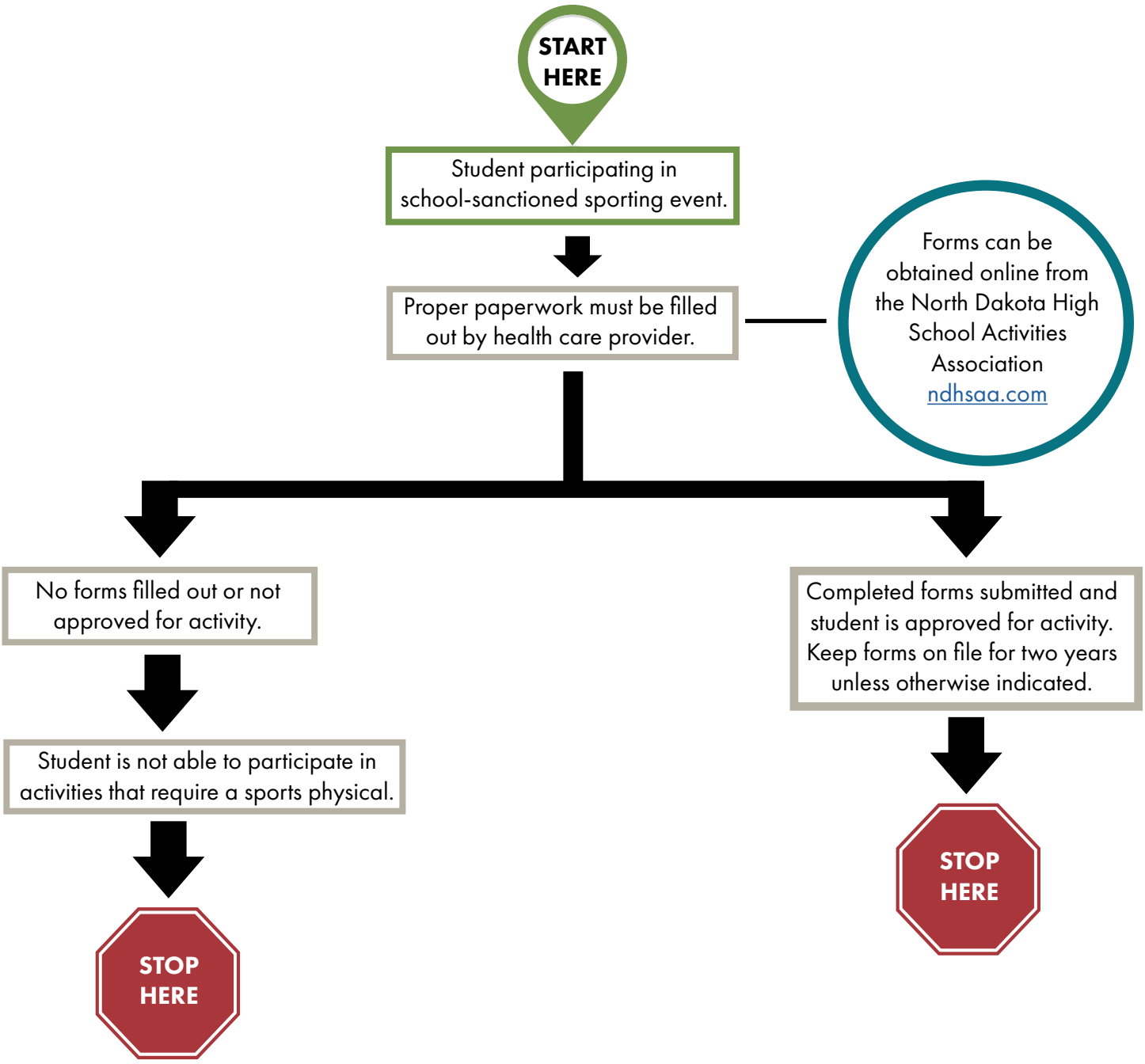
You may modify each form as needed. Documentation is the best protection in cases where people may question school practices. **If it is not written down, it did not happen.**

Rules of Privacy and Records

Issues of confidentiality, privacy of records and questions have been raised regarding the interplay of the Health Insurance Portability and Accountability Act (HIPAA) and the Family Educational Rights and Privacy Act (FERPA). Is a school health program or its staff covered by the HIPAA Privacy, Security or Transaction Rules if it transmits any information electronically in connection with a HIPAA standard transaction? For general purpose, all records are private and are not to be shared with individuals not having a legal right to access. Parents have the right to review records unless the following conditions are present:

- The parent has had rights terminated or suspended by court order.
- Student is 18 years of age or older (in this case student has access).

Sports and Activities Physicals



Sports and Activities Physicals

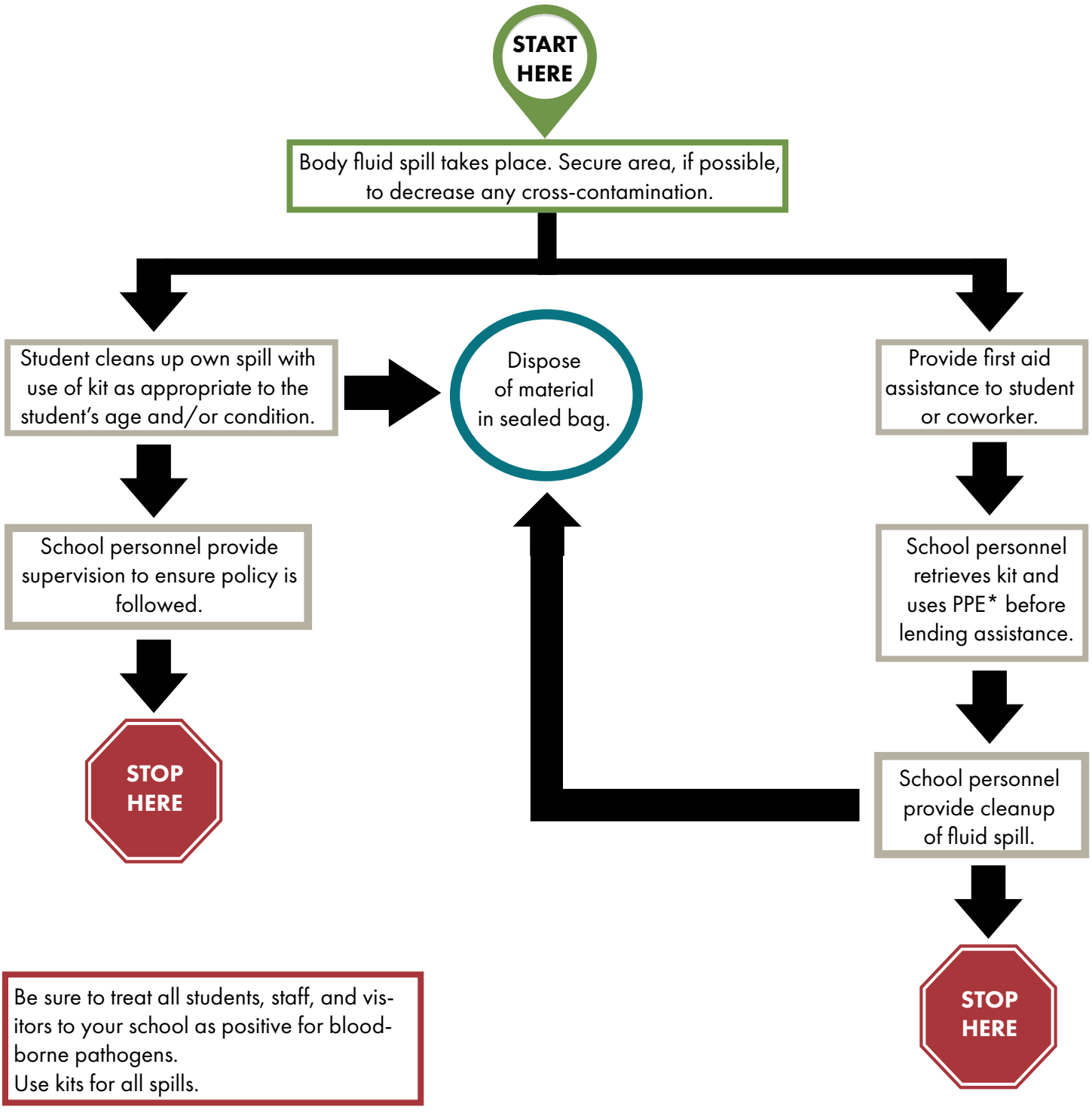
Overview

Sports and activities physicals are required for all students who participate in a sanctioned sport sponsored by the North Dakota High School Activities Association (NDHSAA).

Starting with the 2010-11 school year, student athletes participating in NDHSAA sanctioned sports programs will be required to file a pre-participation health history screening and physical examination with their school office prior to their participation on a yearly basis. The Athletic Pre-Participation Health History Screening and Physical Examination is valid for one school year; a physical examination must be completed on or after April 15th to be valid for participation the following school year. Proper forms and instructions for completing can be obtained from the NDHSAA website at ndhsaa.com/.

Students should not be allowed to participate in a sport until documents are completed and turned in to a school official.

Universal Precautions



*Personal protective equipment.

Universal Precautions

Treat all body fluid spills as positive for blood-borne pathogens.

Overview

Schools should keep universal precaution kits to assist staff and students in the event of body fluid spills. Kits can be either purchased prepackaged or assembled by the school. These kits are to be used in the event of any body fluid spill of any size and should be kept in an area readily accessible to all staff. Personal protective equipment (PPE) will be kept in each kit. **It is recommended that kits be kept in all classrooms and buses and with playground staff.**

Kit Supplies	Purpose	Recommendations
Container for kit: plastic container, tote tray or fanny pack	To safely store kit materials.	Each kit should be restocked after each use and reviewed annually for outdated materials.
Large, resealable plastic bag	To dispose of bloody and/or soiled materials	A sealable plastic bag will help contain soiled materials.
4 single use, disposable, non-sterile gloves	To use as a barrier against body fluids	Stock gloves in a variety of sizes.
4 – 4x4 gauze squares	To cover wounds and stop bleeding	
6 assorted bandages	To cover wounds	
Absorbent paper towels	To clean up blood, vomit, etc.	The site must be cleaned and properly disinfected with bleach or an antiseptic.
Alcohol-based hand sanitizer	If soap and water are not immediately available, hand sanitizers can be used temporarily for germs	Hand washing with soap and water for at least 15 to 20 seconds is the best single way to prevent the spread of germs from one person to another.
One kit containing personal protective equipment (PPE) should be available at each school. PPE may include gloves, gown, face shields or masks, eye protection, and resuscitation bags or pocket masks for ventilation (CPR).		

Universal Precautions

(continued)

In the event of a fluid spill, staff must put on PPE before attending to the situation, then attend to the needs of the student, allowing the student to do as much for himself/herself as possible. This minimizes the number of people exposed to possible contaminants. After the student's basic first aid is complete, proceed with cleanup.

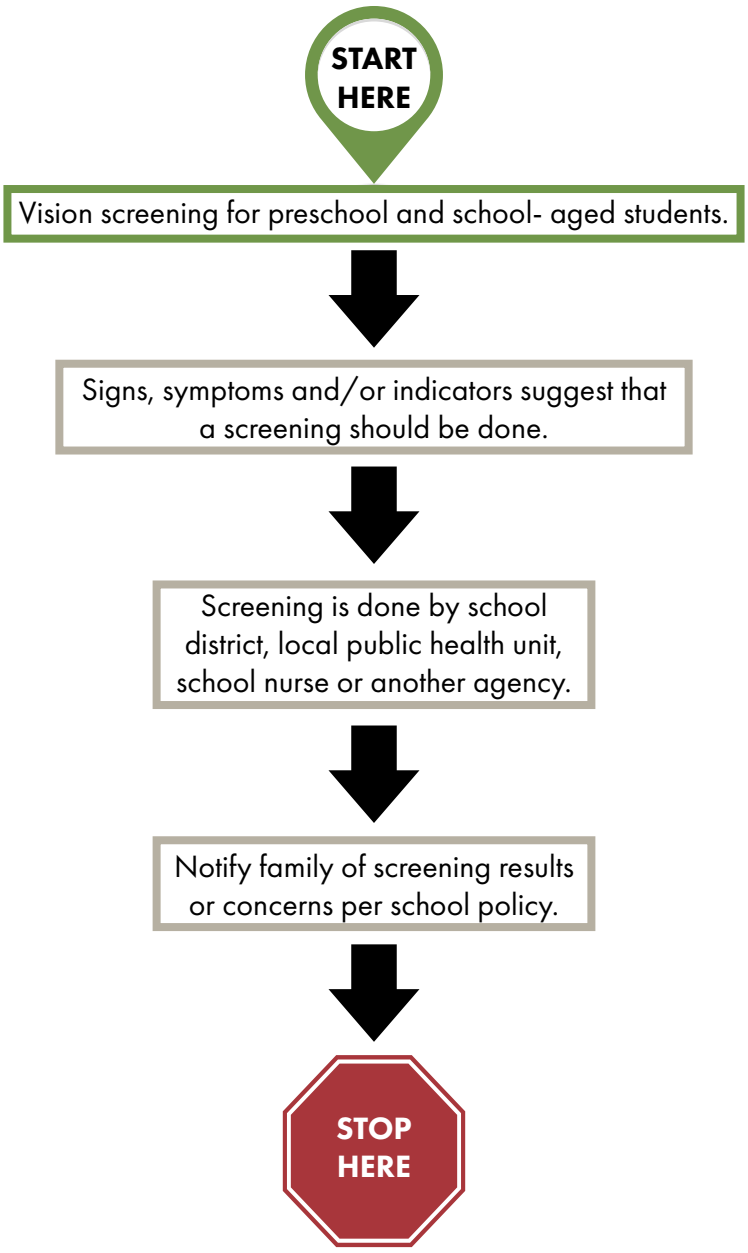
1. Be sure PPE is still intact, and if any part needs to be replaced, do so.
2. Use the product the school has purchased to sanitize body fluid spills. Follow instructions on package.
3. Use paper towels and wipe up spill area as well as you can. Place paper towels into large, resealable bag.
4. Repeat steps 2 and 3 until area is clean.
5. When area is clean, place your PPE into bag and seal.
6. Place all material inside a second bag for double protection.
7. Once all cleaning is complete, place sealed bags into proper disposal container designated by policy for hazardous material removal.
8. Follow hand washing procedure for cleaning up after event.

Body fluids to which universal precautions apply:

- Saliva
- Vomit
- Vaginal secretions
- Breast milk
- Semen
- Fecal matter
- Urine
- Blood

This is a list of the most common fluids, but any fluid from the body should be treated as potentially dangerous and precautions are to be taken.

Vision Screening



Vision Screening

Overview

If not treated early, vision problems in children can lead to a variety of long-term consequences. Vision problems can and do affect the physical, intellectual, social, and emotional development of children. Early detection of vision problems will provide a child more opportunity for educational success.

The North Dakota Optometric Association has developed a Vision Referral and Report Form, and Instructional Guidelines. The Instructional Guidelines contain information about how to complete near vision, far vision, color vision, depth perception, muscle coordination and accommodation testing. In addition, recommended screening procedures and criteria for referral are discussed. These forms can be accessed by going to ndeyecare.com/ and clicking on ND School Nurses Information.

Many states have created Vision Screening Manuals that detail all aspects of a comprehensive school vision screening program. Here is a link to a comprehensive vision screening manual:

- **Minnesota Department of Health** – Vision Screening Procedures: health.state.mn.us/people/childrenyouth/ctc/visionscreen/index.html

Resources

Resources are available to assist students and families with financial support for eye exams and/or glasses.

- **Vision USA** – North Dakota Project provides free eye care to uninsured, low-income workers and their families
  - Website: ndeyecare.com (click on Vision USA – North Dakota Project)
- **VSP Eyes of Hope**, a Vision Service Plan (VSP) program, provides eye exams and glasses for children 18 years and younger whose families cannot afford vision care.
  - Telephone: 888.290.4964
  - sightforstudents.org
- **New Eyes for the Needy** provides vouchers for the purchase of new prescription eyeglasses.
  - Address: 549 Millburn Ave., PO Box 332, Short Hills, N.J. 07078-0332
  - Telephone: 973.376.4903
  - E-mail: neweyesfortheneedy@verizon.net
  - neweyesfortheneedy.org
- Vision screening equipment can be purchased through numerous sources:
  - **School Health** provides technical support for products
    - Telephone: 800.323.1305
    - schoolhealth.com
  - **Good-Lite**
    - Telephone: 800.362.3860
    - good-lite.com
  - **MacGill**
    - Telephone: 800.323.2841
    - macgill.com
  - **School Nurse Supply, Inc.**
    - Telephone: 800.485.2737
    - schoolnursesupplyinc.com

Allergic Reactions

Children may experience an allergic reaction after food ingestion, bee sting, medication administration, etc. This reaction may be immediate or occur up to two hours or more after the initial event. For students with known allergic reactions, refer to their Individualized Health care Plan and/or Emergency Care Plan.

Mild Reaction

No severe signs noted, **mild** reaction only. Red or watery eyes; itchy, runny nose; hives; or rash are mild reaction signs.

Supervise student during normal activities. Ask student what exposure they had if known. Watch student for up to two hours. If reaction becomes severe, return to flow chart for severe reaction. Notify parent or legal guardian.

If child is too uncomfortable to be in school, notify parent or legal guardian. Document activities.

Severe Reaction

Signs of **severe** allergic reaction include hives, flushed face, paleness, blueness around mouth and eyes, breathing problem, drooling, dizziness, weakness, confusion, nausea and vomiting, seizures, loss of consciousness.

If available, refer to student's individualized and/or emergency care plan. If there is no plan, contact emergency medical personnel (9-1-1) and responsible parties (parents/legal guardian or school authority).

Administer parent/guardian-approved medication/care or wait until emergency aid arrives. Keep student under observation. Notify parent or legal guardian.

When emergency assistance arrives, stay with student, and answer any questions asked by emergency services. Document activities.

Allergic Reactions

Overview

It is important to remember that allergic reactions can occur from anything a person ingests or is exposed to. Allergic reactions can be mild or severe. A mild reaction might show up as a skin rash; itching, watery discharge from nose; or red, watery eyes. Reactions can occur anytime. A severe allergic reaction known as anaphylactic shock usually occurs immediately after the exposure but may occur up to two hours or more after the initial event. See below for symptoms of anaphylaxis. It is important to know if your students are allergic to any medications, food, bee stings, or other issues in the environment and how to treat the reaction if it occurs. The use of the Epi-pen, if available, is suggested for reactions that are severe. Refer to student's Individualized Health care Plan and/or Emergency Care Plan for those known to have reactions. Refer to the Forms section of this manual for sample form, including Allergy Management Plan, Anaphylaxis Action Plan and Authorization for Epi-pen, Emergency Plans, Epi-pen Emergency Plan, and Individualized Health care Plan.

Anaphylaxis is a severe allergic response to specific triggers such as foods, medications, insect venom or latex. A student may be at a higher risk for experiencing anaphylaxis if he/she has a history of allergies or asthma or has had an anaphylactic response previously.

Symptoms of Anaphylaxis

The most distinctive symptoms of anaphylaxis include:

- Hives
- Swelling of the throat, lips, tongue or around the eyes
- Difficulty breathing or swallowing

Other common symptoms of anaphylaxis may include:

- A metallic taste or itching in the mouth
- Generalized flushing, itching or redness of the skin
- Abdominal cramps, nausea, vomiting or diarrhea
- Increased heart rate
- Rapidly decreasing blood pressure and accompanying paleness
- A sudden feeling of weakness
- Anxiety or an overwhelming sense of doom
- Collapse
- Loss of consciousness

In 2005, legislation was passed that enables students to possess and administer anaphylaxis medications (Epi-pen). Training for medical and school personnel to help meet the requirements of this law, along with fact sheets, parent letters and forms can be found at hhs.nd.gov/school-healthschool-nursing. It is highly recommended that medical and school personnel view this training.

Allergic Reactions
(continued)

Overview of Latex Concern

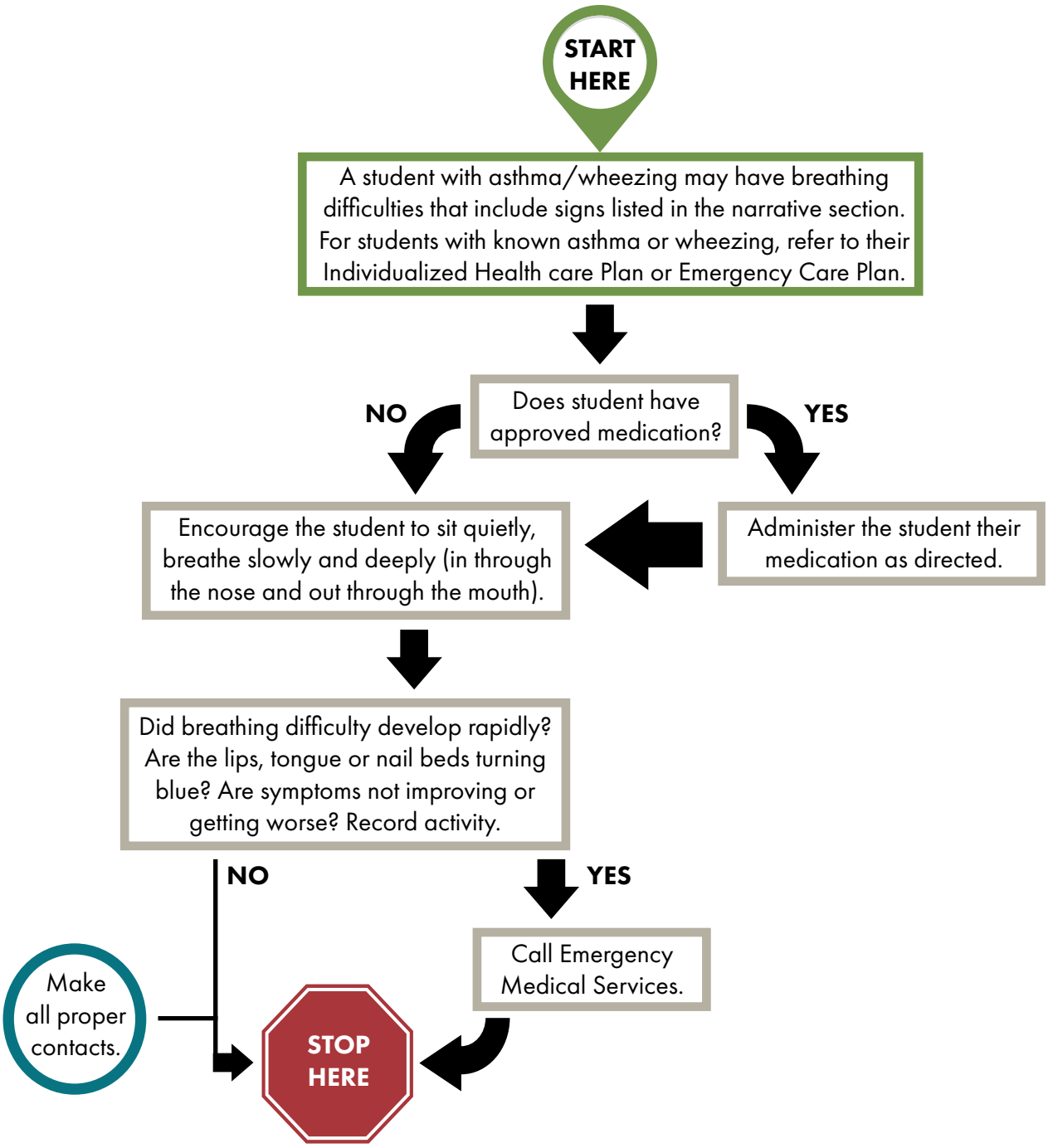
Latex allergies are a reaction to the flexible, elastic material used in many rubber products. Health care workers are among those most susceptible to the allergy, which is often triggered by exposure to the latex gloves and instruments that they use every day as part of their jobs. Children with special medical needs also have high incidences of the reaction because they frequently are exposed to latex-based products during surgeries and treatments.

Most latex allergies are caused by exposure to dipped latex, a common material found in "stretchy" products such as rubber gloves, balloons, rubber bands and condoms. These products are especially powerful triggers because they usually come into direct contact with the skin. However, latex particles also can be inhaled once they become airborne.

Commonly Used Latex Medical Products

- Rubber gloves
- Balloons
- Elastic bandages
- Adhesive tape
- Urinary catheters
- Stomach and intestinal tubes
- Protective sheets
- Rubber tourniquets
- Rubber nasal-pharyngeal airways
- Rubber oral-pharyngeal airways
- Blood pressure cuffs
- Rubber endotracheal tube
- Latex cuffs on plastic tracheal tubes

Asthma/Wheezing Concerns



Asthma/Wheezing Concerns

Overview

Asthma is a lung disease that affects the airways in the lungs, causing difficulty with breathing. Asthma is the most common chronic childhood disease. On average, in a classroom of 30 children, about 3 are likely to have asthma.

According to the Center for Disease Control (CDC), asthma is one of the leading causes of school absenteeism. In addition, it can result in emergency-care visits to the hospital, interrupted sleep, limited physical activity, and disruption of family and caregiver routines. Asthma episodes can be life-threatening.

Asthma is chronic. In other words, you live with it every day. There is no cure for asthma, but it can be managed so you live a normal, healthy life. Asthma that is well controlled will allow the student to participate in school activities without having any asthma signs or symptoms.

Is your school up to the asthma-friendly challenge?

1. Does your school collect Asthma Action Plans or asthma management plans from students identified as having asthma?
   Yes / No

2. Does your school communicate the "Self-Carry of Medications" policy?
   Yes / No

3. Are there educational opportunities for school staff on asthma management?
   Yes / No

4. Does your school campus have a comprehensive tobacco-free policy?
   Yes / No

5. Are students with asthma encouraged to participate in physical education and activity when their asthma is under control?
   Yes / No

If you said "Yes" to all the questions above, your school is on its way to being asthma friendly.

Respiratory vs Asthma

Respiratory Virus	Asthma
Fever of over 100.4	No fever
Coughing with or without wheeze	Audible cough and wheeze
Shortness of breath	Shortness of breath
Nasal congestion	Chest tightness and/or congestion
Nausea/vomiting/diarrhea	Inability to catch breath, having to stop talking
Headache and fatigue	Fatigue
Muscle or body aches	Inability to perform daily activites
Poor appetite	
Swelling or rash on hands and feet	
Loss of taste and smell (COVID-19)	

Asthma/Wheezing Concerns

(continued)

Asthma symptoms may include one or more of the following:

- Coughing
- Wheezing
- Chest tightness
- Shortness of breath
- Rapid breathing

*Please note that cough may be the only symptom. Some people with asthma may never wheeze.

Triggers and Control Strategies:

There are many common substances that can start an asthma episode. These substances, along with environmental conditions, are commonly referred to as triggers. Triggers cause asthma symptoms to begin or get worse. Asthma triggers may differ between individuals, what affects one person may not affect another.

If known triggers are present, susceptible people should be protected from exposure to the triggering agents and whenever possible, be removed from exposure to the trigger.

Infections

Colds, upper respiratory tract infections, influenza, sinusitis, and respiratory syncytial virus (RSV) may aggravate asthma symptoms.

- Diagnosing and treating upper respiratory tract infections and disease (rhinitis/ sinusitis) is an integral part of managing asthma.
- Wash hands often.
- Use paper towels.
- Don't share cups, towels, or tissues.
- Keep hands away from face.
- Get an influenza shot yearly.
- Get the COVID-19 vaccinations and booster(s)

Allergens

There is a strong link between asthma and allergies, so it is important to keep allergens under control.
Common allergens include:

- Pets with fur or feathers
- Dust Mites
- Mold Spores
- Cockroaches
- Pollens
    - Showers, restrooms, basements, materials and containers stored in damp areas, leaky roofs, old books and newspapers, exercise and athletic mats, vaporizers/room humidifiers, aquariums, plants
        - Fix leaky faucets and pipes.
        - Clean visible mold with a stiff brush, hot water and non-ammonia soap.
        - Reduce indoor humidity to less than 50%. Run a dehumidifier and empty collection bucket daily.
        - Use the exhaust fan in bathroom when bathing.
        - Throw away moldy items.

Asthma/Wheezing Concerns

(continued)

Other Medical Conditions

- Acid reflux
- Sensitivity to aspirin:
  - examples: Bayer, Excedrin
- Vocal cord dysfunction
- Non-steroidal anti-inflammatory medications (NSAIDs): examples: Ibuprofen (Advil, Motrin), naproxen (Aleve), celecoxib (Celebrex)

Irritants

- Smoke
- Weather
  - Exposure to cold air or high humidity
- Dust/Chalk Dust
- Aerosols / Strong Odors / Fumes Cleaning solutions, air fresheners, room deodorizers, perfumes and colognes, paints, fumigation chemicals, art supplies, bus exhaust / fumes, biology, or chemistry labs.

Behaviors

- Emotions
  - Crying, laughing, stressful situations
- Exercise-induced
  - Also referred to as exercise-induced bronchospasm (EIB), it is not a separate disease. Exercise can trigger an asthma episode. It is often caused by cold, dry air that can produce a spasm in the airways.
    - Decreased activity should only be a temporary solution. With proper asthma management, everyone should be able to exercise comfortably.
    - Warm up before and cool down after exercising.
    - Follow health care provider's advice on pre-medication. Quick relief medications should always be available close by during physical exertion.
    - Monitor air quality and only exercise outside when air quality is good.

Peak Flow Monitoring

As with any chronic condition, daily monitoring is critical to ensure positive outcomes. If a child is too young to understand or is unable to perform peak flow monitoring, then treatment is based upon symptoms only. A peak flow meter is a hand-held device that measures how much air a person can breathe out from their lungs in one second. The speed, or velocity, at which the air leaves the lungs, is called the peak flow.

After moving the indicator to zero, the person standing takes a deep breath, places the mouthpiece into his/her mouth (in between the top and bottom teeth), and blows the air out as rapidly as possible (huff). The procedure should be repeated two to three times (if feasible) and the best effort recorded in the daily log.

Treatment decisions and action plans are based upon the personal best peak flow value. The personal best may change over time. Peak flow meters are helpful in monitoring breathing, catching breathing problems early, identifying when to take quick relief medications, and identifying when to call a health care provider or seek emergency care.

Asthma/Wheezing Concerns

(continued)

ASTHMA ACTION PLAN:

Asthma Management in School

Management of asthma often involves use of medications. Asthma medications belong in two broad categories:

1. Long-term control or "controller" medications reduce inflammation of the airways. Typically, anti-inflammatory drugs are taken on a regular basis, usually once or twice daily, even in the absence of symptoms. This medication is not typically needed while a child is in school.
2. Quick relief or "rescue/emergency" medications open the airways by relaxing the muscles around the bronchial tubes. They usually are taken when symptoms begin to occur or when they are likely to occur (e.g., physical education classes or sports events). This medication can be needed during school.

What to do in the event of an asthma episode at school

Students with asthma are more likely to succeed in school when students, parents, school nurses, principals, teachers, other school personnel and the student's health care providers work together to ensure effective asthma management. Written plans are recommended to ensure appropriate asthma management in the school setting.

An Asthma Action Plan is an individualized management plan developed by a health care provider and the student with his or her family.

ASTHMA ACTION PLAN

ZONE	ACTION
Green Zone	**GO**
Breathing is good **and**	Proceed with normal activities
No cough or wheeze **and**	Keep quick relief medication on hand
Can work and play **and**	Keep Asthma Action Plan on file
Peak flow is 80-100% of Personal Best	Eliminate asthma triggers in the classroom

****For asthma with exercise****
Take quick relief medicine 20 minutes prior to activity as needed.

ZONE	ACTION
Yellow Zone	**CAUTION**
Coughing **or**	Reduce activity
Wheezing **or**	Take quick relief medicine (every 4 hours)
Shortness of breath **or**	Stay calm
Peak flow is 50-79% of Personal Best	Slowly inhale through the nose (sniff the flowers) / Slowly exhale through the mouth (blow out the candles)

ZONE	ACTION
Red Zone	**Stop! Get Help! Call 911 or go to the nearest Emergency Room!**
Quick relief medicine is not working or not available **or**	Restrict all activity
Peak flow is less than 50% of personal best **or**	Use quick relief medicine every 20 minutes
Retractions, lots of effort needed to breathe **or**	Call 911 or go to the Emergency Department
Fingernail beds or lips turning blue / gray **or**	
Can't talk well	

- Contact the parent or legal guardian.
- Document activities as appropriate.

Asthma/Wheezing Concerns

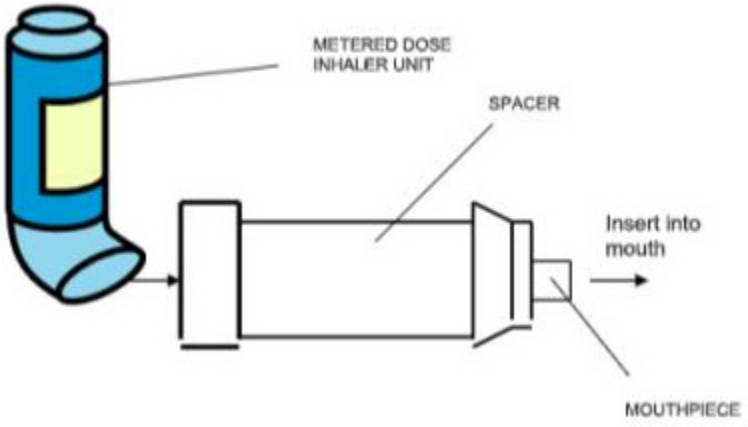
(continued)

This plan is very beneficial because it provides comprehensive information needed for intervention and education of students and supports consistent communication with the family and health care provider. An Asthma Action Plan, which can be accessed at hhs.nd.gov/school-healthschool-nursing. Refer to the Forms section of this manual for additional sample health care plans.

Proper Use of a Metered Dose Inhaler (MDI)

1. Shake the inhaler vigorously five or six times immediately before it is used.
2. Remove the cap from the mouthpiece.
3. Check the mouthpiece for dirt and foreign objects that could be inhaled. If the inhaler hasn't been used for several days, discharge one or two sprays into the air before it is used.
4. Consider attaching a spacer tube to the mouthpiece of the inhaler. A spacer is a 4- to 8-inch length of tubing. It helps send more of the medication deep into the lungs instead of depositing it in the mouth, which can lead to side effects.
5. Have the student hold his/her head erect and sit up tall or stand. Have the student exhale normally but not forcefully.
6. The student closes his/her mouth around the open end of the spacer tube. Make sure the tongue or teeth aren't blocking the opening. If a spacer tube is not available, the student should place the mouthpiece of the inhaler unit about 2 inches in front of his/her open mouth.
7. The student should breathe in very slowly while squeezing the inhaler once. The student should not stop inhaling while squeezing and should continue to breathe in slowly for several seconds or for as long as it feels comfortable. The student then removes the spacer tube from his or her mouth but does not exhale.
8. The student should hold his/her breath for as long as comfortable, or up to 10 seconds, to help the medication settle in the airways. The student can then exhale slowly.
9. The student should rinse his/her mouth with water (spitting out the water) or brush his or her teeth after using a corticosteroid inhaler.
10. Repeat if ordered.
11. Document activities on the Medication Record Administration form. Refer to the Forms section of this manual for a sample form.

Metered Dose Inhaler Unit and Spacer



Asthma/Wheezing Concerns

(continued)

Nebulizers

Prior to COVID-19, nebulizer treatments were often frequently given in the school. In response to the COVID-19 pandemic and concerns related to aerosolizing procedures in the nurse clinic, guidance has been provided to avoid use of nebulizer treatments whenever possible.

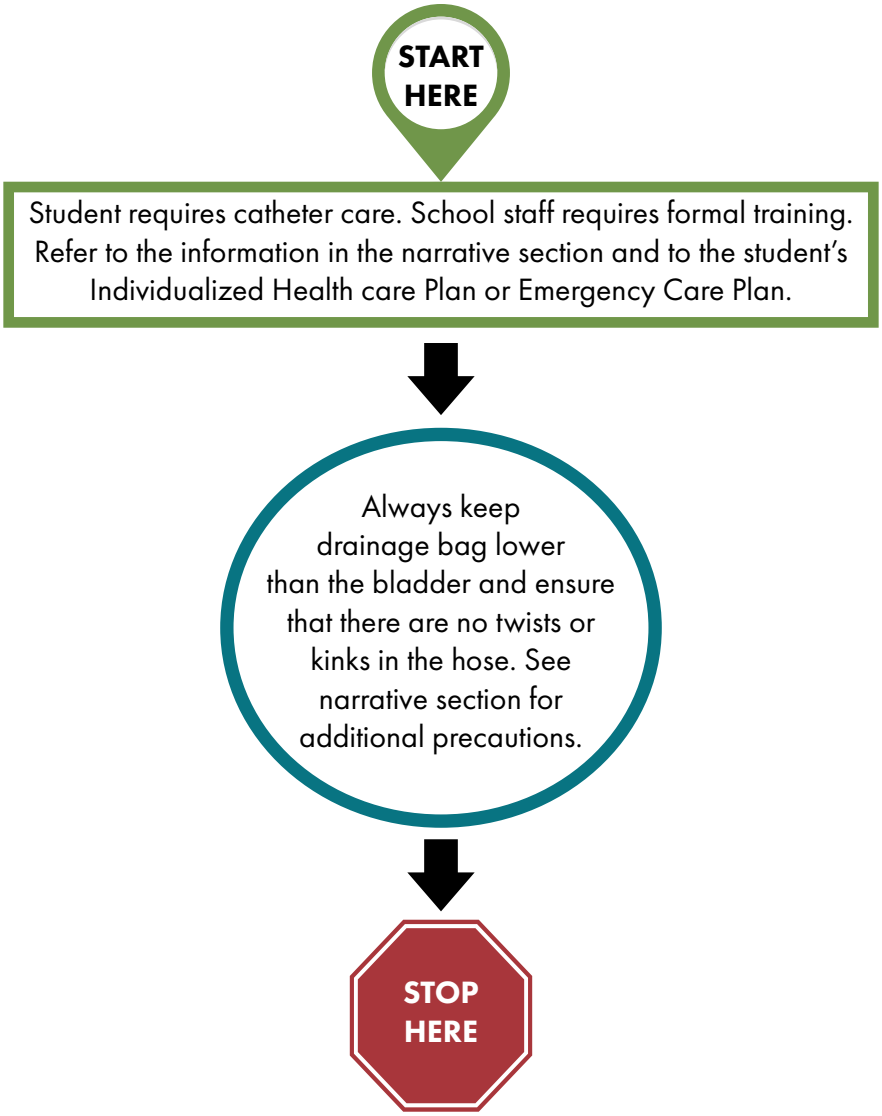
In 2005, legislation was passed that enables students to possess and administer emergency asthma medication. Training for medical and school personnel to help meet the requirements of this law – along with fact sheets, parent letters and forms – can be found at hhs.nd.gov/pediatric-specialty-clinics-and-condition-specific-resources. It is highly recommended that medical and school personnel view this training.

**Please note that the law does not provide for carrying and administration of asthma inhalers that are used daily to control asthma.*

References

1. Center for Disease Control Strategies for Addressing Asthma in Schools. Publication date: January 2017. cdc.gov/asthma/pdfs/strategies_for_addressing_asthma_in_schools_508.pdf
2. American Lung Association Asthma-Friendly Schools Initiative Toolkit. Last updated April 8, 2020. lung.org/lung-health-diseases/lung-disease-lookup/asthma/asthma-education-advocacy/asthma-friendly-schools-initiative
3. cdc.gov/asthma/schools.html Accessed March 1, 2022.
4. allergyasthmanetwork.org/news/covid-19-vs-asthma/ Accessed March 1, 2022.

Cathetar Care (Urinary)



Catheter Care (Urinary)

Overview

A urinary catheter, often called a Foley catheter, is a thin rubber tube that is put into the bladder (organ that holds urine). It is used to drain urine out of the body. To keep the catheter from slipping out, it has a balloon on the end that is inflated with sterile water once the end is inside the bladder. Urine drains into a bag that is usually attached to the thigh with rubber straps.

A urinary catheter is used when a person cannot urinate by himself or herself. This may occur because of medical conditions or when the lower part of the body is paralyzed. A Foley catheter can stay in the bladder for a short or long time. Because the catheter can be left in the bladder for a period, it is also called an "indwelling catheter."

Precautions

The urine collection bag always should be below the level of the bladder (the bladder is about at the level of the waist). Keeping the bag below this level will prevent urine from flowing back into the bladder. Backflow of urine can cause an infection.

Care should be taken to ensure that there are no twists or kinks in the drainage tubing that would impede the flow of urine. In addition, precautions should be taken not to tug or pull on the tubing. This can cause bleeding and irritation at the insertion site.

The student's parent/legal guardian should be called if any of the following situations occur:

- No urine or very little urine is flowing into the collection bag for four or more hours.
- The student is complaining of a full bladder and no urine or very little urine is in the collection bag.
- The urine has changed color, is cloudy or has blood in it.
- The urine has foul order.
- The student's underwear is wet with urine. This indicates that urine is leaking around the catheter insertion site.
- The student is complaining of pain at the catheter insertion site or in their abdomen, back, pelvis or legs.
- The student has nausea, vomiting, fever, or chills.
- The catheter falls out.

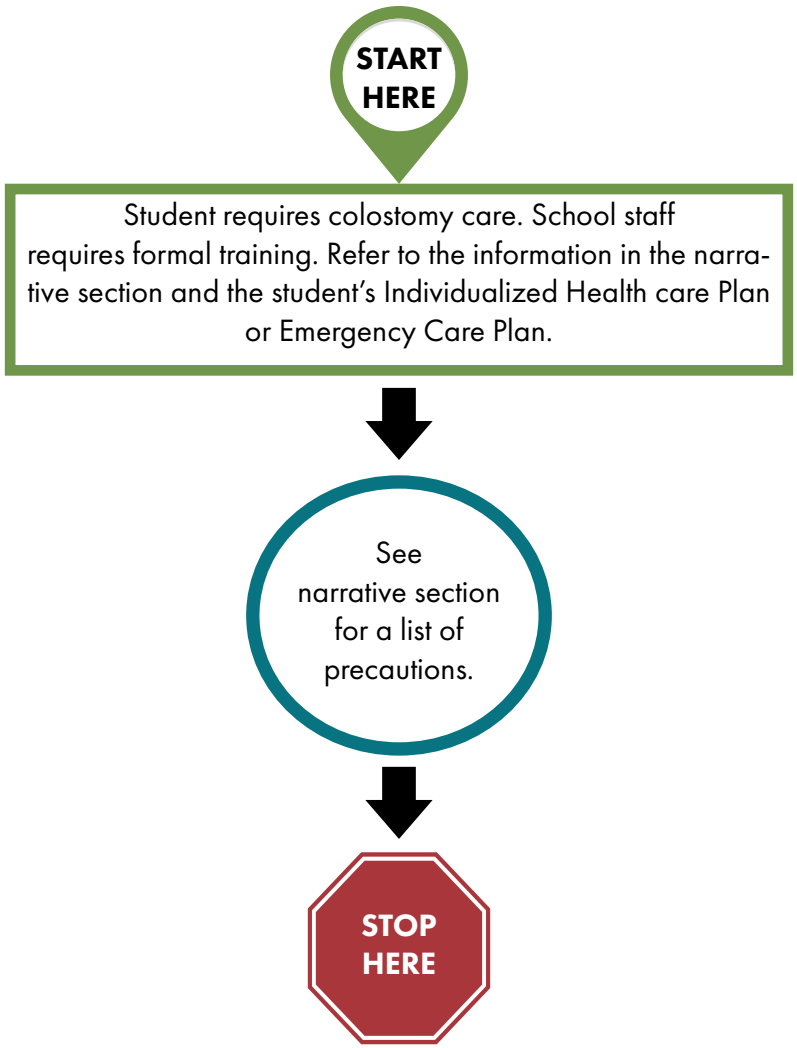
School staff dealing with students who require catheter care during the school day require formal training by the student's parent/guardian, or preferably by a health care provider. Be sure to record the training on the staff training record. Refer to the Forms section of this manual for a sample Specialized Procedure Training form.

The student's Individualized Health care Plan (IHP) and/or Emergency Care Plan (ECP) should outline the details of care, cleaning procedures, how to empty the drainage bag and what to do if the tube comes out; hence, steps for these procedures are not included in this manual. Refer to the Forms section of this manual for a sample of a general IHP and ECP.

Documentation of all cares should be recorded. Refer to the Form section of this manual for a sample Documentation of Procedure Administration form.

As with any procedure being performed, good hand washing with soap and water is critical to prevent infection.

Colostomy Care



Colostomy Care

Overview

A colostomy is an opening that is made in the colon with surgery. After the opening is made, the colon is brought to the surface of the abdomen to allow stool to leave the body. The opening at the surface of the abdomen is called a stoma. The stool leaves the colon through the stoma and drains into a flat, changeable, watertight bag or pouch. The pouch is attached to the skin with adhesive.

A colostomy sometimes is needed for certain health conditions or diseases. A temporary colostomy may be needed to allow the colon to rest and heal for a period and will eventually be closed and bowel movements will return to normal. A permanent colostomy usually is needed when a part of the colon must be removed or cannot be used again.

Precautions

School staff should be aware that body imagine and/or self-esteem are common concerns many students have with a colostomy. Students with colostomies may have concerns about participating in gym or swimming classes and using the restroom or locker room. Some students also may be concerned with the inability to control when they have a bowel movement and/or the passage of gas and the accompanying odor. Many interventions can be implemented to decrease these concerns and should be addressed in the student's Individualized Health care Plan (IHP) and/or Emergency Care Plan (ECP).

The student's parent/legal guardian should be called if any of the following situations occur:

- Severe cramps lasting more than a few hours.
- Watery discharge from the stoma for more than a few hours.
- Blood in the stool/pouch.
- Bleeding or discoloration of the stoma.
- Injury or cut to the stoma.
- Bulging or other changes in the abdomen.
- Unusual odor lasting more than a week.

School staff dealing with students who require colostomy care during the school day require formal training by the student's parent/guardian, or preferably by a health care provider. Be sure to record the training on the staff training record. Refer to the Forms section of this manual for a sample Specialized Procedure Training form.

The student's IHP and/or ECP should outline the details of care, cleaning procedures, how to empty the pouch and what to do if the pouch falls out; hence, steps for these procedures are not included in this manual. Refer to the Forms section of this manual for a sample of a general IHP and ECP.

Documentation of all cares should be recorded. Refer to the Forms section of this manual for a sample Documentation of Procedure Administration form.

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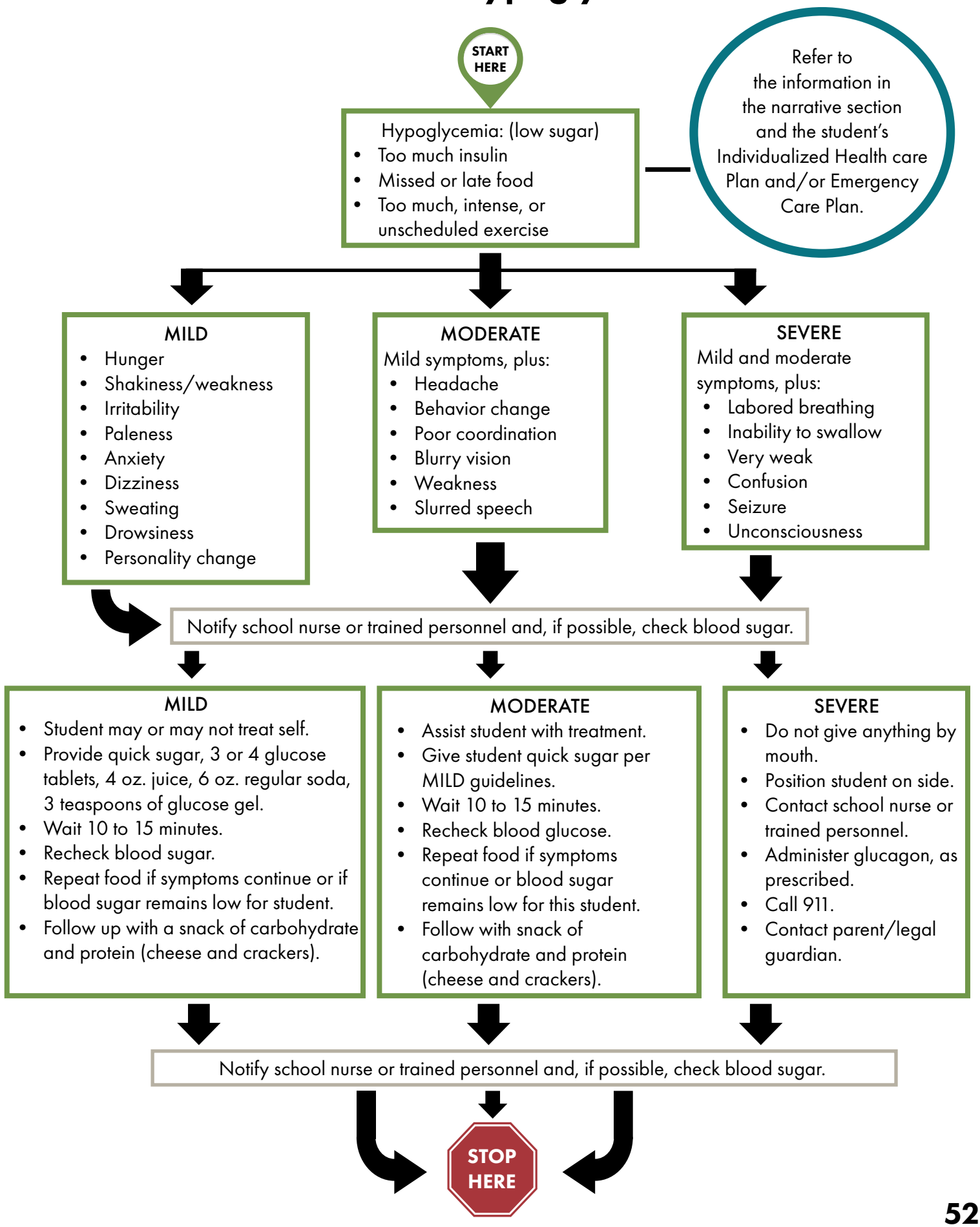
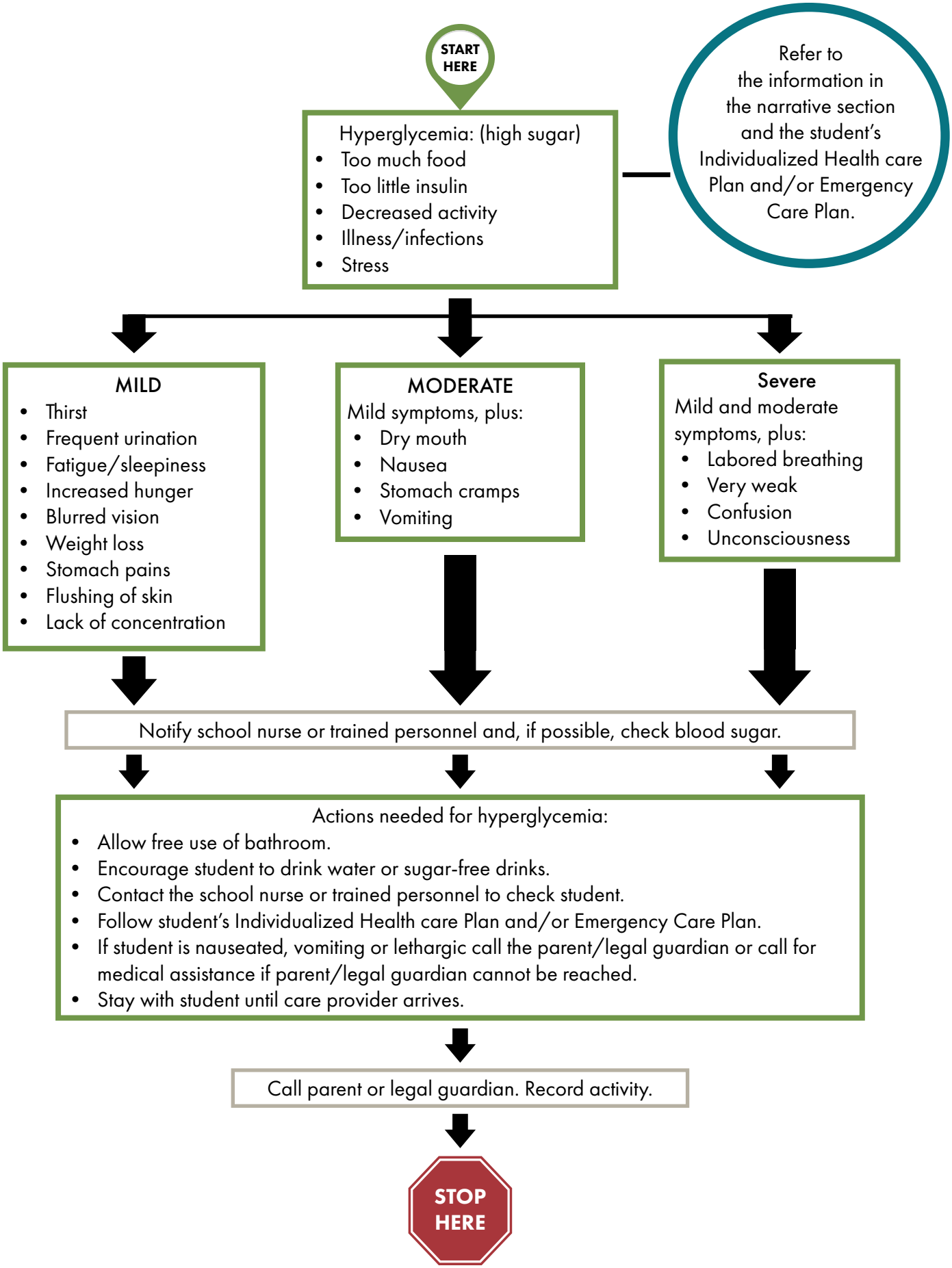
Diabetes - Hypoglycemia



Diabetes - Hyperglycemia



Diabetes

Overview

Diabetes is a chronic disease in which the body does not make or properly use insulin, a hormone needed to convert sugar, starches, and other food into energy. There are two main types of diabetes: type 1 (juvenile onset) and type 2 (adult onset). A third type – gestational diabetes – occurs only during pregnancy and ends after delivery. Diabetes is one of the most common chronic diseases in school-age children.

People with diabetes have increased blood glucose (sugar) levels because they lack insulin, have insufficient insulin or are resistant to insulin's effects. High levels of glucose build up in the blood and spill into the urine. As a result, the body loses its main source of fuel. When insulin is no longer made, it must be obtained from another source – insulin shots or an insulin pump. When the body does not use insulin properly, oral medications may be taken instead of, or in addition to, insulin shots. Neither insulin nor other medications are cures for diabetes; they only help control the disease.

Taking care of diabetes is important. If not treated, diabetes can lead to serious health problems. The disease can affect the blood vessels, eyes, kidneys, nerves, gums, and teeth and is the leading cause of adult blindness, lower limb amputations and kidney failure. People with diabetes also have a higher risk of heart disease and stroke. Although there is no cure, the disease can be managed, and complications delayed or prevented by keeping blood glucose levels near normal.

Diabetes Management in School

The school nurse, teachers, and other school staff members play an important role in helping students manage their diabetes. As with any procedure, school staff providing assistance to students with diabetes require formal training by the student's parent/guardian, or preferably by a health care provider. Be sure to record the training on the staff training record. Refer to the Forms section of this manual for a sample Specialized Procedure Training form.

The goal of effective diabetes management is to control blood glucose levels by keeping them within a target range that is determined for each child. The key to optimal blood glucose control is to carefully balance food, exercise, and insulin or medication. Elements of effective diabetes management in school include:

- Developing and following the student's Individualized Health care Plan and/or Emergency Care Plan. (Refer to the Forms section of this manual for sample plans.)
- Monitoring blood glucose.
- Understanding and recognizing hyperglycemia.
- Following an individualized meal plan.
- Getting regular physical activity.
- Administering insulin.
- Planning for special events.
- Planning for disasters and emergencies.
- Dealing with emotional and social issues.

Students with diabetes are more likely to succeed in school when students, parents/legal guardians, school nurses, principals, teachers, other school personnel and the student's health care providers work together to ensure effective diabetes management. Written plans are recommended to ensure appropriate diabetes management in the school setting.

Diabetes

(continued)

Examples include:

- *Diabetes Medical Management Plan, Education Plans (Section 504) or Individualized Health care Plan or Emergency Care Plan* – describes the diabetes health care regimen developed by the student's health care provider. The American Diabetes Association has training resources for school staff at: diabetes.org/tools-support/know-your-rights/safe-at-school-state-laws.
  You may also refer to the Forms section of this manual for sample diabetes care plans.

Hypoglycemia

If blood glucose levels are too low or too high, students often can take corrective action, such as eating, modifying their activity level or administering insulin to prevent more severe symptoms.

Hypoglycemia means LOW blood sugar. It usually occurs because of administering too much insulin, skipping, or delaying meals or snacks, not eating enough food as prescribed in the meal plan, exercising longer and more intensely than normal, or a combination of these factors.

Hypoglycemia is the greatest immediate danger to students with diabetes.
It can usually be treated easily and effectively but, if not treated promptly, can be life-threatening.

Hypoglycemia Symptoms

Mild	Moderate	Severe
• Hunger • Shakiness/weakness • Irritability • Paleness • Anxiety • Dizziness • Sweating • Drowsiness • Personality change • Inability to concentrate	Mild symptoms, plus: • Headache • Behavior change • Poor coordination • Blurry vision • Weakness • Slurred speech • Confusion	Mild and moderate symptoms, plus: • Labored breathing • Inability to swallow • Very weak • Confusion • Seizure • Unconsciousness

Many students who use insulin may have a Glucagon Emergency Kit for Low Blood Sugar on hand at all times to counteract severe hypoglycemia that causes loss of consciousness or if sugar cannot be given. Storage temperatures should be less than 90 degrees F (28 degrees C). In the United States, the glucagon kit is dispensed by prescription only. If glucagon is available and you have trained personnel, administer it per the instructions. Glucagon can cause vomiting, so be sure to place the person on his or her side prior to injecting so they do not choke. After injecting glucagon, call 911 or your emergency response number. Follow with food once the person regains consciousness and can swallow. Never give food to a person with diabetes who is unconscious from hypoglycemia.

Diabetes

(continued)

Hyperglycemia

Hyperglycemia means HIGH blood sugar. It is usually caused by too little insulin, illness, infection, injury, stress or emotional upset, ingestion of food that has not been covered by the appropriate amount of insulin, or decreased exercise or activity. In the short term, hyperglycemia can impair cognitive abilities and adversely affect academic performance.

Over a long period of time, high blood glucose levels can lead to serious complications. Diabetic ketoacidosis (DKA) is a condition that can occur due to insufficient insulin in the body and may be the first sign of diabetes in people who have not yet been diagnosed. DKA usually develops slowly and presents with early symptoms of thirst and frequent urination. If left untreated, more severe symptoms may appear quickly and include fruity/acetone-smelling breath, deep and rapid breathing, flushed face, headache, muscle stiffness, stomach pain, nausea, vomiting, and sleepiness. DKA can lead to coma and death if not treated promptly.

Hyperglycemia		
Mild	**Moderate**	**Severe**
• Thirst • Frequent urination • Fatigue/sleepiness • Increased hunger • Blurred vision • Weight loss • Stomach pains • Flushing of skin • Lack of concentration • Sweet, fruity breath	Mild symptoms, plus: • Dry mouth • Nausea • Stomach cramps • Vomiting	Mild and moderate symptoms, plus: • Labored breathing • Very weak • Confusion • Unconsciousness

Sometimes, an extra dose of insulin may be given for high blood sugar levels. The instructions for administration of extra insulin should be outlined in the student's Individualized Health care Plan and/or Emergency Care Plan. Refer to the Forms section of this manual for a sample Diabetes Medical Management Plan form and Emergency Care Plan.

Monitoring Blood Sugar Levels

A glucose (blood sugar) meter is used to check blood sugar levels and helps to treat low or high blood sugar before it becomes an emergency. Glucose meters vary, but all require a small drop of blood to be placed on a test strip to record the blood sugar level. Some students may be able to use the monitor independently, while others may require assistance. Because there are many different types of glucose meters, staff assisting students should be instructed about the use of a specific student's meter by the parent/legal guardian or a health care provider. It is important to remember that even if the student is independent with checking his/her blood sugar level, assistance may be required if the student is feeling ill. Students and staff should be aware of the appropriate procedures for sharps disposal of lancets for the glucose meter and insulin syringes. Refer to the Disposal of Sharps section of this manual for more information.

Resources

- *Helping the Student with Diabetes Succeed – A Guide for School Personnel*
  A joint program of the National Institutes of Health and the U.S. Centers for Disease Control and Prevention. The purpose of the guide is to educate and inform school personnel about diabetes, how to manage it and how each member of the school staff can help meet the needs of students with diabetes.

Gastronomy Tubes

Student requires gastrostomy tube feeding, care and/or medication administration. School staff requires formal training. Refer to the information in the narrative section and the student's Individualized Health care Plan and/or Emergency Care Plan.

Gastrostomy tube comes out. DO NOT PANIC.

- Cover the hole with a clean, dry cloth.
- Call parent or guardian.
- See narrative section for additional precautions.

Gastrostomy Tubes

Overview

A gastrostomy feeding tube is either a tube or a button (skin-level device) that is surgically placed into the stomach through the abdominal wall. There are a wide variety of tubes and skin-level devices that are used. Children require gastrostomy feeding tubes for a variety of reasons. The primary indication for a gastrostomy tube is the child's inability to take adequate nutrition or liquids by mouth for growth and development. The reasons why the child is unable to take proper nutrition can be developmental, mechanical, or secondary to other health problems. Medications also can be administered through a gastrostomy tube.

Precautions

It is possible for the student's gastrostomy tube to accidentally come out. If this should happen, DO NOT PANIC. The site may bleed a little, stomach contents may leak out of the hole, and the child may complain of slight pain or discomfort. Cover the hole with a clean, dry cloth and call the child's parent/guardian. Follow additional instructions as outlined on the student's Individualized Health care Plan (IHP) and/or Emergency Care Plan (ECP).

School staff dealing with students who require gastrostomy feedings and/or medication administration during the school day require formal training by the student's parent/guardian, or preferably by a health care provider. Be sure to record the training on the staff training record. Refer to the Forms section of this manual for a sample Specialized Procedure Training form.

The student's IHP and/or ECP should outline the details of feedings and/or medication administration, cleaning procedures and what to do if the tube comes out; hence, steps for these procedures are not included in this manual. Refer to the Forms section of this manual for a sample of a general IHP and ECP.

Documentation of all cares should be recorded. Refer to the Forms section of this manual for a sample Documentation of Procedure Administration form.

As with any procedure being performed, good hand washing with soap and water is critical to prevent infection.

Homeless Students

Homeless Students

Overview

Although we do not see large numbers of homeless students in North Dakota, it is important for us to become familiar with laws and regulations relating to this.

Each school district homeless education liaison must ensure that the parent or legal guardian of a homeless student and any unaccompanied youth are fully informed, in the language of the home, of all transportation services, including transportation to the school of origin, and are assisted in accessing transportation to the school selected.

Changing schools can impede students' academic and social growth. It may take a student four to six months to acclimate educationally after changing schools. Highly mobile students have been found to have lower test scores and diminished academic achievement. Therefore, McKinney-Vento permits homeless students to remain in their school of origin despite their residential instability and to receive the transportation services that will help provide that educational stability.

McKinney-Vento Homeless Assistance Act

The educational program for Homeless Children and Youth administered by the North Dakota Department of Public Instruction provides funding to local educational agencies, shelters and other organizations that provide services to homeless children and youth in North Dakota. Such services may include, but are not limited to tutoring, counseling, help with transportation, school supplies, etc.

The program's goal is to provide activities/services to homeless children and youth, including preschool-age children, that enable them to enroll in, attend and succeed in

school. Homeless children and youth have the right to have access to the same free and appropriate public education as other children and youth.

The North Dakota Department of Public Instruction began providing McKinney-Vento, formerly known as McKinney Act, funds in 1988 to programs for homeless children and youth. North Dakota receives annual funding for this program. The funding averages at approximately $120,000. It is estimated that about 700 homeless children and youth are served annually with McKinney-Vento Act funds.

Section 725 (2) of the Act defines the term "homeless children and youths" as an individual who lacks a fixed, regular, and adequate nighttime residence. This includes:

- Children and youth who are sharing the housing of other individuals due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, trailer parks, or camping grounds due to the lack of alternative adequate accommodations; are living in emergency or transitional shelters; are abandoned in hospitals; or are awaiting foster care placement.
- Children and youth who have a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings (within the meaning of section 103(a)(2)(C)).
- Children and youth who are living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings.
- Migratory children (as such term is defined in section 1309 of the Elementary and Secondary Education Act of 1965) who qualify as homeless for the purposes of this subtitle because the children are living in circumstances described in clauses (i) through (iii).

This information was taken from 42 U.S.C. 11434a(2); Pub. L. 100-77 Title VII §725 (2); 115 Stat. 2005.

Homeless Students

(continued)

School Selection and Transportation Requirements for Homeless Students

This advisory is intended to provide guidance to school officials as they implement the federal McKinney-Vento Homeless Education Assistance Act requirement regarding a homeless student's rights to school selection and transportation services.

Local school districts must act in the best interest of the homeless student by:

- Continuing the student's education in the school of origin until the end of the year in which the student obtains permanent housing.
- Enrolling the student in a public school that area or district non-homeless students attend.

In addition, school districts must adopt policies and practices to ensure that transportation is provided at the request of the parent, legal guardian, or liaison (as in the case of an unaccompanied youth) to and from the school of origin.

Furthermore:

- If the homeless student continues to live in the area served by the district in which the school of origin is located, that district must provide or arrange transportation.
- If the homeless student moves to an area served by another district though continuing his or her education at the school of origin, the district of origin and the district in which the student resides must agree upon a method to apportion responsibility and costs for transportation to the school of origin.
- If the districts cannot agree upon such a method, the responsibility and costs must be shared equally.

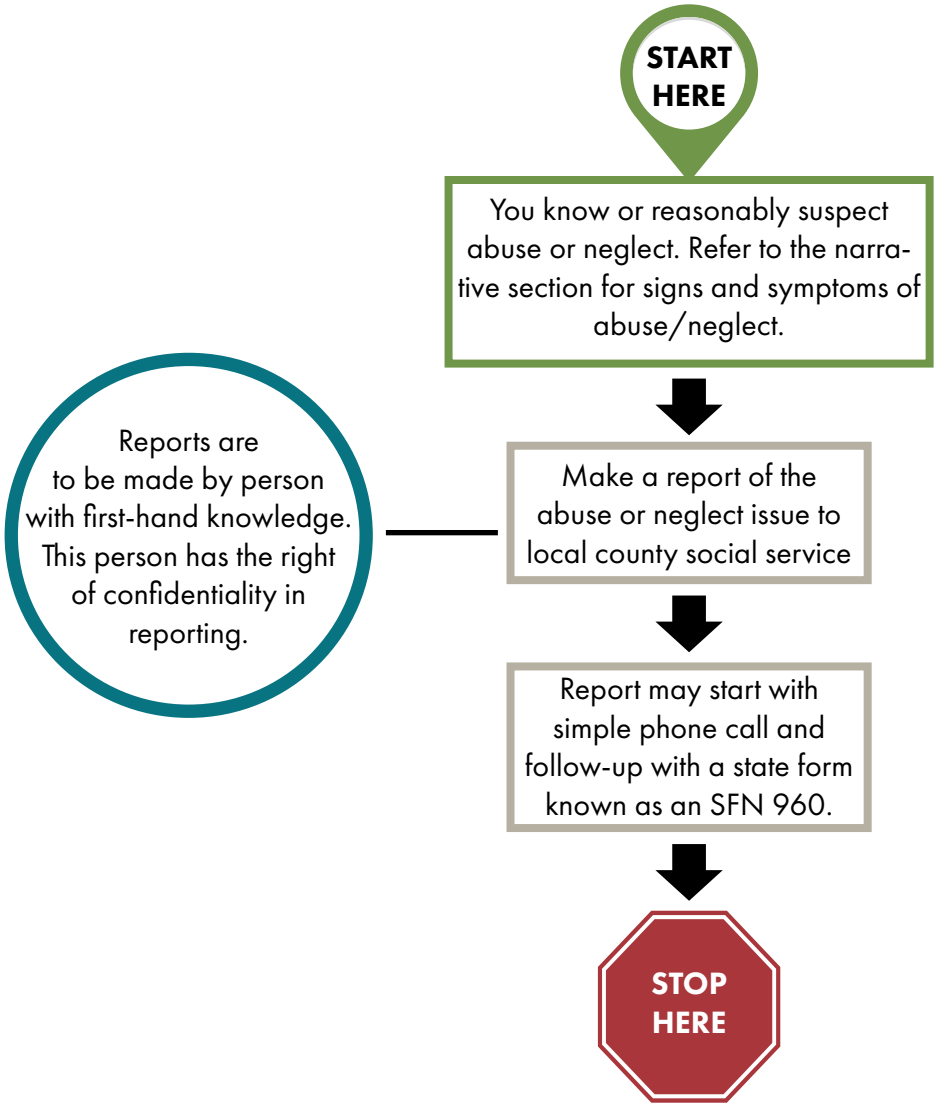
In addition, districts must provide transportation services to homeless children and youth that are comparable to those received by other students.

North Dakota Century Code 15.1-19-08. Homeless Child - Education.

1. A homeless child is entitled to a free public school education, in the same manner as that provided to other public school students, in accordance with the Stewart McKinney Homeless Assistance Act [Pub. L. 100-77; 101 Stat. 525; 42 U.S.C. 11431 et seq.].
2. A school district shall allow a nonresident homeless child to attend school.
3. For the purposes of this section, "homeless child" means a homeless individual as described in the Stewart B. McKinney Homeless Assistance Act [Pub. L. 100-77, section 103(a); 101 Stat. 485; 42 U.S.C. 11302] and as defined in rules adopted by the superintendent of public instruction.
4. The superintendent of public instruction shall adopt rules to implement this section. The rules must provide for the educational placement of homeless children according to each child's best interest.

This section leads to the conclusion that students that fall into this category will still be given the same access to medical care and services in our school systems as other students.

Mandatory Reporting of Abuse and Neglect



Mandatory Reporting of Abuse and Neglect

Overview

Professionals having knowledge of or reasonable cause to suspect that a child is abused or neglected or has died because of abuse or neglect must make a report of the circumstances.

Those professionals required to report include:

- Physicians, nurses, dentists, optometrists, medical examiners, coroners, or any other medical professional
- Mental health professionals
- Religious practitioners of the healing arts
- School teachers, administrators, school counselors
- Addiction counselors
- Social workers
- Day-care center or any other child-care workers
- Police or law enforcement officers
- Members of the clergy
- People having reasonable cause to suspect that a child is abused or neglected or has died because of abuse or neglect

Physical abuse is an injury to a child that is not accidental. Most individuals do not intend to hurt children, but abuse is defined by the effect on the child, not the motivation of the individuals. Physical abuse can include but is not limited to:

- Bruises or cuts
- Head injuries
- Poisoning
- Fractures, sprains
- Burns or scalds
- Internal injuries
- Electrical shocks
- Death

Sexual abuse occurs when a person uses or attempts to use a child for their own sexual gratification. This includes incest, rape, sodomy, sexual penetration, fondling, voyeurism, and sexual harassment.

Neglect is the most common form of abuse seen and may have long-term effects. Neglect is failing to provide adequate food, clothing, shelter, supervision, or medical care. Parents must provide adequate supervision, care, guidance, and protection to keep children from physical or mental harm. Parents also must provide appropriate treatment for children's problems. Children will have minor injuries during childhood; however, when accidental injuries are frequent, they may be the result of neglect. Signs of possible neglect include:

- Poor hygiene
- Improper clothing for the weather
- Extreme hunger
- Falling asleep in class
- Medical issues not attended to
- Reported lack of supervision in home
- Missing above normal or expected amounts of school days without reasonable explanation

Mandatory Reporting of Abuse and Neglect

(continued)

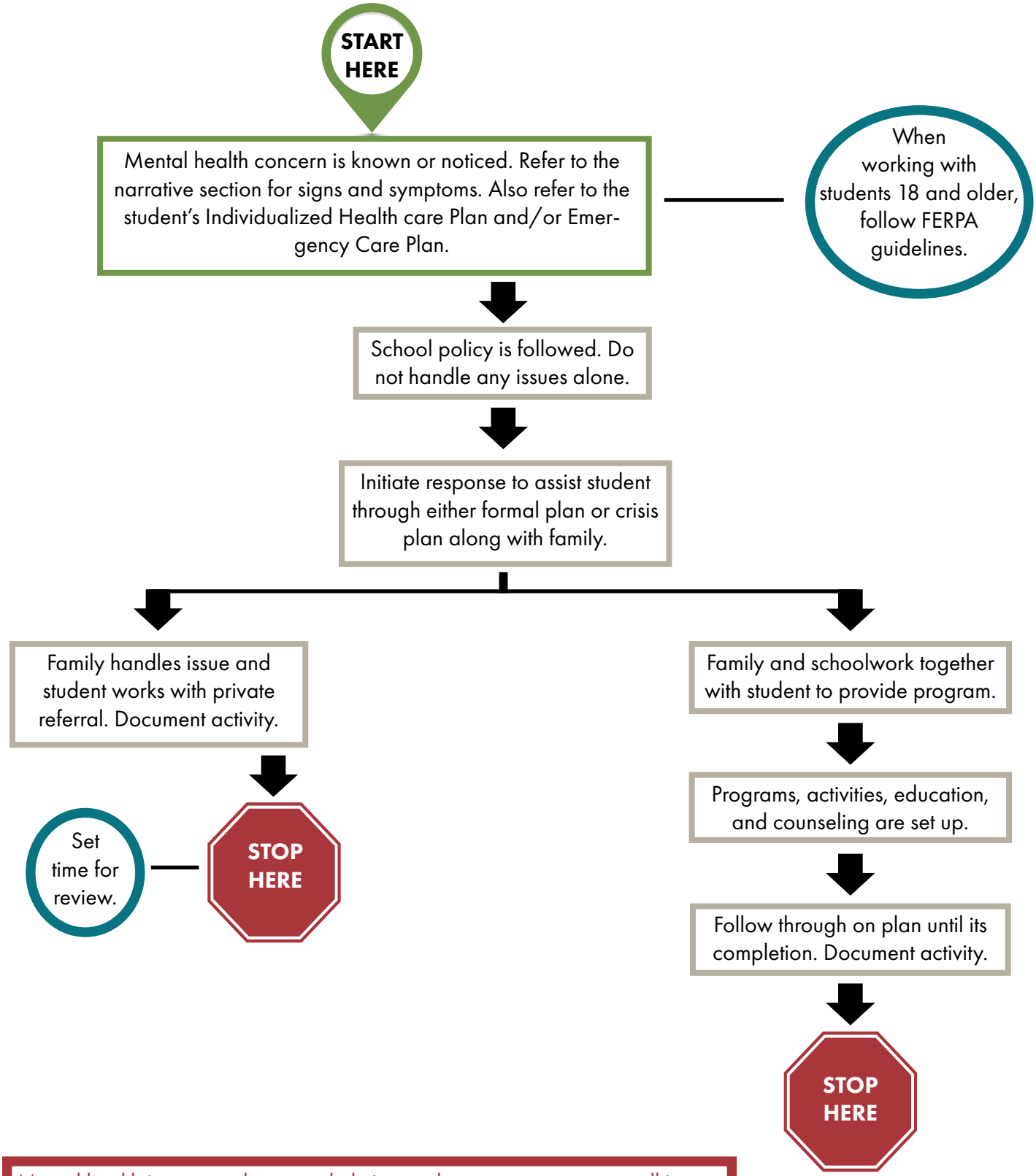
Procedure To Make a Report:

- When you suspect that a child has been abused or neglected or you reasonably suspect that a child has been harmed or is in danger of being harmed, you must make a report to the local county of residence of the child.
- Reporting is done as soon as possible and can be initiated by calling the statewide toll-free Child Abuse & Neglect Reporting Line at 833.958.3500.
  If it's an emergency and a child is in immediate danger, call 911 NOW.
- Remember, it is not your responsibility to investigate or prove the possible abuse or neglect. Your job is just to report.
- Once you have reported the event, you may choose to report to your supervisor. Most schools will have a policy on this. It is your right to confidentiality in reporting.
- Your responsibility is done. You may be questioned by the county personnel, but do not question the child any further. This may hamper the investigation.

Some Suggestions for Professional Staff and Rulings:

- Always report suspected concerns. Failure to report is a Class B misdemeanor and carries fines.
- Never tell a child that you will keep his or her secrets.
- Report as soon as you can to keep information clear and factual.
- Never make the decision on your own that the child is lying.
- Never assume that this must have been reported before. Children will sometimes open up after they feel that they can trust the adult. This trust may take time.
- Don't try to investigate. Your job is to report.
- Reporting parents/legal guardians, caregivers, coworkers, or school systems is stressful at best. Remember, protecting the child is your priority.
- Reporting does not mean you are condemning the person being reported. You are just reporting what a child tells you or what is suspected with given information. Your report is confidential, and your name is not to be given out to family or coworkers.

Mental Health Issues



Mental health issues can be overwhelming, so be sure to team up on all issues and involve family as well as the student, when possible. Plans can be formal, such as an Individualized Education Plan, or informal, such as a crisis plan developed on the spot for the student until a more formal plan is developed by either the family or the family and the school. COMMUNICATION is key.

Mental Health Issues

Overview

Mental health issues in schools can be very difficult to identify and/or deal with. The first thing we should do is try to understand normal development of children. There are many books on the topic, and you are encouraged to get reference material for staff. Primary prevention is providing students with tools and skills that will allow them to have a positive educational experience. Secondary prevention is identifying issues and resources for students who are struggling within the school setting. The third level is providing services to students who are actively displaying mental health issues.

Common School Issues (This is not intended to be a complete listing.)

Depression

Depression is an illness that evolves from a normal emotional reaction into a disorder typified by feelings and behaviors that last longer than a few days. Depression may require treatment of some kind. Some signs of depression are:

- Depressed or irritable mood for most of the day
- Diminished interest in most, if not all, activities
- Significant increase or decrease in weight
- Sleeplessness or sleep-pattern changes
- Slowed body movements or hyperactivity
- Loss of energy
- Feelings of worthlessness and guilt
- Thoughts of death/suicide – with or without a plan

What Can Schools Do?

- With assistance of family, refer child to mental health professional
- Implement a primary prevention program that stresses the normalcy of feelings following certain events and proactive techniques daily
- Provide in-service for staff to help them understand the issue
- Promote awareness about stress and other issues to students, family, and staff
- Establish procedures for issues your school faces

Suicide Concerns

Suicide tendencies may be a symptom of depression and may have implications for your school and community. Good planning and awareness are key to being ready to deal with the potential issues. Some triggers for suicide can be:

- Humiliation
- Bullying
- Fighting with parents
- School problems
- Abuse
- Breaking up with girlfriend/boyfriend

Red Flags That May Show the Need for Staff to Have a Higher Level of Awareness:

- Reduced class participation for some time
- Sudden lowering of grades
- Loss of interest in activities
- Fatigue
- Inability to concentrate

Mental Health Issues

(continued)

- Outbursts of shouting, complaining or unexplained irritability
- Fear and anxiety
- Aggression, refusal to cooperate and antisocial behavior
- Change in peer group
- Physical complaints
- Alcohol and other drug abuse
- Ongoing thoughts of death and dying with suicide as a theme
- After periods of agitation, sometimes days and weeks, the student is very content as if nothing were ever wrong – all is right with their world.

Signs To Be Taken Seriously and That Require a Response Right Away:

- Making final arrangements
- Loss of family or friend to death
- Previous suicide attempts
- Giving away possessions
- Making statements with realistic plan for completion
- Outright statements about killing oneself

What can schools do?

- Start a suicide prevention program with the help of mental health personnel.
- If someone has talked about suicide, talk to a school counselor or other professional attached to your school right away.
- Do not display shock.
- Show person you are truly concerned.
- Do not keep the communication private. Tell student that this will not be kept private.
- Do not leave the individual alone.
- Develop a crisis manual, that includes:
  - Checklist of steps or procedures to use
  - List of crisis intervention team members and contact information
  - List of community resources

Eating Disorders

Because everyone today seems concerned about weight and because most people diet at least occasionally, it is hard to tell what normal behavior is and what is a problem that may escalate to threaten life and happiness. No one person will show all the characteristics listed below, but people with eating disorders will manifest several of the signs and symptoms listed:

Food behaviors

- Skips meals
- Eats only tiny portions
- Will not eat in front of others
- Mixes strange food combinations
- Chew's food, but spits out before swallowing
- No longer likes favorite foods
- Restricts diet and misses needed food groups
- Gorges or eats large amounts in relation to normal eating habits
- May or may not purge
- Uses laxatives or other forms of food disposal other than natural means

Mental Health Issues

(continued)

- Abuses other drugs to medicate feelings
- Eats constantly – food is kept in places for easy access
- Takes diet supplements to replace poor eating habits

Appearance and image behaviors

- Loses or tries to lose weight
- Hides body shape to cover either underweight or overweight issues
- Inspects self in mirror for any flaws, even small ones
- Gains large amount of weight

Exercise behaviors

- Exercises obsessively or compulsively to gain desired look
- Uses steroids to gain mass rather than by using proper diet and exercise
- Becomes tired often
- Performance in athletics suffers

Thoughts and beliefs

- "If I am thinner, I will feel better about myself."
- "There is nothing wrong with what I am doing."
- Has rigid standards for self and others
- Envies thin people

Feelings

- Has trouble talking about feelings
- Becomes moody
- Withdraws into self and expresses no need for others
- Is fearful of messing up
- Seems depressed
- Displays anxiety
- Shows despair

Self-harm

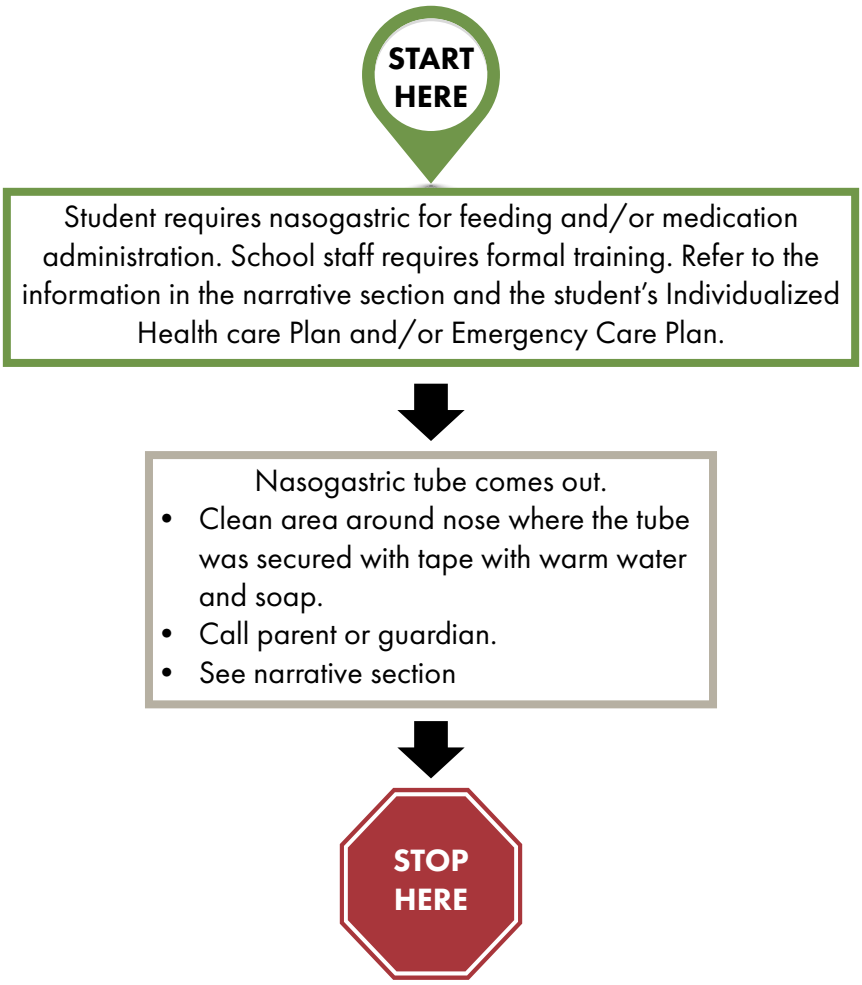
- Cutting self to cover pain
- Causing other injuries, but not suicidal

Other behaviors

- Tries to please everyone
- Uses chemicals to self-medicate
- Rage attacks
- Place's self in harm's way
- Stealing
- Engages in criminal behavior
- Generally anything that may cause self-harm

There are many other issues that will show up in school. Some resources would include local social service units, school psychologists, school guidance personnel and others specific to your local area. For more information and behavioral health resources, visit hhs.nd.gov/behavioral-health/directory.

Nasogastric Tubes



Nasogastric Tubes

Overview

A nasogastric tube is a long, narrow, flexible tube that goes down the nose and into the stomach. Children require nasogastric tubes for a variety of reasons. The primary indication for a nasogastric tube is the child's inability to take adequate nutrition or liquids by mouth for growth and development. The reasons why the child is unable to take proper nutrition can be developmental, mechanical, or secondary to other health problems. Medications also can be administered through a nasogastric tube.

The nasogastric tube usually is used when tube feeding and/or medication administration will be required for a short time (i.e., less than three months), although in some cases it can be used for several years. The major advantage of nasogastric tubes over gastrostomy tubes is getting nasogastric tubes do not require surgery.

Precautions

The disadvantages of nasogastric tubes include nasal or throat irritation and discomfort (especially if used long-term); increased mucus secretion; and partial blockage of the nasal airways. Nasogastric feeding may contribute to recurrent otitis media (ear infection) and sinusitis. Two additional disadvantages are the possibility that the tube will puncture the esophagus or the stomach and the possibility that the tube will enter the trachea, delivering formula into the lungs. If formula enters the lungs, severe or fatal pneumonitis can result; therefore, it is essential to confirm that the NG tube is in the stomach before feeding and/or medication administration begins.

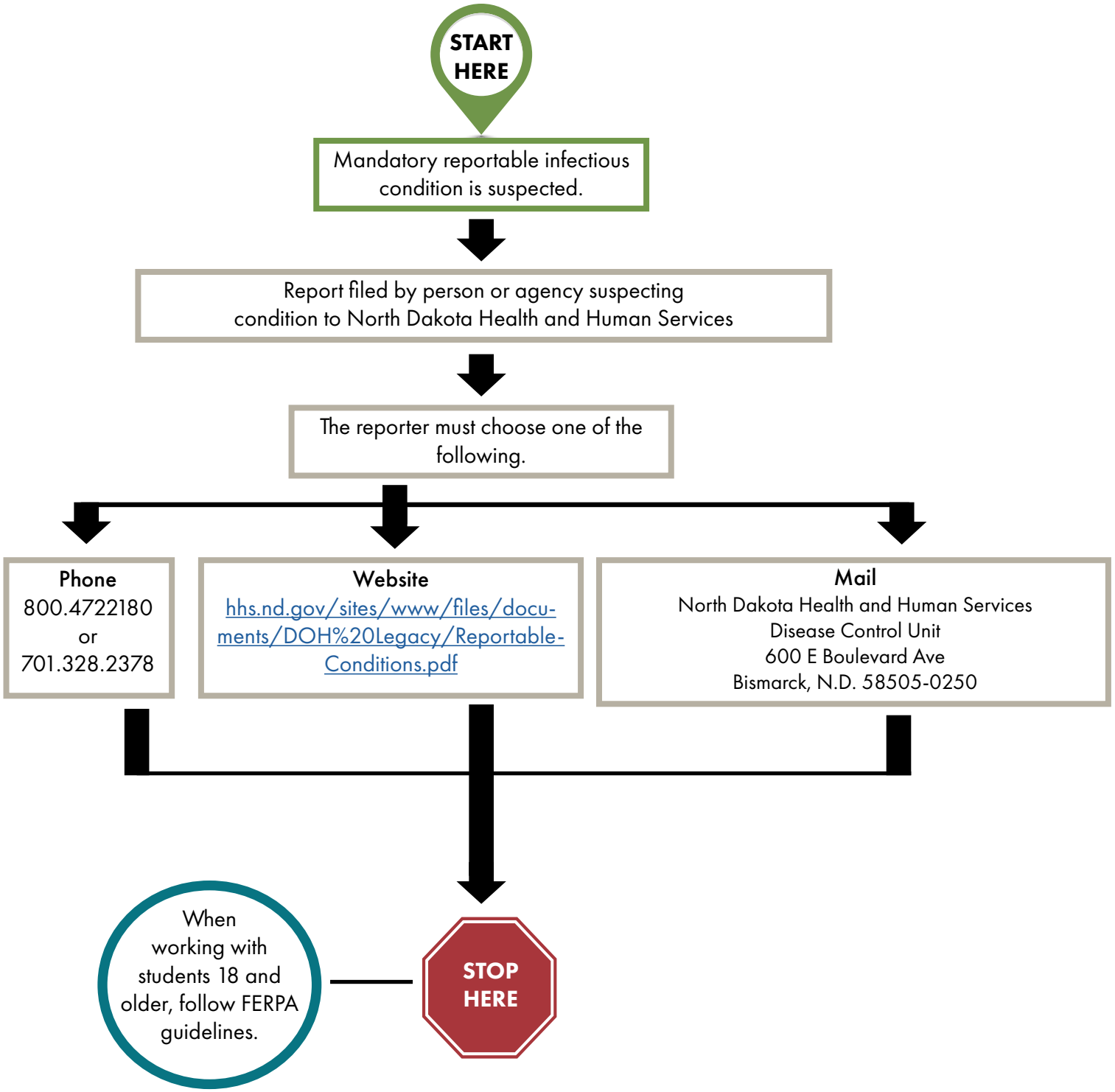
School staff dealing with students who require nasogastric feedings and/or medication administration during the school day require formal training by the student's parent/guardian or preferably by a health care provider. Be sure to record the training on the staff training record. Refer to the Forms section of this manual for a sample Specialized Procedure Training form.

The student's Individualized Health care Plan (IHP) and/or Emergency Care Plan (ECP) should outline the details of feedings and/or medication administration, cleaning procedures and what to do if the tube comes out; hence, steps for these procedures are not included in this manual. Refer to the Forms section of this manual for a sample of a general IHP and ECP.

Documentation of all cares should be recorded. Refer to the Forms section of this manual for a sample Documentation of Procedure Administration form.

As with any procedure being performed, good hand washing with soap and water is critical to prevent infection.

Reporting Infectious Conditions and Immunizations Requirements



Reporting Infectious Conditions and Immunizations Requirements

Overview

North Dakota Century Code 23-07-02 requires public and private elementary and secondary schools to report to North Dakota Health and Human Services any reportable disease coming to their knowledge. A complete list of all mandatory reportable conditions can be accessed at hhs.nd.gov/sites/www/files/documents/DOH%20Legacy/ReportableConditions.pdf. It is recommended that you print out a copy of these conditions for a reference. All mandatory reportable conditions must be reported within seven days unless otherwise specified. Some conditions require immediate reporting by phone, such as measles or pertussis (whooping cough).

To Report a Known of Suspected Condition:

- By telephone: 800-472-2180 or 701-328-2378
  - Electronically at the following website: hhs.nd.gov/sites/www/files/documents/DOH%20Legacy/ReportableConditions.pdf
- Mail a printed form (accessed at the above website) to:
  North Dakota Health and Human Services
  Disease Control Unit
  600 East Boulevard Ave
  Bismarck, N.D. 58505-0250

Disease Fact Sheets

A large variety of disease fact sheets are available online at:
hhs.nd.gov/health/diseases-conditions-and-immunization

School Immunization Requirements

North Dakota Century Code 23-07-17.1 and Administrative Rule 33-06-05-01 state a child may not be admitted to any public, private or parochial school; day-care center, child-care facility, Head Start program or nursery school operating in the state; or be supervised through home-based instruction unless the child's parent or guardian presents to the institution authorities a certificate from a licensed physician or authorized representative of North Dakota Health and Human Services showing that the child has received age-appropriate immunizations. Requirements are updated annually and posted on the Immunization Program website at:
hhs.nd.gov/health/diseases-conditions-and-immunization

Exemptions

Students may be exempt from immunization requirements for the following reasons:

- Medical Exemption: Requires a certificate from a licensed physician stating that the physical condition of the child is such that immunization would endanger the life or health of the child.
- Philosophical, Moral or Religious Belief Exemption: Requires a certificate signed by the parent or legal guardian who's sincerely held philosophical, moral, or religious belief is opposed to such immunization.
- History of Disease Exemption: Requires a certificate signed by the parent or legal guardian or physician stating that the child has a reliable history of the disease.

Seizures

START HERE

Possible signs of a seizure may include loss of eye contact; twitching of arms and legs; jerking movements of arms and legs; unusual behavior for the person (e.g., running, belligerence, making strange sounds, etc.). Refer to student's Individualized Health care Plan and/or Emergency Care Plan.

Beyond normal for the average child.

If student is unstable, place him or her on floor or mat as safely as possible and observe.

- Do not restrain.
- Move objects away from student.
- Do not place anything in mouth of student.

Observe student for details of seizure to relate to parent/legal guardian or medical personnel.

- Duration
- Movement
- Behavior or level of alertness
- Any observations of importance

Call emergency services immediately for a student:

- Having a seizure for the first time.
- Having a seizure lasting longer than five minutes.
- Having seizures that are different from what the student normally experiences.
- Having breathing difficulty.
- Having changes in skin color (bluish, gray).
- Who has sustained a head injury.
- Who appears ill or has been injured.
- Who has diabetes.
- Who has a known heart condition.
- Suspected of ingesting any poisons, medications, etc.

NO

Keep student safe. Often seizures are followed by sleep period. Allow student to recover. Once awake, encourage him/her to get involved with class at a level that is comfortable for him/her and follow health plan.

STOP HERE

YES

Call EMS and contact all parties required by school.

Seizures

Overview

A seizure is a change in sensation, awareness or behavior brought about by a brief electrical disturbance in the brain. Seizures may be convulsions, short periods of unconsciousness, distortion of the senses, or loss of control over movement. There are more than 20 different types of seizures.

The kind of seizure a person has depends on which part of the body is affected by the electrical disturbance, i.e., where in the brain seizure starts and where it spreads. The most common seizure types are classified as either partial or generalized. Partial seizures happen when the disturbance occurs in just one part of the brain, affecting whatever physical or mental activity that area controls. Generalized seizures happen when the electrical disturbance sweeps through the whole brain at once, causing loss of consciousness, falls, convulsions or massive muscle spasms.

Most seizures last from 30 seconds to two minutes and do not cause lasting harm. However, it is a medical emergency if seizures last longer than five minutes or if a person has many seizures and does not wake up between them. Some seizures may be the result of a medical problem. Low blood sugar, infection, a head injury, accidental poisoning, or drug overdose can cause a seizure. A seizure also may be due to a brain tumor or other health problem affecting the brain. In addition, anything that results in a sudden lack of oxygen to the brain can cause a seizure. In some cases, the cause of the seizure is never discovered.

When seizures recur, it may indicate the chronic condition known as epilepsy. Some people with epilepsy experience an aura, an unusual sensation that often acts as a warning device signaling the onset of a seizure. It is characterized by a feeling of fear or sickness or an odd smell or taste. Aura is often beneficial. It can serve as a "warning" giving the affected person time to move away from potentially dangerous obstacles or environments that might be hazardous during a seizure.

Seizure Management in School

A student with a history of seizures should have an Individualized Health care Plan (IHP) or Emergency Care Plan (ECP) that outlines the seizure type, onset, duration, and aftereffects. Refer to the Forms section of this manual for a sample Seizure Action Plan and Emergency Seizure Plan.

A student who is having a seizure should be placed on the ground or floor in a safe area. Remove any nearby objects. Loosen any clothing around the head or neck. Do not try to wedge the student's mouth open or place an object between the teeth, and do not attempt to restrain movements. Once the seizure seems to have ended, roll the student onto his or her side.

Observe the student closely for details of the seizure such as duration, kind of movement, body parts involved, loss of consciousnesses, and loss of bladder or bowel control (incontinence). For students with a known seizure history, it is nice to have a change of clothes available for incontinence.

Call emergency medical services immediately for a student:

- Having a seizure for the first time.
- Having a seizure lasting longer than five minutes.
- Having seizures that are different from what the student normally experiences.
- Having breathing difficulty.
- With changes in skin color (bluish, gray).
- Who has sustained a head injury.
- Who appears ill or has been injured.
- Who has diabetes.

Seizures

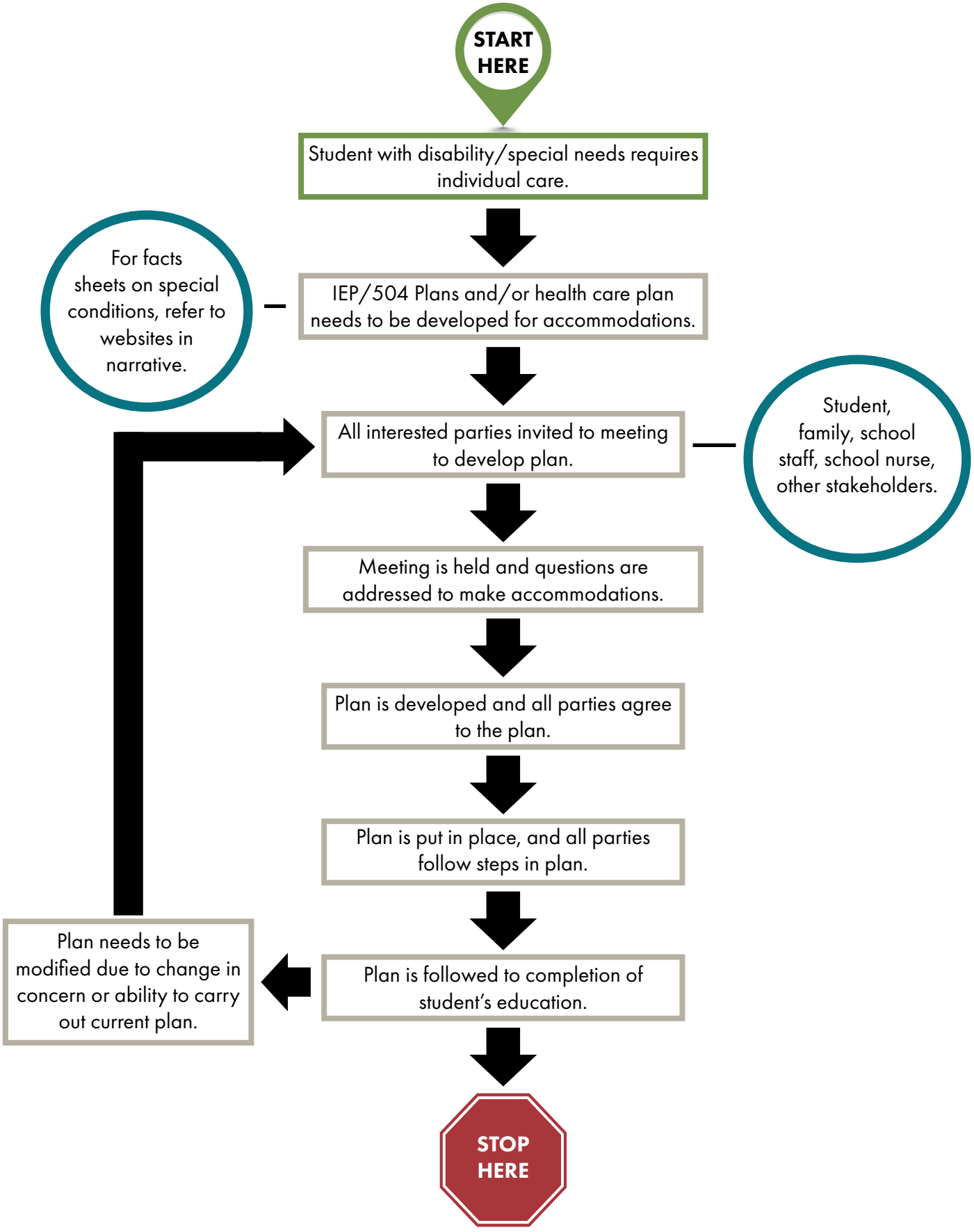
(continued)

- Who has a known heart condition.
- Suspected of ingesting of any poisons, medications, etc.

For students with known seizures, be sure to allow them to complete their pattern of seizure (unless one of the above symptoms is present). Encourage the student to return to class as soon as it is safe for them to do so. For some students, a period of tiredness and/or sleep may occur after the seizure (this is called the postictal period). Do not attempt to give food or drink until the student is fully awake and alert. The parent/guardian may need to be called if the student is too tired to return to classroom activities.

Be sure to document all activity and actions on a Procedure form. Refer to the Forms section of this manual for a sample Documentation of Procedure Administration form.

Special Health Care Needs



Special Health Care Needs

Overview

Approximately 17.3 percent of all children ages 0 to 17 years have a special health care need as defined by the Maternal and Child Health Bureau, based on findings of the 2019-2020 National Survey of Children's Health:

> "...those who have or are at risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of any type or amount beyond that required by children generally."

In addition to an Individualized Education Program (IEP) or 504 Accommodation Plan, it is important to set up an Individualized Health care Plan (IHP). The IHP should contain information about the child's health and identify who will be responsible for monitoring any issues related the child's special healthcare needs at school, during extracurricular activities and field trips, or while being transported to and from school. A meeting should be held involving all partners to have input into the development of the IHP. Partners may include the school nurse, superintendent or principal, other involved school staff, health care providers involved in the child's care, student, parent(s) and other caregivers. The most important component of developing an IHP is good communication between the family and the school. Any person involved with the IHP may call for a new meeting at any time to address evolving concerns. Many different types of IHPs, some developed for a specific condition, generally can be accessed by an Internet search. Refer to the Forms section of this manual for samples of general and specific condition IHPs.

Oftentimes, children with special health care needs are at greater risk for a medical emergency and should have an Emergency Care Plan (ECP) in addition to an IHP. The ECP flows from the IHP with special emphasis on emergency care needed for a student who may have a life-threatening episode and is generally written for the purpose of directing the actions of school personnel. Refer to the Forms section of this manual for samples of a general and specific condition ECPs.

Some conditions that may require an IHP, ECP, IEP and/or a 504 include, but are not limited to:

- Asthma
- Bony deformities
- Burns
- Cancer
- Cerebral palsy
- Cleft lip and/or palate
- Cystic fibrosis
- Dental disorders
- Diabetes
- Genito-urinary tract anomalies
- Growth hormone deficiency
- Hearing loss
- Heart conditions
- Hemophilia
- Joint deformity
- Malocclusion
- Perthes disease
- Phenylketonuria
- Rheumatoid arthritis

Special Health Care Needs

(continued)

- Scoliosis
- Seizure disorders
- Spina bifida
- Strabismus

Below are some questions to be asked in the development of an IHP and/or ECP:

- Do we need to train and supervise school personnel in care of the special medical need?
- Do we need to educate student or classmates?
- Do we need to change school environment to allow access?
- Do we need to change the classroom for lighting, desks, restroom, etc.?
- What are the added safety measures needed?
- What measures do we need to undertake to relieve pain and discomfort?
- Is there a special diet needed?
- Is there assistance for daily living skills needed?
- What medications are being taken?
- Will there be regular contact between school and health care provider?
- Will there be adaptations of school health program?
- Will there be special equipment needed and maintained in school?
- What are the transportation needs?
- Is our building accessible to the student and can it be accessible with the current physical plant?
- What therapies will be done in school?
- What is the student's stamina?
- Are there positioning concerns?
- How independent is the student?
- What backup medical support do we have for the student?
- Will there be a need for special curriculum development?
- Will an aide be needed or is student able to manage own movement and care?
- Are there concerns for fire/evacuation safety for the student?
- What are the needs for field trips?
- What preparations are there for home/hospital tutoring in conditions where this is likely to take place?

These questions and others you find relevant should be addressed when developing the IHP for any special needs student. Care will always vary depending on each individual student and specific needs he or she has. Always follow the health care provider's orders.

Assistive Devices Overview

This section describes equipment needed by students to accommodate their special needs. Each of these is commonly used in schools today.

What Are Assistive Devices? Assistive devices are gadgets that make your life easier. For example, they can help a person pick up food with less difficulty, button a sweater, or maintain stability while walking.

Special Health Care Needs

(continued)

Why Do People Use Assistive Devices?

Research has shown that assistive devices can help alleviate pain and stress on joints, conserve energy and help maintain independence. Assistive devices offer the freedom to lead a more productive daily life than may otherwise be possible.

What Are Some of the Things That Assistive Devices Enable a Person to Do?

Assistive devices can make activities of daily living easier, such as dressing, opening doors, putting on socks and shoes, picking up papers, turning on faucets, eating meals, reading books or writing.

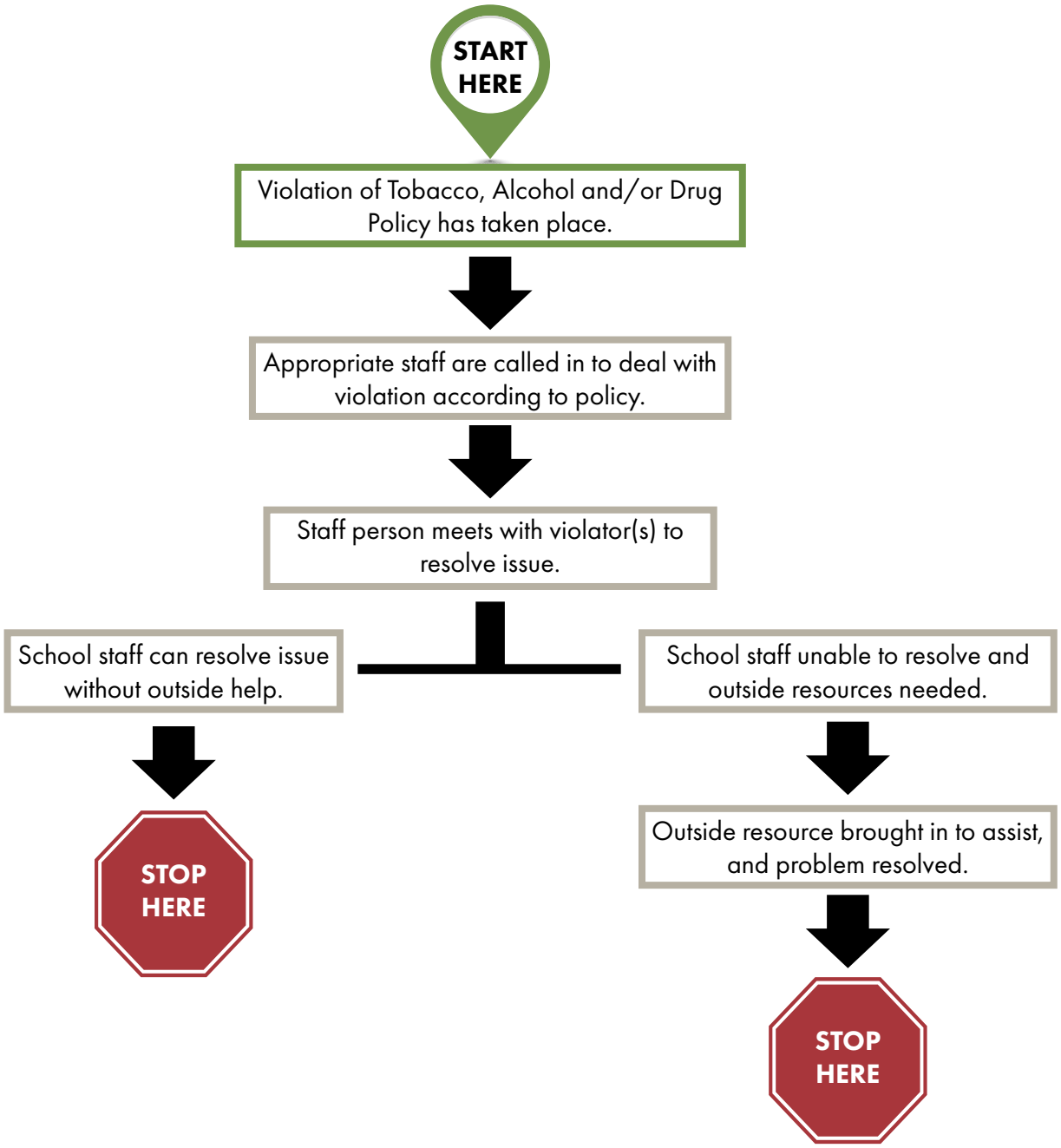
Type of products that are available include:

- Writing grips
- Nonslip placemats
- Hand exercisers
- Reusable hot/cold packs
- Reaching devices
- Easy-pull sock aids
- Wash mitts
- Wheelchairs
- Transfer boards
- Playing card holders
- Keyboards
- Picture cards
- Weighted utensils/equipment
- Braces

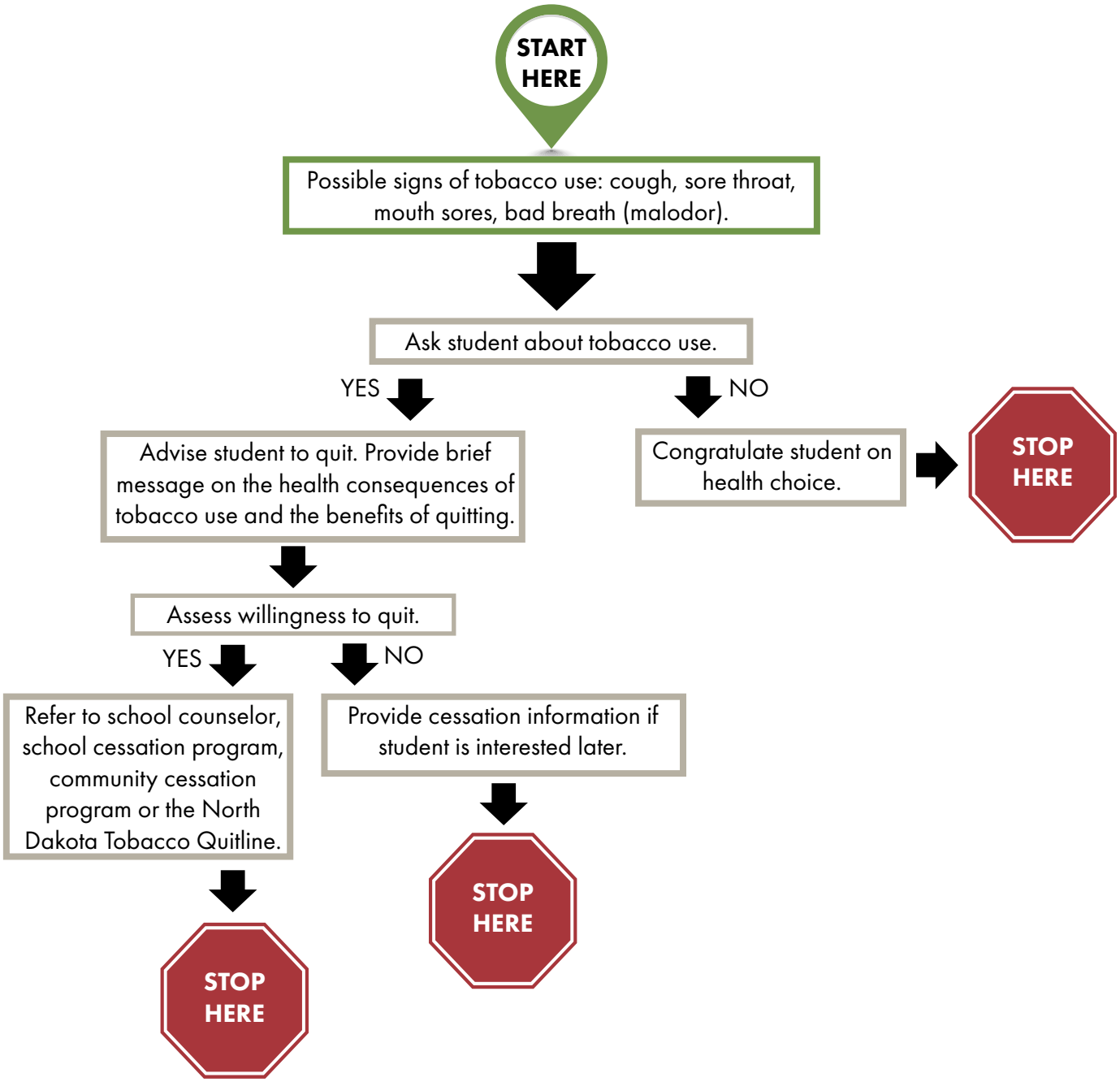
Resources

- *Family Voices of North Dakota* has several fact sheets containing information on disabilities that are common.
  - Telephone: 888-522-9654
  - E-mail: fvnd@drtel.net
  - fvnd.org
- Guidance for the development of an IEP and/or 504 can be obtained through:
  North Dakota Department of Public Instruction
  Special Education and Section 504 Units
  600 E. Boulevard Ave., Dept. 201
  Bismarck, ND 58505-0440
  - Telephone: 701-328-2260
    Fax: 701-328-2461
    nd.gov/dpi/

Tobacco, Alcohol and or Other Drugs



Tobacco, Alcohol and or Other Drugs



Tobacco, Alcohol and or Other Drugs

Tobacco

Commercial tobacco use – including electronic smoking devices (vaping), cigarettes, cigars, and smokeless tobacco – remains the single most preventable cause of death in the United States. Nicotine is found in all commercial tobacco products, including electronic smoking devices. Exposure to nicotine during adolescence and young adulthood can cause addiction and harm the developing brain. The use of commercial tobacco products by children in the United States is a pediatric disease of considerable proportions that results in new generations of nicotine-dependent children and adults. North Dakota Health and Human Services partners with the North Dakota School Board Association to provide a tobacco-free school policy for school districts to adopt. This policy extends additional protections beyond the state smoke-free law to the school grounds to prevent all tobacco products from being used on the campus and promote a safe learning environment, denormalize tobacco use and provide a clear structure for addressing concerns and enforcement. Tobacco coordinators at the Local Public Health Units work with the schools in their service areas to promote and educate on this policy.

Nicotine is a powerful addiction that needs to be treated. Recent addiction treatment research supports a shift towards the decriminalization of addiction in general. In a school setting, suspension, expulsion, and other punitive measures are parallel to and can lead to actual criminalization of addiction in society. While commercial tobacco and nicotine use are not criminalized in the same way as other substances, at its core, nicotine addiction operates in the brain like other addictions. Research also demonstrates that the stress, isolation, and separation that occurs when a student is expelled or suspended can increase commercial tobacco and other drug use and prolong addiction. In contrast, an approach that provides a supportive and fulfilling environment can serve to reduce addiction and promote recovery. Focusing on punishment rather than rehabilitation is likely to drive youth into a deeper, more secretive addiction — rather than seeking help from trusted teachers, coaches, or other school staff to achieve recovery.

Using punitive measures like suspension and expulsion to penalize student violations of a school commercial tobacco policy should be reviewed against the background of targeted commercial tobacco marketing, science of addiction, and long-term consequences associated with expulsion and suspension. Effective school policies attempt to address the underlying addiction to commercial tobacco instead of purely punitive measures, which do not deter continued use and may exacerbate the problem. While schools have an interest in prohibiting behavior that is disruptive and harmful to health, schools may consider weighing the severity of the infraction with the consequences and effectiveness of the punishment. According to the Centers for Disease Control and Prevention, the most effective approaches to helping youth quit tobacco use are through counseling and education. NDQuits is a free resource for North Dakotans seeking assistance to quit smoking or using smokeless tobacco products, including vapes or electronic cigarettes. No single method of quitting works for everyone. NDQuits offers several options so you can find the way that works best for you. All NDQuits services include free counseling, advice and support and free nicotine replacement products for those who qualify. Enroll by phone by calling 1.800.QUIT.NOW (1.800.784.8669) or online at hhs.nd.gov/health/community/tobacco/ndquits/cessation-programs
More information about the NDQuits can be accessed at hhs.nd.gov/ndquits

NDQuits supports individuals of all ages who want to quit but have specific tools available to youth and young adults who are ready to be tobacco-free through the **My Life, My Quit** program. The **My Life, My Quit** program provides youth access to tailored resources for quitting, including:

- Youth coaches who receive special training on the best ways to build relationships with youth.
- Five coaching sessions by phone, live texting, or chat with a coach who will listen and help teens navigate social situations while finding healthy ways to cope with stress.
- Text or call a dedicated toll-free number (1-855-891-9989) for real-time coaching.
- Additional text messages for support to quit vaping, smoking, or chewing tobacco.

Tobacco, Alcohol and or Other Drugs

(continued)

- Additional text messages for support to quit vaping, smoking, or chewing tobacco.
- Simplified program registration and enrollment process to get to coaching faster. · Website mylifemyquit.com with online enrollment, chat with a live coach, information about vaping and tobacco, and activities to support quitting.
- Promotional and educational materials designed for youth with messages from youth about quitting tobacco and vaping and how to ask for support.
- A water-marked certificate of completion of the program.

My Life, My Quit™ is the free and confidential way to quit smoking or vaping. Text "Start My Quit" to 36072 or go to nd.mylifemyquit.org/index and click to talk with a Coach.

Many local programs include cessation services and are available to assist individuals in quitting tobacco use. Service Directory: hhs.nd.gov/health/community/tobacco/ndquits/cessation-programs

Alcohol and/or Other Drugs

According to the Centers for Disease Control and Prevention, alcohol is used by more young people in the United States than tobacco or illicit drugs. Among youth, the use of alcohol and other drugs has been linked to unintentional injuries, physical fights, academic and occupational problems, and illegal behavior. Long-term alcohol misuse is associated with liver disease, cancer, cardiovascular disease, and neurological damage, as well as psychiatric problems such as depression, anxiety, and antisocial personality disorder. Drug use contributes directly and indirectly to the HIV epidemic, and alcohol and drug use contribute markedly to infant morbidity and mortality.

Another area of concern is the high rates of nonmedical use of prescription and over the counter (OTC) medications. Prescription medications most abused by youth include pain relievers, tranquilizers, stimulants, and depressants. Teens also misuse OTC cough and cold medications containing the cough suppressant dextromethorphan (DXM) to get high. Prescription and OTC medications are widely available, free, or inexpensive, and falsely believed to be safer than illicit drugs. Misuse of prescription and OTC medications can cause serious health effects, addiction, and death.

Alcohol abuse is a pattern otherwise known as "problem drinking." The behavioral warning signs of alcohol abuse are:

- Drinking excessive amounts of alcohol frequently
- Drinking when it is dangerous
- Interpersonal difficulties with family, friends, or coworkers
- Legal problems related to drinking
- Odor on the breath
- Intoxication
- Difficulty focusing and/or glazed appearance of the eyes
- Uncharacteristically passive behavior; or combative and argumentative behavior
- Gradual (or sudden in adolescents) deterioration in personal appearance
- Gradual development of dysfunction, especially in performance
- Unexplained bruises and accidents
- Irritability
- Flushed skin
- Loss of memory
- Availability and consumption of alcohol becoming the focus of social activities

Tobacco, Alcohol and or Other Drugs

(continued)

- Changes in peer-group associations and friendships
- Unusual flare-ups or outbreaks of temper
- Withdrawal from responsibility
- General changes in overall attitude
- Association with known substance abusers
- Unusual borrowing of money from friends, coworkers, or parents
- Stealing small items from employer, home, or school
- Secretive behavior

Alcoholism, also known as alcohol dependence, differs from the alcohol abuse pattern in three critical ways. It is:

- Chronic
- Progressive
- Potentially fatal

The symptoms of alcoholism include those of alcohol abuse plus four serious additional symptoms:

- Craving – a strong need or urge to drink
- Loss of control – not being able to stop drinking once drinking has begun
- Physical dependence – withdrawal symptoms, such as nausea, sweating, shakiness, and anxiety after stopping drinking
- Tolerance – the need to drink greater amounts of alcohol to get "high"

Marijuana users can be difficult to recognize unless they are under the influence of the drug at the time of observation. Casual users may show none of the general symptoms. Marijuana does have a distinct odor and may be the same color or a bit greener than tobacco. Signs of marijuana abuse could include:

- Rapid, loud talking and bursts of laughter in early stages of intoxication
- Sleepiness or stupor in the later stages
- Forgetfulness in conversation
- Inflammation in the whites of eyes; pupils unlikely to be dilated
- Odor like burnt rope on clothing or breath
- Tendency to drive slowly – below speed limit
- Distorted sense of time passage – tendency to overestimate time intervals
- Use or possession of paraphernalia, including roach clip, packs of rolling papers, pipes, or bongs

Amphetamine and **methamphetamine** are virtually indistinguishable from one another in effect and composition. Amphetamines can be inhaled, smoked, and injected by the abuser. The clandestine manufacturing process incorporates a large variety of hazardous and volatile chemicals. Methamphetamine labs frequently are in public settings such as residences; hotels and motels; moving vehicles; unused outbuildings; isolated rooms; and storage facilities. Methamphetamine side effects include but are not limited to:

- Hyperactivity
- Irritability
- Visual hallucinations
- Auditory hallucinations (hearing "voices")
- Suicidal tendencies
- Aggression
- Suspiciousness, severe paranoia
- Shortness of breath
- Increased blood pressure
- Cardiac arrhythmia
- Stroke
- Sweating
- Nausea
- Vomiting
- Diarrhea
- Long periods of sleep ("crashing" for 24-48 hours or more)
- Prolonged sluggishness
- Severe depression
- Weight loss, malnutrition, anorexia

Tobacco, Alcohol and or Other Drugs

(continued)

- Itching (illusion that bugs are crawling on the skin)
- Welts on the skin
- Involuntary body movements
- Paranoid delusion

Inhalants are a common substance of abuse among teenagers. Commonly abused inhalants include a few types of model cement, cooking spray, hair spray, deodorant, liquid paper, aerosol spray, paint, paint thinner, gasoline and solvents. Inhalants are used by spraying or pouring the inhalant onto a rag that is placed in a bag or sack, spread on a fingernail or hand or kept on clothing and other areas that allow easy access. The abuser then places the inhalant up to their face and breathes in the vapors emitted by the inhalant. This induces a short-lived, light-headed, euphoric state in the abuser. The effects of inhalant abuse can include severe headaches, nausea, fainting, accelerated heartbeat and vomiting. The signs of inhalant abuse may include:

- Substance odor on breath and clothes
- Paint or other stains on face, hands, or clothes
- Red or runny eyes or nose
- Spots or sores around the mouth
- Drowsiness; unconsciousness; drunk, dazed, or dizzy appearance
- Poor muscle control
- Presence of bags or rags containing dry plastic cement or other solvent at home, in locker at school or at work
- Discarded whipped cream, spray paint or similar chargers (users of nitrous oxide)
- Small bottles labeled "incense" (users of butyl nitrite).

See consumered.org/programs/inhalant-abuse-prevention for more information

North Dakota Health and Human Services employs regional and tribal substance prevention coordinators (PCs). PCs provide culturally appropriate technical assistance, consultation, guidance, and resources to schools/universities/colleges; law enforcement; churches; community organizations; workplaces; and individuals or groups interested in prevention issues in North Dakota. The PCs can offer brochures; posters; public service announcements; health fairs and educational programs for youth, families, workplaces, and communities; drug and alcohol-free activities; coalition-building and multi-agency collaboration; and help promoting the establishment of drug and alcohol policies and laws.

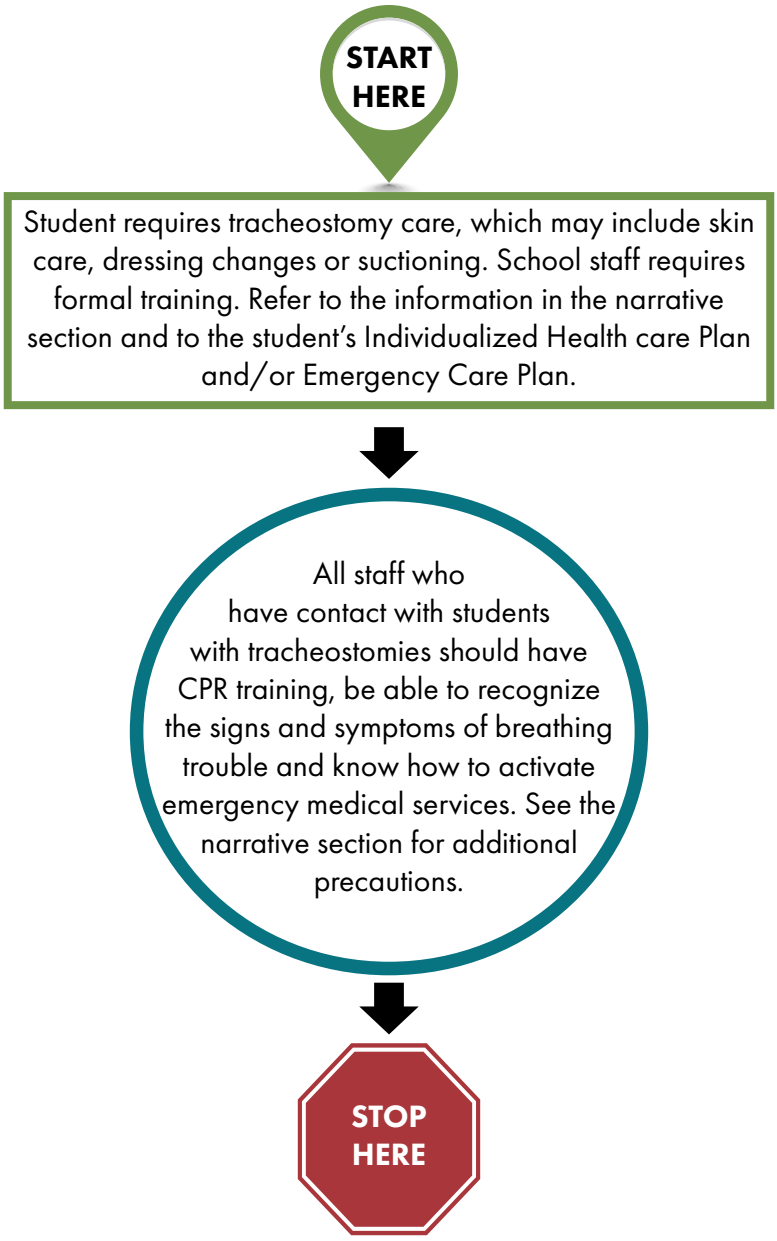
During the 2019 legislative session, Senate bill 2149 established the requirement for each school within a district to designate an individual as a behavioral health resource coordinator. For further information and resources visit hhs.nd.gov/education/resource-coordinators

North Dakota Health and Human Services also has prevention publications, including youth posters and activity books for preschool through grade six.

These publications can be accessed at hhs.nd.gov/behavioral-health/prevention

School policy should be followed when dealing with any concerns of tobacco, alcohol and/or other drug use. Further resources may be found at hhs.nd.gov/behavioral-health/addiction

Tracheostomy Care



Tracheostomy Care

Overview

A tracheostomy is a surgical opening in the neck into the trachea (windpipe) that allows air to go into and out of the lungs. The opening in the neck is called a stoma. A tracheostomy tube is a plastic or metal tube inserted through the stoma and is held in place by ties around the neck. A tracheostomy is performed because of any injury or condition that requires bypassing the normal breathing processes or because of a neurological, muscular, or other condition that make it difficult to breathe or to effectively clear sections. A tracheotomy allows for long-term use of a ventilator (breathing machine) and/or suctioning of mucous, if needed. Depending on the reason a student requires a tracheotomy, it may be temporary or long-term. Speaking and eating with a tracheostomy will depend on the type of tracheostomy and on the condition of the student.

Precautions

Care should be taken not to use substances with small particles around students with tracheostomies, such as powders, aerosols, sand, glitter, etc. In addition, animal hair/dander may cause irritation.

All staff working with a student(s) who has a tracheotomy need to be able to recognize the signs and symptoms of respiratory distress (trouble breathing). Early signs of breathing trouble may include:

- Wheezing, noisy and/or fast breathing
- Change in breathing pattern
- Coughing
- Sweaty, clammy skin
- Restlessness

Later signs of breathing trouble may include:

- Hard breathing, with the sinking in of the chest, ribs, or neck (retractions)
- Head bobbing
- Flaring of nostrils
- Blue, pale, or gray color of the skin or around the lips and nails

It is recommended that all staff in contact with tracheostomies have cardiopulmonary resuscitation (CPR) training, can recognize the signs of breathing trouble, and know how to activate emergency medical services.

School staff dealing with students who require tracheostomy care during the school day require formal training by the student's parent/guardian or preferably by a health care provider. Be sure to record the training on the staff training record. Refer to the Forms section of this manual for a sample Specialized Procedure Training form.

The student's Individualized Health care Plan (IHP) and/or Emergency Care Plan (ECP) should outline the details of care, cleaning procedures, suctioning and what to do if the tube comes out; hence, steps for these procedures are not included in this manual. Refer to the Forms section of this manual for a general IHP and ECP.

Documentation of all cares should be recorded. Refer to the Forms section of this manual for a sample Documentation of Procedure Administration form.

As with any procedure being performed, good hand washing with soap and water is critical to prevent infection.

Tuberculosis (TB)

Overview

Tuberculosis (TB) is a disease that is spread by germs from person to person through the air. When a person with pulmonary (lung) or laryngeal (throat) TB coughs, sneezes, speaks or sings, droplets containing Mycobacterium tuberculosis are expelled into the air. These tiny particles can remain suspended in the air for several hours, depending on the environment. If another person inhales air containing these droplets, he or she may become infected. The chance that TB infection will occur depends on three factors: the infectiousness of the person with TB, the environment in which exposure occurred, and the duration of exposure.

The general symptoms of TB disease include feeling sick or weak, weight loss, fever, and night sweats. The symptoms of TB of the lungs include a productive, prolonged cough (duration of three weeks or longer), chest pain, and coughing up blood. Other symptoms depend on the part of the body that is affected. These individuals are given therapy to cure the disease.

TB usually affects the lungs, but it also can affect other parts of the body, such as the brain, the kidneys, or the spine. People with latent TB infection have TB germs in their bodies, but they are not sick because the germs are not active. These people do not have symptoms and cannot spread the disease; however, they may develop TB disease at some time in the future. Sometimes they are prescribed treatment to prevent them from developing the TB disease.

People with TB disease are sick from TB germs that are active and usually have symptoms. People with lung or throat TB can spread germs and are prescribed drugs to treat their TB disease.

Precautions

A person with latent TB cannot spread germs to others. If a person has been around someone with latent TB, he or she does not need to be tested. However, if a person has been around someone with TB disease or someone with TB symptoms, he or she should be tested.

Two different tests can be used to help detect TB infection: a skin test called Mantoux tuberculin skin test or a special blood test that measures how the person's immune system reacts to the germs that cause TB. A positive test for TB indicates that a person has been infected with TB germs. A culture specimen or radiological (x-ray), clinical or other laboratory testing are needed to confirm TB disease.

A student may return to school only when a health care provider deems that he or she is noninfectious. This usually occurs when there has been a negative sputum sample on three separate occasions or after medical treatment for four weeks.

For more exclusion information review the North Dakota Child Care and School Infectious Disease Exclusion Guide: hhs.nd.gov/sites/www/files/documents/DOH%20Legacy/Immunization/child%20care%20exclusion%20guidance%202022%20_%20new%20logo.pdf

For further assistance or questions please contact the North Dakota Health and Human Services TB Program.

North Dakota Health and Human Services
Disease Control Unit - Tuberculosis Program
Telephone: 701.328.2378 or 800.472.2180
hhs.nd.gov/public-health-information/diseases-conditions-and-immunization/tuberculosis

Tuberculosis (TB)

(continued)

TB controllers are located at each local public health unit. TB controllers provide the following services:

- TB case management and directly observed therapy
- Contact investigation and follow-up for infected contacts
- TB medication administration for treatment of latent TB infection and regular evaluation for side effects
  TB education

Heartland National TB Center: heartlandntbc.org/

- Provides training, medical consultation and technical assistance to Arizona, Illinois, Iowa, Kansas, Minnesota, Missouri, New Mexico, North Dakota, Oklahoma, South Dakota, Texas, and Wisconsin

Forms

It is the decision of each school district to determine what forms they will use. Some of the samples provided in this section are state-developed forms, while others were developed by a school district or a local public health unit that delivers school health services. These forms may be adapted to fit your school's needs. In addition, many associations have sample forms available on their websites (i.e., American Lung Association – Asthma Action Plan). In these cases, website links have been provided.

We want to thank Bismarck and Fargo Public Schools, along with Bismarck-Burleigh Public Health and Fargo Cass Public Health, for providing copies of their forms.

Forms provided in this section:

- Authorization for Administration of Specialized Health care Procedures (Fargo Public Schools)
- Documentation of Procedure Administration (Fargo Public Schools)
- Emergency Plan, General (Bismarck-Burleigh Public Health)
- Emergency Care Plan, General (Fargo Public Schools)
- Epi-Pen Procedure (Bismarck-Burleigh Public Health)Individualized Health care Plan/Health Management Plan, General (Bismarck-Burleigh Public Health)
- Medication Record Administration (Fargo Public Schools)
- Prescription and Authorization for Medication Administration (Fargo Public Schools)
- Request and Authorization for Self-Administration of Medication (Fargo Public Schools)
- Seizure Emergency Care Plan (Fargo Public Schools)
- Seizure Management Plan/Seizure First Aid (Bismarck-Burleigh Public Health)
- Specialized Procedure Training (Fargo Cass Public Health)
- Staff Training Record

Links to forms available online:

- Asthma Action Plan; aafa.org/asthma-treatment-action-plan
- Food Allergy & Anaphylaxis Care Plan; foodallergy.org/living-food-allergies/food-allergy-essentials/food-allergy-anaphylaxis-emergency-care-plan
- Asthma & Allergy self-care authorization form; hhs.nd.gov/school-healthschool-nursing
- Diabetes Care Plan; diabetes.org/sites/default/files/2022-02/DMMP-final-2-3-22.pdf
- North Dakota High School Activities Association Athletic Pre-Participation – Form A; ndhsaa.org/files/Form_A.pdf
- North Dakota High School Activities Association Athletic Pre-Participation – Form B; ndhsaa.org/files/Form_B.pdf
- Seizure Care Plan; epilepsy.com/sites/core/files/atoms/files/GENERAL%20Seizure%20Action%20Plan%202020-April7_FILLABLE.pdf

FARGO PUBLIC SCHOOLS
AF6720-C

AUTHORIZATION FOR ADMINISTRATION OF SPECIALIZED HEALTH CARE PROCEDURES

Students who need specialized health care procedures provided during the school day must have, in writing, a physician's prescription and parental authorization.

Student_____ Date_____

Grade_____ Date of Birth_____ School_____

Diagnosis/Condition for Which Procedure Is Required_____

_____

Treatment Prescription_____

Procedure/Treatment Description_____

_____

_____

Time Schedule Procedure Is To Be Done_____

Precautions &/or Adverse Reactions_____

_____

_____

Interventions for Reactions_____

_____

Continue Procedure Until (Date)_____

Authorization For This Procedure Is Required Annually.

Physician Name (Print)_____ Date_____

Physician Signature_____Phone _____

Address_____

I request the above health procedure and/or medication be given to my child in the manner specified herein. I give permission to school personnel to administer the health procedure and/or medication. I understand that the administration of the health procedure and/or medication will not necessarily be done by a nurse. I will notify the school immediately if my child's health status changes, or there is a change or cancellation of this health procedure and/or medication. I further agree that the school personnel or nurse may contact the prescriber as needed and that medical information may be shared with school personnel who need to know.

In consideration of this authorization made at our request, the undersigned agrees to indemnify, defend, and save harmless the Board of Education, the individual members thereof and any officials or employees involved in the administration of health procedures and/or medications to the above named student from any claims or liability for injury or damages, including but not limited to costs and reasonable attorney's fees, caused or claimed to be caused or to result from the administration of the above described health procedures and/or medications.

Parent_____ Date_____

Address_____ Phone_____(H)

_____(C)_____ (W)

FARGO PUBLIC SCHOOLS
AF6720-D

DOCUMENTATION OF PROCEDURE ADMINISTRATION

Student_____ DOB_____ Grade_____

School_____ Teacher_____

Medication/Procedure_____ Dose_____

From_____20___ To_____ 20___

See "PRESCRIPTION & AUTHORIZATION FOR MEDICATION ADMINISTRATION" or "AUTHORIZATION FOR ADMINISTRATION OF SPECIALIZED HEALTH CARE PROCEDURES". Attach this to that appropriate form for instruction and reference.

Date	Time In /Out	Comments	Initials

Ab=Absent Re=Refused Ns=No Show Dc=Discontinued Ch=Changed

Signatures_____ _____ _____

_____ _____ _____ _____

SCHOOL EMERGENCY PLAN

Student's Name_____ Date of Birth_____ School Year _____
School_____ Grade_____ Classroom Teacher _____

EMERGENCY CONTACTS	Relationship:	Home phone:	Work phone:	Cell phone:
1._____	_____	_____	_____	_____
2._____	_____	_____	_____	_____
3._____	_____	_____	_____	_____

Physician: Clinic: Phone:
_____ _____ _____

Hospital: Phone:
_____ _____

Medical Condition: _____

What needs to be done to manage this condition at school? _____
_____
_____

Signs of an Emergency: _____
_____

Does your child take medication for this condition? Yes ☐ No ☐
*Name and dose of medication(s): _____

***If medication(s) is to be administered during the school day, parents must provide the medication(s) and sign the proper authorization form.**

Emergency Actions for the Staff to Take:

1. _____
2. _____
3. _____

If the condition of the student becomes critical:

- Stay with the student and have someone else **call 911 immediately**.
- Call or have someone else call emergency contacts.
- Notify principal.

This information will be available to appropriately designated school staff.

Parent/Guardian Signature_____ **Date**_____

Health Team Signatures

_____ _____
_____ _____

EMERGENCY CARE PLAN

Student_____ **Date**_____

Grade_____ **Date of Birth**_____ **School**_____

Parent/Guardian_____ **Phone**_____ (H)

_____ (C) _____ (W)

Preferred Hospital In Case Of Emergency_____

Physician Name (Print)_____

Physician Signature_____ **Phone**_____

Medical Condition_____

Non-Emergency Routine Treatment_____

Signs /Symptoms of Emergency_____

Emergency Treatment_____

I give permission to the principal and to the school nurse to share this "Emergency Care Plan" with the specific school faculty and staff listed. This information will be shared for the purpose of providing first aid or other specific emergency care as described in the plan.

I approve of the above "Emergency Care Plan" and request school personnel to follow the above "Emergency Care Plan" in the event of an emergency involving my child. I will notify the school immediately if my child's health status changes, or there is a change or cancellation of this "Emergency Care Plan." I further agree that the school personnel or nurse may contact the prescriber as needed and that medical information may be shared with school personnel who need to know.

In consideration of this authorization made at our request, the undersigned agrees to indemnify, defend, and save harmless the Board of Education, the individual members thereof and any officials or employees involved in the rendering of care in accord with the above "Emergency Care Plan" from any claims or liability for injury or damages, including but not limited to costs and reasonable attorney's fees, caused or claimed to be caused or to result from the administration of care in accord with the above "Emergency Care Plan."

Check **ONE** of the following boxes related to staff members whom are to be informed regarding potential emergency and will initiate the appropriate procedures:

☐ List specific staff _____

☐ Refer to highlighted attached list of names.

☐ Refer to the back side of this sheet for school faculty/staff names.

PARENT SIGNATURE_____ **DATE**_____

EPI-PEN PROCEDURE

1. Have someone else **call 911** and parent/guardian.
2. **Check** the Epi-Pen solution **color**. It must be clear.
3. **Remove** the **gray safety cap** from the Epi-Pen.
4. **Hold** the Epi-Pen with the **black tip against the front side of the thigh muscle**.
   - Refer to the picture on the Epi-Pen.
   - Front side thigh muscle is the only area to be used.
   - If accidentally injected into a hand or foot, go to the emergency department.
5. **Apply** moderate **pressure** to **hear** the **"click"** and then **hold for 10 seconds**. **Note time**. (Pushing the Epi-Pen against the thigh releases a plunger, pushing the concealed needle into the thigh muscle and delivering a dose of epinephrine).
6. **Remove** the Epi-Pen and **massage the site** (to prevent tissue damage).
7. If necessary, the Epi-Pen can be used directly through clothing.
8. Be prepared to begin **CPR**.
9. Stay with the individual, keeping warm and resting until emergency medical help arrives.
10. Send the Epi-Pen along with the EMT's.
11. Make sure the parent/guardian has been called.
12. The effects of the injection wear off after 10-20 minutes. **Symptoms can recur.**
13. After the injection, the individual may feel a more rapid heartbeat, nervous or headache. (Assure them this is normal).
14. Notify the Principal and the School Nurse (if not present) and complete an Incident Report.

INDIVIDUALIZED HEALTH-CARE PLAN

SCHOOL HEALTH MANAGEMENT PLAN

Student's Name_____ Date of Birth_____ School Year _____
School_____ Grade_____ Classroom Teacher _____

EMERGENCY CONTACTS	Relationship:	Home phone:	Work phone:	Cell phone:
1._____	_____	_____	_____	_____
2._____	_____	_____	_____	_____
3._____	_____	_____	_____	_____

Physician: Clinic: Phone:
_____ _____ _____

Hospital: Phone:
_____ _____

Medical Condition: _____
Usual Symptoms: _____
_____
_____
Frequency of Symptoms: _____
_____
Limitations: _____
_____
Other Comments: _____
_____
_____

SCHOOL PLAN OF ACTION (List steps to manage condition at school.)

***(If medication is to be given for this condition, list name of medication, dose, when to give and how often. Parent/guardian must provide the medication(s) and sign the proper authorization form.)**

1. _____
2. _____
3. _____

This information will be available to appropriately designated school staff.

Parent/Guardian Signature_____ **Date**_____

School Health Management Plan/BBPH 07/05

MEDICATION RECORD ADMINISTRATION

AF6720-B

SCHOOL YEAR_____ SCHOOL_____

STUDENT NAME_____ DOB___/___/___ GRADE_____ TEACHER_____

MEDICATION / PROCEDURE_____ DOSE_____ TIME_____

FROM:_____20_____ TO:_____20_____

See "PRESCRIPTION & AUTHORIZATION FOR MEDICATION ADMINISTRATION" or "AUTHORIZATION FOR ADMINISTRATION OF SPECIALIZED HEALTH CARE PROCEDURES." Attach this to that appropriate form for instruction and reference.

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
AUGUST																															
SEPTEMBER																															
OCTOBER																															
NOVEMBER																															
DECEMBER																															
JANUARY																															
FEBRUARY																															
MARCH																															
APRIL																															
MAY																															
JUNE																															

*** See Comments on Back Ab=Absent Re=Refused Ns=No Show Dc=Discontinued Ch=Changed Ho=Holiday Ft=Field Trip OOM=Out of Medication**

INITIALS	NAME	INITIALS	NAME

P:\FORMS\School Nursing\Medication Administration Record.doc

DATE	COMMENTS	DATE	COMMENTS

FARGO PUBLIC SCHOOLS
PRESCRIPTION AND AUTHORIZATION FOR MEDICATION ADMINISTRATION

When it is determined by the physician that medication must be taken during the school hours this form is to be completed.

Student_____ Date_____

Grade_____ Date of Birth_____ School_____

Allergies_____ School Year_____

PHYSICIAN'S ORDER

Medication_____ Dose_____ Route_____

Time /Frequency_____ Continue Until_____

Reason for Medication_____

Special Instructions_____

Major Side Effects_____

_____

Date_____ Physician Name (Print) _____

Physician Signature_____

Phone_____ Address_____

Amount of Medication Received _____ Medication Expiration Date_____

I request this medication be given to my child in the manner specified herein. I give permission to school personnel to administer the medication. I understand that the administration of the medication will not necessarily be done by a nurse. I will notify the school immediately if my child's health status changes, or there is a change or cancellation of this medication. I further agree that the school personnel or nurse may contact the prescriber as needed and that medication information may be shared with school personnel who need to know.

In consideration of this authorization made at our request, the undersigned agrees to indemnify, defend, and save harmless the Board of Education, the individual members thereof and any officials or employees involved in the administration of medications to the above named student from any claims or liability for injury or damages, including but not limited to costs and reasonable attorney's fees, caused or claimed to be caused or to result from the administration of the above described medications.

Date_____ Parent /Guardian_____

Phone (H)_____ Address_____

(C)_____ (W)_____

FARGO PUBLIC SCHOOLS
AF6720-F

REQUEST AND AUTHORIZATION FOR STUDENT SELF-ADMINISTRATION OF MEDICATION

Student_____ Date _____

Grade_____ Date of Birth_____ School _____

Allergies_____ School Year_____

PHYSICIAN'S ACKNOWLEDGEMENT OF PRESCRIPTION

Medication_____ Dose_____ Route_____

Time /Frequency_____ Continue Until_____

I have reviewed the medication with the student and the student's parents, and the medication may be self- administered by the student during school hours.

Date_____ Physician Name (Print) _____

Physician Signature _____

Phone_____ Address_____

The undersigned, as parent(s)/guardian of the above named student, request permission for, and hereby authorize, the student to self-administer the above named medication during school hours. Further, the undersigned acknowledge and understand the following:

1. Medication shall be maintained in the original prescription container with original label;
2. School personnel may examine the medication container upon request, and any medications not maintained in the original container may be confiscated by school personnel;
3. The school may require the student to store the medication in a central location in the school;
4. The undersigned has reviewed the medication administration procedure with the student and believe student understands the administration procedure and is capable of self-administering the above medication;
5. The undersigned will notify the school immediately if the student's health status changes, or there is a change or cancellation of this medication;
6. School employees and personnel will not be involved in the administration of the above medication and will not be monitoring the student for side effects or student's failure to take the medication. The undersigned and student shall be solely responsible to assure that the medication is taken as prescribed.
7. I further agree that the school personnel or nurse may contact the prescriber as needed and that medication information may be shared with school personnel who need to know.

In consideration of this authorization, given at our request, the undersigned agrees to indemnify, defend, and save harmless the Board of Education, the individual members thereof and any officials or employees of the School and Board of Education from any claims or liability for injury or damages, including but not limited to costs and reasonable attorney's fees, caused or claimed to be caused or to result from the administration of the above described medications.

Date_____ Parent/Guardian _____

Phone (H)_____ Address_____

(W)_____ (C)_____

EMERGENCY CARE PLAN FOR SEIZURES

Student_____ **Date**_____

Grade_____ **Date of Birth**_____ **School**_____

Parent/Guardian_____ **Phone**_____ (H)

_____ (C) _____ (W)

Preferred Hospital in Case of Emergency_____

Physician Name (Print)_____

Physician Signature_____ **Phone**_____

Medical Condition SEIZURES **Type**_____ **Average Length**_____

Non-Emergency Routine Treatment (Routine Daily Medication) _____

Triggers or Warning Signs_____

Signs/Symptoms of Emergency_____

First Aid During Seizure • Do not restrain • Turn child on side • Do not put anything in mouth

• Stay with child until fully conscious • Record seizure activity • Record start/end time

☐ Other_____

Emergency Treatment Call 911 if seizure lasts longer than _____ minutes

Notify parent if_____

I give permission to the principal and to the school nurse to share this "Emergency Care Plan" with the specific school faculty and staff listed. This information will be shared for the purpose of providing first aid or other specific emergency care as described in the plan.

I approve of the above "Emergency Care Plan" and request school personnel to follow the above "Emergency Care Plan" in the event of an emergency involving my child. I will notify the school immediately if my child's health status changes, or there is a change or cancellation of this" Emergency Care Plan". I further agree that the school personnel or nurse may contact the prescriber as needed and that medical information may be shared with school personnel who need to know.

In consideration of this authorization made at our request, the undersigned agrees to indemnify, defend, and save harmless the Board of Education, the individual members thereof and any officials or employees involved in the rendering of care in accord with the above" Emergency Care Plan" from any claims or liability for injury or damages, including but not limited to costs and reasonable attorney's fees, caused or claimed to be caused or to result from the administration of care in accord with the above "Emergency Care Plan".

Check **ONE** of the following boxes related to staff members whom are to be informed regarding potential emergency and will initiate the appropriate procedures

☐ List specific staff_____

☐ Refer to highlighted attached list of names.

☐ Refer to the back side of this sheet for school faculty/staff names.

PARENT SIGNATURE_____ **DATE**_____

SCHOOL SEIZURE MANAGEMENT PLAN

Student's Name_____ Date of Birth_____ School Year _____
School_____ Grade_____ Classroom Teacher _____

EMERGENCY CONTACTS	Relationship:	Home phone:	Work phone:	Cell phone:
1._____	_____	_____	_____	_____
2._____	_____	_____	_____	_____
3._____	_____	_____	_____	_____

Physician: Clinic: Phone:
_____ _____ _____

Hospital: Phone:
_____ _____

Please circle type of seizure experienced by student:

Seizure Type:	What it may look like:	What school staff will do:
Generalized Tonic Clonic or Grand Mal	A convulsion. Falling to the ground with bodily stiffness followed by massive jerking movements.	Please refer to Seizure 1st Aid on back of form.
Absence or Petit Mal	A blank stare, lasting only a few seconds, often frequent. Often mistaken for daydreaming or inattention.	Observe child. Try to count episodes. Report to parents. **Keep record of seizures? Yes No**
Partial: **Sensory** **Psychomotor**	**Sensory**: Usually don't result in loss of consciousness. They may cause uncontrolled shaking of an arm, leg, or any other part of your body; altered emotions; change the way things look, smell, feel, taste, or sound; or cause speech disturbance. **Psychomotor**: Altered consciousness and usually cause memory loss (amnesia). Starts with blank stare followed by repeated movements that seem out of place and mechanical. Child unaware of surroundings and may seem dazed. May be mistaken for behavior problem.	Speak calmly and reassuringly. Guide gently away from hazards. Stay close by and report to parents. Complete: **Seizure Reporting Form BPS-SE 40.**

How long do seizures usually last? _____
How often do seizures occur? _____
What triggers a seizure? _____
_____
Are there any warning signs and/or behavior changes before seizure starts? _____
_____
_____
Describe what happens during and after seizure: _____
_____
_____

Does your child take medication(s) for this condition? Yes ☐ No ☐
Name and dose of medication(s)_____
***Parent must provide and medications to be given during the school day and sign the proper authorization form.**

This information will be available to appropriately designated school staff.

Parent/Guardian Signature_____ Date_____

SEIZURE 1st AID

1. REMAIN CALM! Note the exact time seizure begins. **Stay with the student**.
2. Do not move student to another location during seizure. Provide for as much privacy as possible.
3. Position student on side with mouth toward floor so oral secretions flow out.
4. Protect from injury. Loosen tight clothing around neck.
5. Place something soft under head. Do not hold student down.
6. Do not place anything in mouth.
7. As in any emergency situation, observe breathing and color.
   If breathing stops completely, call 911 for emergency medical assistance.
   Begin resuscitation efforts if trained to do so.
8. Report seizure to the student's parents or guardian and the principal immediately.
9. When the seizure stops, provide for hygiene as necessary; s/he may have vomited or lost bladder and/or bowel control.
10. Offer nothing by mouth until fully conscious.
11. After consciousness returns, student may be moved with assistance, unless injury is suspected. If s/he is drowsy allow them to sleep. Observe student during rest.
12. Record how long the seizure lasted and objective description of seizure. Note activities immediately prior to the seizure. Use school form for reporting.

CALL AN AMBULANCE FOR THE FOLLOWING EVENTS:

- Seizure lasting 5 minutes or longer.
- If a second seizure starts shortly after the first has ended.
- If consciousness does not start to return after the shaking has stopped.
- If significant injury has occurred during the seizure.

07/05

Public Health
Prevent. Promote. Protect.
Fargo Cass Public Health

Specialized Procedure Training
Fargo Cass Public Health

Name of Student_____ Today's Date_____

School_____ School Year_____

Name of Medical Procedure_____

Brief description of need and parent's request:

_____

_____

_____

_____

Name of staff member/s receiving training:

_____

_____

_____

Name of parent providing training:_____

Name of school nurse who is present to provide medical consultation regarding this procedure

_____

Brief description of training:

1. _____
2. _____
3. _____
4. _____

This is to certify that the parent listed below has provided the training and the staff names listed have demonstrated competency in the above procedure for:_____.
(Student's name)

Date_____

Acknowledge: (*Signatures)*

Parent_____

Principal_____

Staff member/s_____ _____

Staff member/s_____ _____

Date of required retraining_____

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STAFF TRAINING RECORD

Name of staff person_____ Academic year _____-__

Class name	Hours	Content of class	Intructor/Qualifications	Date

References

- North Dakota Health and Human Services - Division of Special Health Services
  hhs.nd.gov/special-health-services
- North Dakota Department of Public Instruction - Special Education
  nd.gov/dpi/
- North Dakota Health and Human Services - Division of Waste Management
  deq.nd.gov/wm/
- North Dakota Health and Human Services - Injury Prevention Program
  hhs.nd.gov/prevention/injury-prevention
- North Dakota Early Hearing Detection and Intervention (EHDI) Information:
  North Dakota Health and Human Services - Special Health Services
  infanthearing.org/states/northdakota/index.html
- North Dakota Health and Human Services - Division of Health Promotion - Oral Health Program
  hhs.nd.gov/health/oral-health-program
- North Dakota Health and Human Services - HIV/AIDS Program
  hhs.nd.gov/public-health-information/diseases-conditions-and-immunization/hiv
- North Dakota Health and Human Services - Diabetes Prevention and Control Program
  hhs.nd.gov/public-health-information/diseases-conditions-and-immunization/north-dakota-diabetes-prevention-4
- North Dakota Department of Public Instruction - Title I Programs
  nd.gov/dpi/education-programs/federal-title-programs/title-vii-part-b-homeless-mckinney-vento
- North Dakota Health and Human Services - North Dakota Child Protection Program
  hhs.nd.gov/cfs/cps
- North Dakota Health and Human Services - Division of Mental Health & Substance Abuse Services
  hhs.nd.gov/behavioral-health
- North Dakota Health and Human Services - Division of Disease Control
  hhs.nd.gov/diseases-conditions-and-immunization
- North Dakota Health and Human Services - Division of Tobacco Prevention and Control
  hhs.nd.gov/community-health/ndquits/tobacco-prevention-control
- North Dakota Department of Public Instruction - Safety & Health
  nd.gov/dpi/districtsschools/safety-health
- North Dakota Health and Human Services - Division of Mental Health and Substance Abuse Services
  hhs.nd.gov/behavioral-health
- American Association of Poison Control Centers
  aapcc.org
- National Safety Council – Pediatric First Aid and CPR
  nsc.org
- Local Public Health Units
  hhs.nd.gov/lphu
- The North Dakota School Boards Association (NDSBA).
  Contact your school administrator to inquire about the NDSBA's Policy Ponderings Library.
- North Dakota High School Activities Association
  ndhsaa.com/

References

(continued)

- American Academy of Ophthalmology
  aao.org/eye-health/tips-prevention/children-eye-screening
- United Ostomy Associations of America, Inc.
  ostomy.org/
- American Diabetes Association – Minnesota & North Dakota
  Telephone: 763.593.5333
  ADAMN_WI_ND@diabetes.org
- Mental Health America of North Dakota
  P.O. Box 4106
  Bismarck, N.D. 58502-4106
  701.255.3692
  mhand.org
- Mental Health Help Line – First Link 800-273-8255 or in North Dakota dial 211
- North Dakota Century Code (NDCC), Chapter 23-07 Reportable Disease
- NDCC 23-07-02, Who to report reportable diseases:
  legis.nd.gov/cencode/t23c07.pdf
  NDCC 23-07-17.1, Inoculation required before admission to school:
  legis.nd.gov/cencode/t23c07.pdf
- North Dakota Administrative Rule, Chapter 33-06 Reportable Conditions
  legis.nd.gov/information/acdata/html/33-06.html
- Minnesota Epilepsy Foundation
  Telephone: 800.779.0777
  epilepsyfoundationmn.org/
- Epilepsy Foundation
  Telephone: 800.332.1000
  epilepsy.com/living-epilepsy/schools-and-seizure-preparedness
- Center for Tobacco Prevention and Control Policy
  breathend.com/

Head Lice

A Lousy Problem

NORTH Dakota
Be Legendary.
| Health & Human Services

Head Lice
A Lousy Problem

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NORTH Dakota
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About this Manual

This manual was developed to provide information about head lice, prevention actions, treatment options and guidelines appropriate for use in the home, child-care settings, schools and communities. There have been many changes in the recommended approaches regarding screening for and the management of head lice, including research finding that no-nit policies are ineffective in stopping transmission of head lice.

On pages 29-30 of this manual, there is a fact sheet entitled "Head Lice (Pediculosis capitis)" that discuss the facts surrounding the topic of head lice. These pages may be reproduced and given to parents or others trying to get rid of head lice.

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Definitions Within This Manual

AAP – American Academy of Pediatrics

CDC – U.S. Centers for Disease Control and Prevention

Host [hohst]– an animal or person from which a parasite obtains nutrition

Infestations [in-fe-stey-shuhn] – being infested

Infested [in-fest-ed] – having insects in one's hair

Lice [lahys]– more than one louse

Louse [lahys] – (singular) Pediculus humanus capitis (head lice), a small insect that lives on the scalp

Nit [nit] – eggs of a louse; may be alive or dead

Neurotoxic [noor-oh-tok-sik, nyoor-] – poisonous to nerve tissue, as to the brain or spinal cord

Parasite [par-uh-sahyt] – an organism that survives on the body of a host (in this case, lice live off humans)

Pediculicide [puh-dik-yuh-luh-sahyd] – a lice-killing product

Pediculosis [puh-dik-yuh-loh-sis] – having an infestation of head lice

Transmission [trans-mish-uhn, tranz-] – the act of transporting

Vector [vek-ter] – any organism or item that carries head lice

Viable [vahy-uh-buhl] – being able to hatch or survive

What are Head Lice?

Head lice (Pediculus humanus capitis) are small, parasitic insects that live on the scalps and necks of humans. Parasitic refers to an organism that survives on the body of a host. In the case of head lice, the host is a person, since head lice live on people and not on animals.

The adult louse is flat, wingless and crawls. It does not have the ability to fly, hop or jump. Lice tend to adapt to their surroundings (hair and skin color) and range in color from red, brown or black to gray/white and are often hard to see. A louse is very small (about the size of a sesame seed), has six legs, a diamond-shaped head and an elongated body. The mouth is shaped like a stylet (a slender probe or tube). This allows the louse to pierce a person's scalp so it can feed (a blood meal).

Head Louse

Highly magnified louse

Lice at various stages of development

Actual size of the average louse

Life Cycle of Head Lice

The life cycle of the louse consists of three stages:

Stage 1 - Eggs

The head louse begins life as an egg, commonly referred to as a nit. Nits are laid by the adult female. The nits are firmly attached to the base of the hair shaft, next to the scalp, by a glue-like substance produced by the louse. Nits range in color from white, yellow and tan to grayish, depending upon the stage of development and whether or not they have hatched or been killed by treatment. Nits are oval or teardrop shaped, smooth and very small (about the size of a knot of thread). Nits are hard to see and often are confused for dandruff, hair spray droplets or other debris.

Stage 2 - Nymphs

The nits are incubated by body heat for about seven to 12 days before they hatch to release a nymph. The nit shell remains on the hair shaft after hatching and becomes a dull yellow or translucent white and may have a wrinkled look. The nymph looks like an adult louse but is only about the size of a pinhead. Nymphs need a blood meal within hours of hatching to survive. During the next seven to 10 days, the nymph continues to grow and mature, going through three molts, until it becomes a full adult louse.

Stage 3 - Adults

The adult louse is about the size of a sesame seed. The life span of an adult louse is about three to four weeks. The female is typically larger than the male and can lay up to 10 nits per day (only nits that are fertilized will develop and hatch). The live, adult louse needs to feed on blood every three to six hours. Once the louse goes without blood meals or has left from the human host, the adult louse can usually survive for no longer than 24 to 36 hours.

Life Cycle of the Head Louse

DAY 0

LICE EGG IS LAID ON THE HAIR SHAFT

DAYS 6-7

AFTER 6-7 DAYS YOUNG LOUSE HATCHES

DAYS 8-9

FIRST MOULT 2 DAYS AFTER HATCHING

DAYS 11-12

SECOND MOULT 5 DAYS AFTER HATCHING

DAYS 16-17

THIRD MOULT 10 DAYS AFTER HATCHING

DAYS 17-19

MALE & SLIGHTLY LARGER FEMALE BEGIN TO REPRODUCE

DAYS 19-32

FEMALE LAYS 1-2 EGGS AFTER MATING, FEMALE CONTINUES TO LAY 4-8 EGGS A DAY FOR 16 DAYS

DEATH

DAYS 33-35

THE LOUSE DIES

Transmission of Head Lice

Head lice are transmitted by:

Person-to-person transmission (direct contact)

The majority of transmissions of head lice occur by direct head-to-head contact with an already infested person. Contact is common during play (slumber parties, bed sharing, sports activities or games).

Vector transmission (indirect contact)

This may occur through using personal items of an infested person such as combs, brushes, bedding, scarves, hair ornaments, hats and helmets. Although transmission via indirect contact rarely occurs and is unlikely, it is possible.

All people can get head lice; however, some individuals are at greater risk than others. **Those individuals include:**

- Children between the ages of 3 and 11 years are most often infested.
- Girls are more likely to get head lice than boys, possibly because of their play styles and sharing personal items (U.S. Centers for Disease Control and Prevention [CDC]).

Hair length does not seem to matter in regards to likelihood of getting lice. Although all races can get head lice, studies in the United States show children of African American descent are less likely to become infested.

Detecting Head Lice

The gold standard for diagnosing head lice is finding a live louse on the head. Nits that are viable are usually found at the nape of the neck or behind the ears, within ¼-inch of the scalp (CDC).

Signs and Symptoms

For many people, head lice cause no symptoms. When symptoms are present, they include:

- **Itching** – Itching of the head, the most common symptom of head lice, is caused by the saliva-producing toxin that the louse injects into the scalp when it feeds. The amount of itching can vary from slight to severe. The degree of itching that occurs is often dependent upon the extent of infestation. Itching may be very mild if the infestation has just occurred, or it may be severe if the infestation has gone untreated for a long time.

- **Sores on the head** – Very tiny, red areas on the scalp may be seen due to the bites from the louse on occasion. Sores on the head may also develop from continued itching and scratching. Sometimes these sores can become infected. On rare occasions, a person may develop swollen glands in the neck or under the arms. You should contact your health care provider if you think a sore has become infected or if you have any swelling in the neck or under the arms. Most lice infestations do not lead to infections.

- **Tickling feeling of something moving in the hair** – Another symptom reported by some people is a tickling or crawling feeling in the hair.

- **Sleeplessness** – Difficulty sleeping is also a common sign of lice infestation, as the lice are more active at night and may disrupt sleep.

Management and Treatment

Head lice infestations have been occurring for thousands of years and although numerous efforts have been tried to prevent them from occurring, nothing has proven to be 100% successful. However, when they do occur, head lice infestations can be managed. It is important not to panic and/or cause undue stress for those infested and those around them.

If head lice are suspected, it is recommended the individual be screened by a school nurse, public health nurse or medical provider. It is recognized that not all families, schools or child-care facilities have access to a school nurse, public health nurse or medical provider. In those situations, it is recommended that schools and child-care facilities designate an individual or individuals who will be trained to inspect and assess for head lice.

The process of inspection and/or screening is covered in depth in the following pages.

How to Manage and Treat Lice

1. Careful inspection and screening of the hair and scalp to identify lice and/or nits correctly
2. Use of a pediculicidal (head lice) product if live lice or viable nits are found
3. The cleaning of personal items and the environment
4. A repeat treatment with the pediculicidal product nine days following the initial treatment, if not otherwise indicated on the product label

Removal of nits may be recommended in conjunction with some over-the-counter products, although research has shown removal of nits may not be necessary. This process is tedious and time-consuming; however, it may reduce diagnostic confusion during future head checks. Some families may desire to remove the nits for aesthetic reasons. The second treatment, completed nine days after the initial treatment, should kill any newly hatched lice prior to them maturing and gaining their ability to lay nits.

The information on page 24 discusses recommendations for schools, child care facilities and group settings.

Remember: Head lice can infest all people regardless of age, race and socioeconomic status or hygiene practices. Regular bathing, shampooing or swimming will not prevent or get rid of head lice.

Management and Treatment

Step 1

Careful inspection and screening of the hair and scalp to identify lice and/or nits correctly

Head lice may be brought into the home after a person has had head-to-head contact with an infested person at child care, school, camp, sleepovers, etc. The most rapid spread of head lice occurs through the home because of the close proximity of family members. Whenever one person in the family has been identified to have lice, everyone living in the home should be inspected. Any friends, family members or other people who have had close head-to-head contact with the infested person over the previous week should be notified so they can be inspected for head lice as well.

Careful inspection of the hair and scalp is the best way to see if a person has head lice.

Basic supplies needed for a lice inspection include:

- **Time** – The examiner needs to conduct a careful search of the hair and scalp. This will take about three to five minutes per person.
- **A good light source** – Nits reflect ultraviolet light, so sources that contain ultraviolet rays, such as natural light (near a window or outside) are best. There is a special lamp called a Wood's Lamp that works very well, as nits become fluorescent and are easier to see under the light. If none of these light sources are available, a lamp with at least a 60-watt bulb can be used.
- **Magnifying glass** *(optional)* – A magnifying glass can be helpful when looking for nits and lice. It may be especially helpful if the examiner has difficulty focusing on close distances, wears bifocals or has any other visual problems.
- **Disposable hair parting tools** *(optional)* – Some examiners like to use hair-dividing tools such as coffee stirrers, blunted toothpicks or the stick portion of a cotton swab. The stick is used to divide and lift the hair so the base of the hair shafts can be inspected for nits and/or lice. If more than one individual is being inspected, new tools should be used for each person being examined.
- **Vinyl gloves** *(optional)* – Some examiners like to wear vinyl gloves; however, the use of gloves is not necessary. There is no evidence showing lice are spread through hand contact and do not pose a risk for disease transmission. Gloves should be changed in between each inspection (if used).



Performing the inspection for lice

The entire head should be examined, but special attention should be given to the places where lice are most likely to lay their eggs. These areas include the hair directly over and behind the ears, near the crown and at the back of the neck. The hair should be separated or parted into small sections so the base of each strand of hair can be inspected. The lice themselves may be hard to see since they move fast, but more often, the nits can be found. Viable nits are close to the scalp (less than ¼ inch).

It is important to be able to tell nits from other debris in the hair. Debris in the hair such as hair spray particles, lint, scales or dandruff will brush off or can be blown away easily. The female louse produces a glue-like substance that firmly attaches the nit to the hair shaft. Nits cannot be brushed away, washed off or blown from the hair. In order to avoid mistaking debris for nits, attempt to pull the particle from the hair shaft. If the particle remains attached, then suspect nits.

Improper identification of nits is a common problem, especially for new and/or inexperienced examiners. For inexperienced examiners, confirmation of infestation with a school nurse, public health nurse or a health care provider is recommended.

If no nymphs or live lice are seen and the only nits found are more than ¼ inch from the scalp, the infestation is probably old and no longer active and does not need to be treated (CDC).

The gold standard for diagnosing head lice is finding a live louse on the head!

Step 2

Use of a pediculicide product if live lice or viable nits are found

Pediculicidal products – There are many pediculicidal products available for the treatment of head lice. Most nonprescription pediculicidal products contain Permethrin 1% or Pyrethrin (such as Nix or RID*). Permethrin 1% is the most studied pediculicide in the United States (AAP, 2015) and is recommended as the first choice of treatment when no resistance to the product has been identified in the area. Prescription pediculicidal products contain stronger doses of Permethrin, Malathion, Benzyl alcohol (not rubbing alcohol) or Lindane. For further information on pediculicidal products, contact your local public health department, health care provider, clinic or pharmacy.

Important things to know about pediculicides:

- Never treat with pediculicides unless there is definite evidence of head lice.
- Pediculicides are to be used for the treatment of head lice **only** when there are live lice or viable nits present in the hair or when individuals share the same bed with someone who has live lice or viable nits (AAP, 2015).
- Pediculicides should not be used as routine shampoo or conditioners.
- These products do not prevent someone from getting head lice.
- Nonprescription pediculicidal products are typically effective and safe if used according to the manufacturers' directions. To ensure proper treatment, follow all recommendations and directions on the label. All safety precautions listed on the product label should be observed.
- No product is 100% effective at getting rid of lice and their eggs. A second treatment nine days after the initial treatment, or as recommended on the product label, is encouraged.
- Pediculicidal products are for external use only. These products are harmful if swallowed or inhaled. If accidental ingestion does occur, contact Poison Control at 800-222-1222.
- The scalp may continue to itch for several days after treatment. Tender scalp, stinging of the scalp or scalp irritation may be associated with treatment. These symptoms are not evidence of continued infestation. Generally, these symptoms occur within hours after treatment and may last up to 24 hours.
- Permethrin conditioners continue to work after the hair is rinsed during the initial treatment. Do not use other hair conditioners directly prior to, or immediately after using the product, as these may interfere with the effectiveness of the pediculicide. Also, avoid shampoos with conditioners, such as 2-in-1, and rewashing the hair for several days following the treatment.

- Use the entire contents of a container for each individual. Unless the container indicates multiple doses, a bottle of pediculicide should not be split and used by multiple individuals, nor should a dose be divided to use for more than one treatment. A second container of the product may be needed to fully saturate the hair for someone with long hair.

* = Use of brand names does not endorse the specific product. Any similar product may work as well as those mentioned.

Do not use a pediculicide if:

- The person has a known sensitivity to any component in the product.

- The child is younger than the age recommended on the product label. This ranges from ages 2 months to 2 years. For infants younger than 2 months, head lice and nits should be removed manually by picking the lice and nits from the hair. A special comb may be needed for this (see pages 22 and 23 for instructions on the removal of nits and lice).

- The person has an infestation of the eyebrows or eyelashes.
  - When these areas are infested, the person should be inspected for body lice and/or pubic lice.

In each of these instances, a health care provider should be consulted to identify safe treatment options.

The following groups of people should consult their health care providers before treating themselves or another person with a pediculicide:

- Individuals who have neurological conditions, such as seizure disorders, cerebral palsy etc.

- Pregnant women and nursing mothers

- Individuals who have cancer

- Individuals who have asthma and/or allergies
  - Pediculicidal products may cause breathing difficulty or asthmatic episodes in some individuals.
  - Individuals who have an allergy and/or sensitivity to ragweed, chrysanthemum or rosemary have an allergic reaction to some of the pediculicides.

SAFETY PRECAUTIONS

Products containing Lindane (such as the prescription product Kwell) should be used with extreme caution! Neuro-toxic reactions have been reported as a result of the normal use of Lindane shampoos.

Measures for safe use of a pediculicidal product

- Keep pediculicidal products out of reach of children.
- Treatment of all children should be done or supervised by an adult. Do not leave children unattended while a pediculicidal product is on the hair.
- Timing is important, so it may be helpful to use a timer. If the product is rinsed off too soon, lice and nits may not be killed. If left on too long, there will be unneeded exposure to the lice-killing chemicals. Remember to follow all manufacturers' recommendations and label directions.
- Many pediculicidal products contain ingredients that may cause eye irritation. Care should be taken to avoid contact with the eyes. If accidental contact with the eye occurs, quickly wash/flush the eyes thoroughly with tap water. Consult your health care provider if eye irritation results.
- Avoid contact with mucous membranes, such as the lining of the nose or mouth.
- If you need to treat more than one individual, and/or want to avoid unnecessary exposure to the product, it is recommended to wear vinyl gloves when applying or rinsing the product.
- Avoid contamination of food and preparation areas with these products.
- Upon completion of treatment, do not reuse the container. Rinse the container thoroughly and discard in the trash.

Procedure for treatment of an individual

- When head lice have been identified on one family member, all household members should be inspected before treatment is started. All household members found with infestation should be treated the same day. Treat only those who are infested or individuals who share the same bed with an infested individual (AAP, 2015).
- Most pediculicides come packaged in single-dose containers. Do NOT divide the product and/or use a single container for multiple heads unless it is marked as a multiple-dose container. Read the package insert carefully. Use the entire contents during a single treatment, unless the directions say otherwise, and make sure the hair is entirely saturated. If more treatments are necessary, obtain more products.
- Remove the individual's shirt and cover their shoulders and arms with a towel. Cover the individual's eyes with a washcloth in order to keep them protected.
- To confine the product to the head and scalp, have the individual lean over the sink or bathtub. Do not treat while bathing or showering, as the product may flow onto the body and expose greater amounts of skin.
- Follow the manufacturer's directions and apply the treatment.

- Unless instructed otherwise in the product instructions, allow the hair and scalp to dry in open air. Hot hair dryers or blowers may reduce the effectiveness of some lice treatment products.
- Following the treatment, have the individual put on clean clothing.
- Hair conditioners and vinegar rinses may reduce the effectiveness of some lice treatment products. If shampooing is needed during the week following treatment, use regular shampoo only. Remember to follow the manufacturer's instructions.
- No treatment is 100% effective. A second treatment should be provided nine days after the initial treatment if not otherwise specified on the product label.
- Removal of nits immediately after treatment with a pediculicide is usually not necessary to prevent the spread of lice. It may be encouraged for cosmetic reasons, to decrease diagnostic confusion during future head checks or it may be required by some schools or child-care providers. Discussion of the nit removal process starts on page 22.
- Cleaning of personal items and the environment should be done on the same day of treatment. (See page 20.)

If lice persists or if treatment does not seem to be working, consider the following:

- Was the hair too wet during the application of the treatment?
- Were product directions followed exactly as stated on the label?
- Was the product left on long enough?
- Was the person really infested?
- Were other shampoos or conditioners used that may have interfered with the treatment?
- Could the individual have become reinfested with lice due to contact with an untreated, infested person or an environmental source?
- Is this a case of resistant head lice? Resistant head lice is head lice that is resistant to over-the-counter treatments.
- Was enough treatment product used?

Alternative Treatments

There are many products marketed as effective treatments to get rid of head lice and nits. Limited research has shown that hot air treatment is effective in treating head lice, with such products as the Lousebuster. **Some of these products may be expensive and are being recommended as an institutionally based machine.* Hair dryers are not an effective means to get rid of head lice. Many products are listed as "natural." It is important to remember the term "natural" does not always mean safe or effective.

If you choose a product different than those previously mentioned to treat head lice, it is advisable to confirm that the product has been approved by the Federal Drug Administration (FDA) for use in the treatment of head lice. This information can be found on the product label. Products should also have a toll-free telephone number on the package so you can call the company with questions regarding possible side effects, what actions to take if side effects occur and proper use. Products should list the active ingredient(s) so you can consult with a health care provider or pharmacist about the possibility of allergic reactions, possible side effects and contraindications of the use of the product if needed.

Home remedies have been around as long as head lice. Examples of home remedies include olive oil, mineral oil, petroleum jelly, mayonnaise and vinegar. These have been applied to suffocate the lice and are widely used but have not been evaluated for effectiveness (AAP, 2020). Essential oils have been widely used in traditional medicine for the eradication of head lice, but because of the variability of their constitution, the effects may not be reproducible. In addition, these oils may be a source of contact sensitization, which limits their use. Several products have been studied (e.g., Andiroba oil, Quassia vinegar, melaleuca oil [tea tree oil] and lavender oil). As natural products, they are not required to meet FDA efficacy and safety standards for pharmaceuticals (AAP, 2020). It should be noted that these products are generally difficult to remove from the hair. Other home remedies such as applying dye to the hair will not get rid of head lice.

Products and methods to avoid

Centers for Disease Control and Prevention (CDC) recommendations for what NOT to do when getting rid of lice:

- Don't use extra amounts of any recommended or prescribed dose of lice medication in an attempt to get rid of the lice faster. Excessive dosages can be dangerous and may cause severe damage.
- Avoid getting any medication for lice in the eyes. If contact with the eyes occurs, be sure to flush them out and call the North Dakota Poison Center at 1-800-222-1222.
- Don't repeat the same lice treatment more than two or three times. If you repeat a medication treatment too many times, you or your child may build resistance to the medication or an alternative may have to be used.
- Don't use more than one head lice medication at the same time. Using more than one treatment at a time won't work to kill the lice faster, and it can cause more harm than good.

- Don't fumigate the house or living area where an individual who has head lice has been. Fumigation isn't necessary to kill lice and may be toxic to others and to pets.

- Avoid using conditioner for 10 days following treatment. Conditioner acts as a barrier for lice medication and stops it from sticking properly to the hair shaft.

- Don't use lindane shampoo as a first-line treatment for children. The American Academy of Pediatrics (AAP) no longer recommends it, as overuse and misuse can be toxic to the brain or parts of the nervous system. The AAP recommends that Lindane only be used when other treatments have failed.

Head shaving and/or cutting hair

Some parents may want to shave the child's head to get rid of the lice problem. Shaving or cutting hair may be at a high emotional cost to the child and is not necessary. Others think cutting a child's hair reduces the chance of infestation. Shorter hair may make it easier to locate and remove lice and nits but does not reduce the risk of infestation.

** = Use of brand names does not endorse the specific product. Any similar product may work as well as those mentioned.*

SAFETY PRECAUTIONS

Treatment should never consist of toxic and/or flammable household products such as kerosene, gasoline, paint thinner, turpentine or any other household cleaners.

Pesticides intended for use on insects or bugs other than head lice, or pesticides intended for use on animals, should not be used on humans. Every year, children are killed or seriously burned as a result of these types of products.

Never put a child to bed with a shower cap or with plastic covering his or her head! This can cause a suffocation concern.

Step 3

Cleaning of personal items and the environment

1. All combs/brushes, bows, hair ties, headbands, barrettes and other hair pieces should be bagged tightly and placed in the freezer for 12 hours, put in a mesh bag and placed in the dishwasher on the sanitize cycle or set aside (in the tightly closed bag) for a week.

2. All glasses, goggles, earrings, hearing aids, phones and headphones should be wiped down gently with soap and water.

3. All hats, jackets, sweaters and sporting gear worn prior to treatment should be washed. It is not the washing that kills the lice, it is the high heat produced in the dryer. Place all things in the dryer on high heat for 40 minutes. If the fabric won't tolerate the high heat, then place the item(s) in the freezer for 12 hours or bag for five days.

4. Cleaning bedrooms: Strip all sheets and mattress pads and place them in the dryer on high heat for 40 minutes. Vacuum the mattress and all areas surrounding the mattress. You will need to repeat this step daily for five days. Pillows can be placed in the dryer for 40 minutes, placed in the freezer for 12 hours or bagged for five days.

5. Car seats: Vacuum the car seats/headrests thoroughly. If you have leather seats, wipe them off with a damp rag. If your child sits in a car seat/booster, remove the seat cover and dry on high heat for 40 minutes, place in the freezer for 12 hours or bag for five days.

6. All dolls, blankets, stuffed animals and rugs should be put in the dryer on high heat for 40 minutes, placed in the freezer for 12 hours or bagged for five days.

SAFETY PRECAUTIONS

Many pediatricians and safety groups recommend hot water heaters in the home be set to a temperature of no more than 120°F to help reduce scalding burn accidents to children. If the hot water heater is increased to 130°F for the purpose of cleaning head lice articles, remember to turn down the heater after the washing has been completed.

The use of pediculicidal (or pesticides) or insecticidal sprays is strongly discouraged and is NOT recommended, as these may be harmful to family members and pets.

Remember: **Head lice can infest all people regardless of age, race and socioeconomic status or hygiene practices. No disease or health risks have been associated with head lice. It is important to avoid treatments (of individuals or the environment) that pose a greater risk than the condition of head lice.**

Step 4

Repeat treatment with the pediculicidal product

No treatment is 100% effective. Some nits may survive the initial treatment and hatch live nymphs. Retreat nine days after the initial treatment if not otherwise specified on the product label. A second treatment with the pediculicidal product should kill any newly hatched nymphs prior to them maturing into lice and gaining their ability to lay new nits.

- The procedure outlined on page 16 should be repeated.
- All precautions and safety guidelines discussed on pages 12-21 should be followed

Don't forget the steps!

Step 1 Carefully inspect and screen the hair and scalp to identify lice and/or nits correctly

Step 2 Use a pediculicide product if live lice or viable nits are found

Step 3 Clean personal items and environment

Step 4 Repeat treatment with pediculicial product

Manual Removal of Nits

Although removing all nits from the hair may be done to reduce worries of another lice infestation, or for cosmetic reasons, research has shown the removal of nits may not be necessary. The application of a second treatment, completed nine days after the first treatment, should kill any newly hatched lice prior to maturity and their ability to lay nits.

The American Academy of Pediatrics and the North Dakota Health and Human Services agency do not recommend "no-nit" policies as they have not been shown to be effective in reducing the incidence of head lice.

Child care sites and schools may still require children to be nit-free before returning to the child care facility or school. These policies vary from one setting to another. Parents should be familiar with the head lice policies of the facility or school their children attend. If your child's facility has a "no-nit" policy or if you feel you need to remove them for aesthetic reasons, the following actions should assist you in the process of removing nits.

- It is not recommended to self-treat, which means trying to remove nits from your own head, as this is very difficult to do.

- Wearing gloves during lice/nit removal is a personal choice; however, it is not necessary. There is very little chance of spreading the infestation, and gloves often make the job more difficult.

- Work in an area with good visibility and light, such as areas with a lamp or natural sunlight through a window. It may be easier to see and remove nits during the day when there is more natural light.

- Hair should be clean, damp and untangled.
  - Use a grooming comb or hairbrush to remove tangles.
  - During the combing to remove the nits, using a lice or nit comb is most effective. If one is not available, use a comb with closely spaced teeth.
  - It is best to have hair that is slightly damp when removing the nits.
    - If the hair is too wet, the nit comb slips through too quickly.
    - If combing is done on dry hair, individuals often complain of discomfort.

- Part the hair into sections and hold sections in place with hair ties or hair clips.
  - Separating the hair into small sections makes it easier to see lice and nits.

- Comb and/or pick out all the nits.
  - Some examiners recommend combing the hair slowly away from the scalp, inserting the comb as close to the scalp as possible and pulling the comb completely through the hair from root to the end. Pay special attention to the nits right next to the scalp.
  - Others advise holding the hair at the end and combing with a back motion towards the scalp, reporting this approach as more likely to break the nit from the glue-like substance that attaches it to the hair shaft.

- Comb one section at a time, pulling the comb slowly through the hair several times.
  - Examine all sides of the hair shafts for nits.
  - Although using a nit comb removes most of the nits, sometimes you may need to remove a stubborn nit by pinching it between two fingernails.
  - If you are unable to remove a stubborn nit by combing or with your fingernails, you can simply cut off the hair shaft with small scissors.
  - Check the section one last time to make sure it's clean and then pin it out of the way by laying it flat against the head. This will help you keep track of the sections you have already combed and those that still need combing.

- Check the comb after each pass through the hair. Whenever you comb out nits or lice, clean the comb under running water or dip it into a bowl of water. You also can clean the comb with a paper towel or tissue. Hold the comb up to the light to make sure it is completely clean before the next stroke.
  - Paper towels or tissues can be thrown into the garbage. Simply tie the garbage bag and remove it from the house when finished.
  - Clean the comb under running water. Rinse the sink with hot running water when finished.

- After combing is complete, soak the lice comb in hot water (130°F) for at least 10 minutes. Use an old toothbrush to clean the comb.
  - Check the comb under a bright light to make sure all lice and nits are gone. The comb can now be used on another family member or is ready for the next combing.

- When fingernails are used to remove nits, they also should be cleaned frequently during and after the process. Wash with soap and water and use a nail brush.

There are many different nit-removal combs on the market. Nit combs are often included in the packages of many head lice removal products. The comb should have an inner tooth space smaller than the nits (0.5 to 0.8 mm) to be effective. Combs that are light-colored allow for better visualization than dark-colored combs. Metal combs are sturdier and less apt to break than plastic combs. Well-designed combs that meet these requirements often can be bought at pet stores for less money.

Remember: Head lice can infest all people, regardless of age, race, socioeconomic status or hygiene practices. Take care not to blame anyone if an infestation occurs in your household. Head lice are not life threatening, nor do they carry disease. They are just annoying, so try to keep things in perspective.

Schools, Child Care and Groups

There is no state law governing the management of head lice control in schools or child care centers. The National Association of School Nurses and the American Academy of Pediatrics support the position not to exclude children from school due to head lice. The North Dakota School Boards Association also supports this position.

General Recommendations

It may be helpful to periodically provide information for parents and caregivers about the prevention, diagnosis and treatment of head lice, along with information about local policy.

If a child is demonstrating symptoms, have a school nurse, public health nurse, medical provider or designated trained staff person check the student's head.

If a child is found to be infested with head lice during school or child care, he or she can remain in class. There are no known health risks from head lice, and research has shown immediate removal of children from school or child care is not effective in controlling or reducing the spread of head lice.

- Confidentiality must be maintained. Removing a child immediately after a screening increases the risk of breaks in confidentiality.

- When a child is found to be infested, they should be treated as soon as possible after school that day and should be discouraged from having head-to-head contact with others.

Parents of children with positively identified infestations of head lice should be notified that day by phone if possible. If phone contact is unsuccessful, a note should be sent home with the child. The parents should be encouraged to provide prompt treatment after school or child care, with a second treatment provided nine days following the first dose. The parents also should be encouraged to have all household members screened. All household members found to be infested also should be treated.

Children likely to have had direct head-to-head contact (such as hugging or sharing pillows) with an infested child in the past 48 hours also should be screened. Efforts should focus on maintaining privacy during the screening.

Routine classroom or school-wide screening is discouraged. Screening for nits alone is not an accurate method of diagnosing head lice. Routine lice screenings of large numbers of children in school have not been proven to have significant effects on reducing the incidence of head lice in schools.

Developing a Policy

It is recommended that schools and child care settings develop a written policy addressing how infestations or suspected infestations of head lice will be managed in the school/child care setting.

Points to consider and address within a policy include:

- Inspection/screening procedures.
  - Who will inspect children demonstrating symptoms?
  - How will inspections be managed?

- Maintaining confidentiality of the children.

- Parent/guardian notification.

- Exclusion protocol
  - *Example:* A child with head lice can remain in class unless he or she is unable to participate due to discomfort. Children with head lice should avoid head-to-head contact with others and should be treated after school or child care.

- Communication process for parents and staff regarding education about head lice and local policy.

- Protocol for responding to treatment refusals.

- If or when referrals will be made to other agencies.

Written policies and procedures regarding specific responsibilities and recommendations will facilitate efficient and consistent implementation by all schools and child care centers. These help to ensure all children are treated in a fair and equal manner.

Seek input from your local public health unit, clinics or health care providers, child care health consultants, child care providers and school personnel in the development of a head lice management policy. To locate the child care health consultant in your area, contact your local Child Care Resource and Referral agency. For more information, visit hhs.nd.gov/service-locations/local-public-health.

The "no-nit" Standard

When a "no-nit" policy is in place, infested children are sent home when lice or nits are found on the child. The child needs to be treated and all nits must be removed before they are allowed back in the school or child care facility. Although "no-nit" policies were the norm for schools and/or child care facilities in the past, research has shown they do not decrease the occurrence of head lice. However, they do result in increased absences of children from school or child care. They also increase the risk of violating the privacy of the children involved.

The American Academy of Pediatrics and National Association of School Nurses discourage such policies and believe a child should not miss or be excluded from school because of head lice. Because a child with an active head lice infestation likely has had the infestation for one month or more by the time it is discovered and poses little risk to others from the infestation, he or she should remain in class but be discouraged from close, direct head contact with others (AAP, 2020).

Other disadvantages of "no-nit" policies include:

- Studies show "no-nit" policies increase the risk of incorrect diagnosis of head lice and have no bearing on reducing the incidence of head lice.
- "No-nit" policies may be carried out too rigidly, and students are often excluded from school due to the misidentification of nits or the presence of nonviable nits.
- Mandatory exclusion may hinder academic performance and increase social stigma.
- "No-nit" policies, and the increase of an incorrect diagnosis associated with them, may lead to overuse of lice treatment products as parents/caregivers try to eliminate lice and nits.

Recommended Preventive Measures

- Regularly vacuum carpeted or upholstered areas and wipe down any sports or nap mats with a damp cloth.
- For young children in school or child care who nap, bedding/pillows should not be shared. Store nap items separately and space mats/cots apart so children are not touching when they are napping.
- If an outbreak of head lice occurs, assign individual lockers or cubbies. If lockers are not available, assign hooks 12 or more inches apart or have the children hang their coats on the backs of their chairs.
- If bus drivers express concern regarding outbreaks of head lice, they can wipe school bus seats with a damp cloth.
- If cars or vans are used for transportation, regularly vacuum upholstered seats or go over them with a lint remover (rollers with a sticky surface).
- Although indirect transmission of head lice is rare, the sharing of headphones should be avoided if possible.
- While it is recommended that children should avoid sharing items such as helmets, safety should be the first priority as the risk of transmission is low. If helmets need to be used, they can be cleaned by being vacuumed and wiping with a mild soap and water
- Data show that head lice are unlikely to spread through the water in a swimming pool, even though chlorine levels in water do not kill head lice. Head lice hold tightly onto human hair underwater. Head lice are more likely to be spread through sharing personal items with an infected person, such as towels and combs.
- Swimming or washing hair within one to two days after head lice treatment might make some treatments/ medications less effective.

SAFETY PRECAUTIONS

The use of insecticides, lice sprays or environment fumigants of any kind to fog the school or child care room or to treat walls, floors, desks and carpets is of no value in the control of head lice.

These products are more harmful to people and pets than they are effective in getting rid of lice. The CDC, AAP and the North Dakota Health and Human Services agency strongly discourage the use of these spray products for the control of head lice.

Myths and Facts

Myth	Fact
It's easy to get lice.	Lice are spread by head-to-head contact and are much harder to get than a cold, the flu, ear infections, pink eye, strep throat or impetigo.
Avoiding lice is important, as they are dirty and spread disease.	Lice do not spread any known disease, nor are they impacted by dirty or clean hygiene. They are simply an incovenience.
Head lice are very sturdy creatures and can survive many days off of people on furniture, linens or clothing.	Head lice need a blood meal every few hours and the warmth of the human scalp to survive. When off the human body, they cannot survive for more than 24-36 hours.
Nits (lice eggs) can fall off a person's head, hatch and cause another person to get lice.	Nits are glued to the hair shaft by a cement-like substance and are very hard to remove. When a nymph (baby louse) is hatched, it must quickly have the warmth and food source of a head to survive.
Cutting a person's hair will prevent head lice infestations.	The length of a person's hair does not impact his or her risk of getting head lice.
You can get head lice from sitting in a desk next to someone who is infested with head lice.	Head lice are spread through direct head-to-head contact. The lice do not hop, jump or fly, so sitting near someone with head lice does not increase the risk of getting the lice.
Lice are commonly spread throughout schools.	Transmissions in schools are rare. It is more common to get head lice from family members, overnight guests and playmates who spend a lot of time together.
Lice are commonly spread through hats or helmets.	Although spread through hats or helmets is possible, it is rare. It is more common for transmission to occur from pillows, hairbrushes or sheets. The most common type of transmission is from head-to-head contact.
Schools and child care facilities should screen all children for head lice, so everyone can be treated and the spread of head lice will be prevented.	Having regularly scheduled mass screenings does not reduce the incidence of head lice.
"No-nit" policies reduce the risk of head lice in schools and child care facilities.	Research shows "no-nit" policies do not decrease the number of cases of head lice. They do increase the risk of incorrect diagnosis of head lice, the number of days children are out of school and negative social stigma associated with head lice. These policies also may hinder academic performance.
The only way to ensure you will not get head lice after a treatment is to remove all the nits.	Studies have shown the removal of nits immediately after treatment with a pediculicide is usually not necessary.
You can get lice from your dog or other pets.	Head lice are specific to humans. You can get human lice only from other humans. You cannot get lice from your pets, nor can you give your pets lice.

Head Lice (Pediculosis Capitis)

Head lice are small insects (less than 1/8 inch long, approximately the size of a sesame seed). Head lice live on blood they draw from the scalp and lay tiny, gray/white eggs (known as nits) near the scalp. The warmth from the scalp is needed for the eggs to hatch. Head lice are not known to spread disease.

Transmission

Head lice can affect anyone and can spread as long as lice or eggs remain alive on the infested person or clothing. In the United States, head lice are most common among preschool children attending child care, elementary school children and household members of infested children.

Head lice are commonly spread by direct contact with hair. People can spread head lice by sharing combs, brushes, hats, blankets, or sheets with others, but this is less common. Head lice can only be spread by live lice and not nits. A person who previously had head lice may get it again.

Symptoms

For many people, head lice cause no symptoms. The time from laying eggs to hatching is about one week (six to nine days). Lice mature to the adult stage approximately seven days later. When symptoms are present, they include:

- **Itching-** this is one of the most common symptoms. Itching is often located on the skin on the scalp or neck.
- **Sores on the head-** small red areas on the scalp may be seen due to bites from the louse. Sores may also develop from continued itching.
- **Tickling feeling of something moving in the hair-** some people report a crawling feeling in the hair.
- **Sleeplessness-** lice are more active at night and may disrupt sleep.

Diagnosis

Diagnosing head lice is done by identifying live lice or nits within 1/4 inch of the scalp. Eggs and lice can be seen with the naked eye; however, the use of a hand lens or microscope may help to confirm the identification.

Treatment

- **Medicated shampoos or cream rinses** containing lindane or pyrethrins.
- **Over-the-counter products** containing pyrethrins.
- **Prescribed medication** containing lindane or pyrethrin.
    - Lindane is not recommended for infants, young children, and pregnant or lactating women.
- **Nit combs** remove lice eggs from hair and are more useful than medications on eggs.

Dose and duration of shampoo treatment should be followed according to label instructions. Extra amounts should not be used, and multiple products should not be used at the same time. Retreatment after seven to ten days is recommended to assure that no eggs have survived.

For more information about the treatment of head lice, visit www.cdc.gov/parasites/lice/head/treatment.html. If you have further questions about the treatment of your head lice infestation, contact your health care provider.

Prevention

- **Avoid physical contact with infested individuals and their belongings**, especially clothing, headgear and bedding.
- **Examine close contacts and playmates of infected persons.**
- **Educate** on the life cycle of lice, proper treatment, and the importance of laundering clothing and bedding in hot water (130°F for 20 minutes) or dry cleaning to destroy lice and eggs.
- **Inspect regularly for lice**, on the scalp (and when indicated on the body and clothing), particularly of children in schools, and persons in institutions, nursing homes, and summer camps, is important.

Exclusion Guidance

Children or others do not need to be excluded from childcare, school, work, or other activities if they have head lice. Exclusion and treatment of children in child care can occur at the end of the day with return the following day after their first treatment. Children can remain in school but should be treated for lice as soon as possible. Head-to-head contact with others should be discouraged.

For more information about head lice, head lice removal, school exclusions, etc., contact North Dakota Health and Human Services, Division of Family Health, at 800.472.2286.

Resources:

1. North Dakota Department of Health. (2012). *Head Lice: A Lousy Problem.* Division of Family Health. [pages.1-30]. www.ndhealth.gov/head-lice/publications/headlicebooklet.pdf
2. Kimberlin, D. W., Barnett, E. D., Lynfield, R., Sawyer, M. H. (2021) *Red Book: 2021- Report of the Committee on Infectious Diseases.* 31st ed. American Academy of Pediatrics. [*Management and Prevention of Infectious Diseases*] [pages 122-133; 567-571].
3. Heymann, D. L. (2015). *Control of Communicable Diseases Manual, 20th Edition*. Pediculosis and Phthiriasis. American Public Health Association. 2015: 446-448.
4. Centers for Disease Control and Prevention. (2013, September 24). *CDC - lice - head lice*. Centers for Disease Control and Prevention. Retrieved March 29, 2023, from https://www.cdc.gov/parasites/lice/head/index.html

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