

**STUDENTS****Health Care at School: Protocols**

The school nurse is responsible for the maintenance of student health records as part of student's permanent record.

The principal is responsible to assure that a parent/guardian is contacted and information is shared as soon as possible when a health concern is suspected, and immediately after an initial screening for such a suspicion. The staff member responsible for making such a contact must be clearly designated (i.e., the student's teacher, counselor, nurse, etc.)

The school nurse is responsible for development of protocols for the care of ill or injured students at school. Designated personnel at each building will be responsible for following those protocols. A record of all care administered at school will be kept for a minimum of eight years.

The following protocols are included in alphabetical order:

Abrasions (scrapes)	Frost Bite
Anaphylaxis	Headaches
Appendicitis	Herpes Simplex
Asphyxiation	Hives (Urticaria)
Asthma	Impetigo
Back and Neck Injury	Insect Bites/Stings
Bites: Animal and Human (if skin is broken)	Lacerations (Cuts)
Blunt Injury - Abdomen	Lice
Blunt Injury - Chest	Mononucleosis (mono)
Boils	Nose Bleed
Brain Injury - Concussion	Pink Eye or Conjunctivitis
Burns	Poisoning
Dental Emergencies	Poison Ivy/Oak: Contact Dermatitis
Diabetes: Juvenile Onset - Type I	Puncture wound: pencil lead, splinters, etc
Dislocation of Joint	Scabies
Eczema	Seizures
Electric Shock	Sprain of Ankle or Knee
Eye Trauma	Sunburns
Fever	Sun Stroke
Foreign Bodies: Ear, Eye, Nose	Tick Removal
Fractures	

**1.0 Protocol: Abrasions (Scrapes)****1.1 Physical Findings:**

- 1.1.1 Denuded area of skin resulting from a scrape on a rough surface, e.g., sidewalk, asphalt, or gravel.
- 1.1.2 Amount of bleeding greater when deeper layers of skin are scraped off.
- 1.1.3 Most often seen on elbows, knees, and face.

**1.2 Management:**

- 1.2.1 Wash gently with plain soap and water.
- 1.2.2 During wash, try to remove loose skin tags and crusts by gently rubbing with 4x4 gauze.
- 1.2.3 Rinse with copious amounts of water to remove foreign material. Cleansing the wound well is the most important treatment.
- 1.2.4 Cover loosely with gauze or Band-Aid.

**2.0 Protocol: Anaphylaxis**

2.1 Physical Findings:

- 2.1.1 Sudden onset.
- 2.1.2 Appears flushed, then faint.
- 2.1.3 Feeling of apprehension
- 2.1.4 Sweating
- 2.1.5 Weakness
- 2.1.6 Shallow respiration, may have crowing or wheezing sound
- 2.1.7 Tingling sensation around mouth or face.
- 2.1.8 Nasal congestion
- 2.1.9 Itching
- 2.1.10 Coughing
- 2.1.11 Low blood pressure with weak, rapid pulse.
- 2.1.12 Loss of consciousness, shock, coma.
- 2.1.13 May be accompanied by hives and/or laryngeal edema.

2.2 Management:

- 2.2.1 Give Epi-Pen and/or Benadryl if ordered per Emergency Care Plan
- 2.2.2 Immediately call 911. See Emergency Procedures Checklist (3415P)
- 2.2.3 If reaction is known to follow an insect sting, see protocol Insect Bite/Sting.
- 2.2.4 Notify the parents.

**3.0 Protocol: Appendicitis**3.1 Physical Findings:

- 3.1.1 Fever - usually low, between 99 and 102
- 3.1.2 Location of pain - begins in pit of stomach or navel and progresses to right lower quadrant
- 3.1.3 Severity of pain - mild at first but always increases in severity
- 3.1.4 Tenderness to pressure usually present
- 3.1.5 Facial expression - child looks uncomfortable, worried, and apprehensive
- 3.1.6 Position of comfort - Child prefers to lie down, usually on left side with right leg drawn up
- 3.1.7 Age differences - all findings progress more rapidly in younger children
- 3.1.8 Vomiting - usually present
- 3.1.9 Diarrhea - almost never present
- 3.1.10 Constipation - almost always present

3.2 Management:

- 3.2.1 If child has symptoms 1-5 of above characteristics on first evaluation, notify parent immediately.
- 3.2.2 Pain, low-grade fever, and tenderness to pressure are the most consistent finds. If present, keep child in clinic and observe for 15 to 30 minutes.
- 3.2.3 If symptoms persist, request parent to take child to doctor.
- 3.2.4 If parent or relative is not available, observe another 30 minutes. If symptoms persist or get worse, send child to hospital by emergency ambulance. Follow Emergency Procedure Checklist (3415P).
- 3.2.5 Symptoms always get worse if child has appendicitis. If symptoms diminish, child can be sent to class. Alert the teacher to keep an eye on student.

**4.0 Protocol: Asphyxiation**4.1 Physical Findings:

- 4.1.1 Student conscious and making attempts to breathe.
- 4.1.2 Complete or near complete inability to speak.
- 4.1.3 Grasping of neck, usually with both hands, palms towards neck.
- 4.1.4 Rapid onset of cyanosis (blueness of lips and fingertips), cessation of breathing efforts, and loss of consciousness.

4.2 Management:

- 4.2.1 If student is able to cough, speak or breathe, no immediate intervention is necessary - observe only. If student's own efforts cease proceed to step 2.
- 4.2.2 If student is unable to cough, speak or breathe:
  - 4.2.2.1 If a solid object is in the throat, administer Heimlich maneuver, if properly trained.
  - 4.2.2.2 If no pulse, begin CPR: mouth to mouth resuscitation and chest compression, if properly trained.
  - 4.2.2.3 Follow Emergency Procedures Checklist (3415P)

## 5.0 Protocol: Asthma

### 5.1 Definition:

An allergic condition which causes swelling and narrowing of bronchial tubes, and excess secretions. This reaction can be caused by: A response to a foreign substance (pollen, dust), virus or bacteria, physical factors (cold, sunlight), or other agent to which the patient is allergic.

### 5.2 Physical Findings:

- 5.2.1 Rapid or sudden onset.
- 5.2.2 Respiratory difficulty, with cough and wheeze.
- 5.2.3 Prolonged expiration.
- 5.2.4 High-pitched whistling wheezes maybe heard.
- 5.2.5 Pulse rate over 150 suggest severe asthma or excess medication.
- 5.2.6 No fever in typical cases.
- 5.2.7 Student breathes easier sitting up.
- 5.2.8 Symptoms may be initiated or made worse by exercise.

### 5.3 Prevention:

Avoidance of dust, molds, animals, pollens, foods, medicines, and other allergic substances.

### 5.4 Management:

Follow Emergency Care Plan developed for each child by personal physician.

## 6.0 Protocol: Back and Neck Injury

### 6.1 Physical Findings:

- 6.1.1 Pain, made worse by pressure or movement (do not move).
- 6.1.2 Pain may radiate into arm or leg.
- 6.1.3 Nerve involvement: Weakness, tingling, numbness, or inability to move arm or leg.

### 6.2 Management:

- 6.2.1 Do not move, bend, or rotate neck of student.
- 6.2.2 Assess student's ability to move extremities slowly, and only a small amount. Test response to a finger touch.
- 6.2.3 If sensation is intact, pain is minimal to absent, and student is able to move all extremities normally allow student to slowly sit up and then walk.
- 6.2.4 If pain, sensory impairment, or weakness persists, have student remain lying down, call emergency ambulance for additional evaluation. Follow Emergency Procedures Checklist (3415P).
- 6.2.5 If all neurological signs are normal and the patient is able to move all extremities freely, ice may be applied to relieve pain.
- 6.2.6 Notify parents.

## 7.0 Protocol: Bites-- Animal and Human (if skin is broken)

- 7.1 Wash with copious amount of soap and water.
- 7.2 Apply loose dressing and elevate extremity.
- 7.3 Notify school nurse.
- 7.4 Notify parent.
- 7.5 Refer to physician.

- 7.6 Notify parent & physician of date of last tetanus booster.
- 7.7 Report to local authorities, health department and/or police.

## 8.0 Protocol: Blunt Injury - Abdomen

8.1 History: Accident, sports injury, child abuse

8.2 Physical Findings:

Symptoms may appear following the blow or as late as the next day.

- 8.2.1 Possible bruise visible.
- 8.2.2 Gradual onset of apprehension
- 8.2.3 Pain and tenderness to mild pressure.
- 8.2.4 Abdominal swelling
- 8.2.5 Vomiting
- 8.2.6 Rapid, weak pulse with low blood pressure.
- 8.2.7 Gradual onset of shock and coma.

8.3 Management:

- 8.3.1 Allow resting in position of comfort during 15-30 minute observation period.
- 8.3.2 If student has none of the above symptoms occur, notify parent- refer to physician.

## 9.0 Protocol: Blunt Injury - Chest

9.1 History:

- 9.1.1 Accident
- 9.1.2 Sports Injury
- 9.1.3 Child Abuse

9.2 Types of Injury:

- 9.2.1 Rib fracture or contusion. Chest wall is thin and compliant in younger children so heart or lungs can be injured without rib fracture.
- 9.2.2 Pneumothorax (air in chest) or hemothorax (blood in chest).
- 9.2.3 Bruised or lacerated lung.
- 9.2.4 Cardiac tamponade (blood in space around heart causing compression of heart).

9.3 Physical Findings:

- 9.3.1 Symptoms such as pneumothorax can develop slowly, even over 1 or 2 days.
- 9.3.2 Rapid shallow respiration.
- 9.3.3 Painful breathing.
- 9.3.4 Distended neck veins
- 9.3.5 Cyanosis
- 9.3.6 Muffled heart sounds.
- 9.3.7 Low blood pressure.

9.4 Management:

- 9.4.1 Following chest injury of unusual severity have child rest in clinic for 15-20 minutes. Notify school nurse.
- 9.4.2 Do not use elastic bandage to wrap chest.
- 9.4.3 If no pain or other symptoms, allow to return to class and observe one hour later.
- 9.4.4 If any symptoms persist, notify parents and physician.

## 10.0 Protocol: Boils

10.1 Physical Findings:

- 10.1.1 Skin abscess originating under the skin in a sweat gland.
- 10.1.2 Pain, swelling, and redness
- 10.1.3 Gets to be about the size of a marble (1-2 cm)

10.1.4 Redness progresses to yellowish center of pus.

10.2 Management:

10.2.1 Warm packs

10.2.2 Notify parent of need for physician evaluation and treatment.

**11.0 Protocol: Brain Injury - Concussion**

11.1 Physical Findings:

11.1.1 State consciousness: Classify the injury as mild, moderate or severe by the following criteria:

11.1.1.1 Mild: Momentary clouding of consciousness or memory lapse (seeing stars, ringing bells) and then apparent normality.

11.1.1.2 Moderate: Brief period of unconsciousness, distinct memory loss, short period of unusual behavior.

11.1.1.3 Severe: Deeper loss of consciousness lasting 1-2 minutes or longer vomiting, fast or slow pulse, irregular breathing, neurological signs such as irregular pupils of the eye, seizure, unilateral weakness, abnormal reflexes, etc.

11.1.2 Vomiting

11.1.3 Unequal size of pupils of the eyes

11.1.4 Unusually rapid or slow pulse rate.

11.1.5 More severe brain injury (contusion, laceration, subdural or epidural hematoma).

11.2 Management:

11.2.1 If any of the Brain Injury signs listed above are present, follow Emergency Procedures Checklist (3415P).

11.2.2 If the child is slightly woozy, but all other findings are normal, notify parents to take child to the doctor.

11.2.3 If all findings are normal, have the student rest in the clinic for 15-30 minutes, the length of time depending on the severity of the head injury and appearance of the child, and then allow child to return to class. Ask teacher to give you a report on the child's status in one hour. Notify parents: What happened, child's response and symptoms need to watch (call doctor for guidance).

**12.0 Protocol: Burns**

12.1 Physical Findings:

12.1.1 First degree:

12.1.1.1 Begins with pain and redness as in minimal sunburn.

12.1.1.2 Later, slight to no peeling of skin.

12.1.2 Second degree:

12.1.2.1 Begins with pain, redness, and blisters as in moderate to severe sunburn.

12.1.2.2 Later, skin peels in large pieces, scarring only if secondary infection ensues.

12.1.3 Third degree:

12.1.3.1 Begins with little or no pain, with red, black or white discoloration. Some unbroken blisters may be present.

12.1.3.2 Heals with moderate to severe scarring.

12.2 Management:

12.2.1 If first or second degree:

12.2.1.1 Apply cold running water for 5-10 minutes.

Immersion is acceptable if no running water is available.

12.2.1.2 May cover with a non-stick sterile dressing if necessary to protect from further damage.

12.2.2 If third degree burn:

12.2.2.1 Cover with clean or sterile dressing or sheet.

12.2.2.2 Follow Emergency Procedures Checklist (3415P).

**13.0 Protocol: Dental Emergencies**13.1 Toothache:

- 13.1.1 Have student rinse mouth vigorously with plain warm water.
- 13.1.2 If swelling of the gum, jaw, or face occurs apply a cold compress to the cheek.
- 13.1.3 Notify parent of need to see dentist.

13.2 Bleeding: Prolonged or recurrent, after extraction of a tooth.

- 13.2.1 Place a sterile gauze pad on the extraction site and have the student gently bite on it for 30 minutes.
- 13.2.2 Replace soaked gauze pads as necessary.
- 13.2.3 Notify parents to consult a dentist if bleeding appears excessive.

13.3 Knocked-out tooth:

- 13.3.1 Have the student rinse mouth gently with warm saltwater.
- 13.3.2 Find the tooth. Handle only by top, not root portion. Place the tooth in a cup of milk or wrap it in clean wet gauze. Do not attempt to clean the tooth as this may destroy the reimplantation process.
- 13.3.3 Apply cold compress on the face next to the injured tooth to minimize swelling.
- 13.3.4 Notify parents to refer to dentist.

13.4 Chipped tooth:

- 13.4.1 Clean any dirt, blood, and debris from the injured area with a sterile gauze pad and warm water.
- 13.4.2 Prevent tongue or cheek lacerations by covering any sharp edges of the broken tooth with gauze and have student hold gauze in place by keeping mouth closed. Take large fragments to dentist.
- 13.4.3 Apply cold compress on the face next to the injured tooth to minimize swelling.
- 13.4.4 Notify parents to refer to dentist.

13.5 Fractures Jaw:

- 13.5.1 Immobilize the jaw by placing a scarf, handkerchief, tie, or towel under the chin, tying the ends on top of the child's head.
- 13.5.2 Notify parents to obtain immediate dental care.

13.6 Orthodontic Emergencies:

- 13.6.1 Protruding wire from a brace can be gently bent out of the way to relieve discomfort by using a tongue depressor or pencil eraser. If wire cannot be bent easily, cover the end with a piece of wax or a small cotton ball to prevent irritation. Do not try to remove any wire embedded in the cheeks, gum, or tongue.
- 13.6.2 Notify parents to obtain orthodontic care the same day.

13.7 Bitten Lip or Tongue:

- 13.7.1 Apply direct pressure to the bleeding area with a sterile gauze pad.
- 13.7.2 If the lip is swollen, apply a cold compress.
- 13.7.3 Notify parents to obtain emergency medical care if bleeding persists or if the bite is severe.

**14.0 Protocol: Diabetes: Juvenile Onset, Type I**14.1 Facts about Diabetes

- 14.1.1 Nearly every diabetic child requires insulin to maintain control of his/her disease. Know if the child is on insulin.
- 14.1.2 Successful treatment depends on a good balance between diet, exercise and insulin.
- 14.1.3 Insulin reactions are apt to occur after a recess, or a play period, or two to three hours after a meal.
- 14.1.4 If you are responsible for a diabetic child, always have close at hand some form of sugar. (Remember field trips.)
- 14.1.5 The child needs to assume responsibility for his/her own condition.
- 14.1.6 Insulin reactions occur more frequently than diabetic acidosis.

14.2 Physical Findings:14.2.1 Early:

- 14.2.1.1 Increased appetite and thirst.
- 14.2.1.2 Increased urination
- 14.2.1.3 Rapid weight loss.

14.2.2 Late:

- 14.2.2.1 Loss of appetite, nausea and vomiting, abdominal pain.
- 14.2.2.2 Weakness.
- 14.2.2.3 Disorientation.
- 14.2.2.4 Rapid respiration.
- 14.2.2.5 Coma and eventual death.

14.3 Complications:

- 14.3.1 Insulin Reaction - due to low blood sugar, symptoms develop within a few hours.
  - 14.3.1.1 Early: Shaky, sweaty, pale, hungry, irritable, fast pulse, stomachache, nausea, and vomiting.
  - 14.3.1.2 Late: Confusion, poor coordination, restlessness, mood changes (aggression, crying, bizarre behavior). With any unexpected, sudden behavior change in an adolescent, suspect diabetes.
  - 14.3.1.3 Advanced: Convulsions and coma. Permanent brain damage can result if reaction is prolonged.
- 14.3.2 Out-of-control Diabetes: Symptoms develop in one or two days. Symptoms are the same as under "Physical Findings" above.

14.4 Management:

- 14.4.1 If complications occur, follow Emergency Care Plan developed for each child by his/her personal physician.
- 14.4.2 In general, an insulin reaction occurs suddenly. The student should be given sugar in some form to eat if conscious and parent/guardian should be notified. If student is unconscious, follow Emergency Checklist Procedure (3415P).
- 14.4.3 Diabetic Acidosis:
  - 14.4.3.1 Comes on slowly.
  - 14.4.3.2 Inquire about recent excess food intake or insufficient exercise. Keep student in clinic.
  - 14.4.3.3 Call parent for instruction on how to proceed.
- 14.4.4 Local Reactions:
  - 14.4.4.1 Lipodystrophy: Hypertrophy or atrophy at multiple injection sites. Requires change of sites and/or change of type of insulin.
  - 14.4.4.2 Allergy:
    - a. Local: Redness, itching, and burning at injection site. Lasts few minutes to several hours. Usually requires change in type in insulin.
    - b. Generalized (systemic): Hives, pallor, and palpitations progressing to vascular collapse. Requires immediate emergency care. Follow Emergency Procedures Checklist (3415P).
- 14.4.5 Maintenance of a diabetic student:
  - 14.4.5.1 Support student in all efforts at self-maintenance.
  - 14.4.5.2 Inform principal, teacher, PE teacher, and cafeteria manager.

**15.0 Protocol: Dislocation of Joint**15.1 Physical Findings:

- 15.1.1 Visible lack of symmetry compared to other side, usually following trauma.
- 15.1.2 Localized pain and swelling.

- 15.1.3 Most common in distal phalanx (tip) of finger. Shoulder is next in frequency, followed by elbow and knee.
- 15.1.4 May be associated with a chip fracture, especially in finger.

15.2 Management:

- 15.2.1 Ice pack applied with as little pressure as possible.
- 15.2.2 Do not compress.
- 15.2.3 Do not try to put back into place.
- 15.2.4 Notify parents of need for immediate medical care.

**16.0 Protocol: Eczema**

16.1 Physical Findings:

- 16.1.1 Acute: Itchy, moist, weepy, red generalized rash, usually on front of elbows, back of knees, face, and neck.
- 16.1.2 Chronic: Same locations, but usually dry and scaly. May be red or depigmented. May also be on upper or lower eyelids.

16.2 Management:

- 16.2.1 Acute: Moist cold or hot compresses to relieve itching. Do not put powders, lotions, or ointments on weepy skin.
- 16.2.2 Notify parents of need for physician's evaluation.

**17.0 Protocol: Electric Shock**

**DO NOT TOUCH THE PERSON DIRECTLY WHILE HE/SHE IS STILL IN CONTACT WITH THE CURRENT!**

- 17.1 Follow the Emergency Procedures Checklist (3415P).
- 17.2 Attempt to turn off the current by removing fuse, breaching the circuit, or unplugging the electric cord.
- 17.3 If that is not possible, stand on something dry and non-conductive (blanket, rubber mat, newspaper) and push the person away from the electric source with a dry wooden pole or board or pull the person away with a dry rope loped over a foot or arm.
- 17.4 When safely away from electric current, assess whether breathing. If not begin CPR.
- 17.5 Cover to keep warm and remain with person until paramedics arrive.
- 17.6 Complete accident report.

**18.0 Protocol: Eye Trauma**

18.1 Physical Findings:

- 18.1.1 History of blow or other trauma to eye.
- 18.1.2 Pain in eye.
- 18.1.3 Redness of conjunctiva.
- 18.1.4 Eye held closed.

18.2 Diagnosis:

- 18.2.1 If student is unable to open eye do not force.
- 18.2.2 Check for visible lacerations on lids or eyeball.
- 18.2.3 Check for fluid or blood in anterior chamber (between iris and cornea.) May be accompanied by drowsiness.
- 18.2.4 Check for double vision.

18.3 Management:

- 18.3.1 Refer to physician if there is laceration on lid or other visible trauma to lid or eyeball, or if vision is impaired in any way.



- 18.3.2 Patch both eyes with 4 x4 gauze pads prior to referral to physician (this minimizes eye movement).
- 18.3.3 Ice packs may be used if physician referral is not necessary.
- 18.3.4 Notify parents.

**19.0 Protocol: Fever**

Notify parent and send home if oral temperature is over 100 F.

**20.0 Protocol: Foreign Bodies -- Ear, Eye, Nose**20.1 Physical Findings:

- 20.1.1 Eye: Pain, tearing, irritation
- 20.1.2 Ear: Usually none of the above; child may tell you he has something in ear.
- 20.1.3 Nose: Usually none at first; Child may state he/she placed object in nose. After a few days, a foul-smelling discharge.

20.2 Management:

- 20.2.1 Eye:
  - 20.2.1.1 Pull down lower lid with tip of index finger. If foreign body can be seen in the lower lid, remove with cotton tipped applicator.
  - 20.2.1.2 If not successful after 1-2 attempts or if foreign body is in any other location, patch eye, notify parents, and refer to physician.
  - 20.2.1.3 Chemical foreign substances in the eye constitute serious emergency. Have someone call 911 while you flush eye with copious amounts of cool tap water while eye lids are held open; Patch eye, follow Emergency Procedures Checklist (3415P).
- 20.2.2 Ear:
  - 20.2.2.1 Do not try to remove unless foreign body can be easily seen and grasped with forceps or fingers.
  - 20.2.2.2 Notify parents and refer to physician.
- 20.2.3 Nose:
  - 20.2.3.1 Do not attempt to remove unless object can be seen extruding from nose and can be grasped with fingers or forceps.
  - 20.2.3.2 Try having child blow nose forcibly with unobstructed side held closed.
  - 20.2.3.3 Notify parent and refer to physician.

**21.0 Protocol: Fractures**21.1 Physical Findings:

- 21.1.1 Localized pain following trauma.
- 21.1.2 Frequently, asymmetry compared to opposite side. Not always present.
- 21.1.3 May be swelling and/or redness but not always present.
- 21.1.4 Suspect "stress" fracture if painful from excess exercise, jogging, gymnastics, ballet training, etc. Produces pain without swelling at site of fracture, especially on movement.

21.2 Management:

- 21.2.1 Stabilize limb, ice, compression, elevation.
- 21.2.2 Notify parents and refer for immediate medical care.

**22.0 Protocol: Frostbite**22.1 Physical Findings:

- 22.2.1 Cold, itchy, or tingly, numb feeling.
- 22.2.2 Mild: Edema or mild purplish color that soon subsides.
- 22.2.3 Moderate: More edema and deeper purple-blue color. Blisters appear in 24-48 hours.
- 22.2.4 Severe: More edema and black color with death of tissue. Blisters do not appear.
- 22.2.5 Most common on fingers, toes, nose, cheeks, and earlobes.
- 22.2.6 Severity not apparent until frostbitten area is warmed.

22.2 Prevention:

- 22.2.1 Cover exposed skin when temperature is below freezing.
- 22.2.2 Students with previous frostbite need to be told that they are more susceptible, and therefore need to take extra precautions.

22.3 Management:

- 22.3.1 Remove wet clothing.
- 22.3.2 Warm with warm moist compresses for 20-30 minutes.
- 22.3.3 Elevate affected area.
- 22.3.4 Check oral temperature for generalized hypothermia.
- 22.3.5 Notify parents.
- 22.3.6 Refer to physician if beyond mild stage.
- 22.3.7 Keep student indoors for remainder of school day.

**23.0 Protocol: Headaches**23.1 Physical Findings:

A headache is a diffuse pain in different portions of the head. The severity and area of pain may help to decide whether it needs medical attention.

It may be frontal, temporal (sides) or occipital (back), confined to one side of the head or to the region immediately over one eye. The character of the pain may vary: A dull aching; acute, almost unbearable pain, intermittent, intense pain; throbbing pain; pressure pain or penetrating pain driving through the head.

23.2 Common Causes:

- 23.2.1 Too much sun and exercise without adequate fluids. Sunburn is often accompanied by a headache.
- 23.2.2 As part of or early symptom of a cold or viral illness.
- 23.2.3 Trauma - accidentally hitting the head during play.

23.3 Management:

- 23.3.1 Rest or sleep in darkened room of moderate temperature.
- 23.3.2 Observation: If not relieved by rest and time, or unusual complaints are offered such as numbness of an arm or leg, persistent vomiting or visual disturbances, then notify parents and refer to a physician.

**24.0 Protocol: Herpes Simplex**24.1 Physical Findings:

- 24.1.1 Small, dark to light grayish - amber crusts around nose or lips.
- 24.1.2 "Canker-sores" inside cheeks or tongue may or may not be due to herpes simplex virus.
- 24.1.3 Usually comes and goes over a period of 1-3 weeks and then disappears. (Recurrent viral infection.)
- 24.1.4 May reappear with emotional or physical stress.

24.2 Special Information:

- 24.2.1 Only contagious when external lesions are present and visible.
- 24.2.2 May be spread by direct (kissing) or indirect (finger or lip to drinking glass) contact.
- 24.2.3 Genital herpes simplex (type II) does not require exclusion (see sexually transmitted).
- 24.2.4 Two to five percent of healthy individuals with no visible lesions in mouth or on lips carry herpes simplex virus in their saliva.

**25.0 Protocol: Hives (Urticaria)**25.1 History:

A skin allergy that may be due to the following factors in order of frequency:

- 25.1.1 Foods
- 25.1.2 Medications

- 25.1.3 Emotional factors
- 25.1.4 Inhalants (e.g., pollens, dust)
- 25.1.5 Contact substances (e.g., dust, plants)
- 25.1.6 Physical factors (e.g., sun, cold)

25.2 Physical Findings:

- 25.2.1 Round, reddish pink wheels on skin surface varying in size from 1/2 cm. to 2-3 cm.
- 25.2.2 May become confluent and larger.
- 25.2.3 Tend to be clear in center with surrounding redness.
- 25.2.4 Not tender or painful, but itchy.
- 25.2.5 Characteristically short-lived but reappears, often in parts of body.
- 25.2.6 May be accompanied by swelling of lips, eyes, fingers, and genitalia.
- 25.2.7 Laryngeal Edema is the most serious complication: Hoarseness and difficulty breathing.

25.3 Management:

- 25.3.1 If laryngeal edema occurs, follow Emergency Procedures Checklist (3415P).
- 25.3.2 Cold compresses for itching.
- 25.3.3 Notify parents.

**26.0 Protocol: Impetigo**

Impetigo is a primary superficial skin infection caused by staphylococci or streptococci.

26.1 Physical Findings:

- 26.1.1 The skin eruption may begin with small blisters that later can contain pus and/or become scabbed.  
If is contagious on direct or secondary contact.
- 26.1.2 The sores may be on any part of the body but are most common on the face or hands.
- 26.1.3 Itching is a common complaint.

26.2 Prevention:

- 26.2.1 Good personal hygiene will prevent spread.

26.3 Management:

- 26.3.1 Notify parent of need for physician diagnosis and treatment.
- 26.3.2 Keep sores covered with loose dressing or Band-Aid.
- 26.3.3 May attend school if under treatment. Exclusion from school not necessary unless the condition of the outbreak or the behavior of the child puts other children at risk.

**27.0 Protocol: Insect Bites/Stings**

27.1 Prevention:

- 27.1.1 Make sure students and staff with known allergic reactions are identified and appropriate teachers (PE teachers, coaches, etc.) are alerted.
- 27.1.2 Most people who know they are allergic carry or have some form of medicine readily available. Appropriate staff members should know how to administer these substances. Parents should provide school with Care Plan from physician for allergic students.
- 27.1.3 Teachers should use good judgment in selection of areas for carrying on activities. Avoid the following:
  - 27.1.3.1 Clover patches.
  - 27.1.3.2 Areas near garbage cans.
  - 27.1.3.3 Areas that have been used for picnics where food may have been spilled.
  - 27.1.3.4 Areas where these insects are seen in quantity.
- 27.1.4 Teachers should instruct students in procedures and behavior that are least likely to invite the insects to sting.
  - 27.1.4.1 Keep calm.

- 27.1.4.2 Don't wave, swat at, jump and run, or exhibit any vigorous physical movements. These quick movements may cause aggressive reaction by bees.
- 27.1.4.3 Attempt to make students aware without creating anxiety or over-reactions.

#### 27.2 Management:

- 27.2.1 Checklist of known allergic students: Follow Emergency Procedure Checklist (3415P) then follow Care Plan for that child.
  - 27.2.1.1 The school nurse, or trained staff member (in nurses absence) should give emergency injectable and/or oral medication at school as ordered by the physician.
  - 27.2.1.2 If able, the child should be allowed to give own injectable and/or oral medication if it has been properly prescribed by the physician, and written consent has been obtained from the parent.
  - 27.2.1.3 If the school nurse (designated substitute) is not present and the child cannot self-administer the medication, the child must be evacuated to an emergency medical facility as soon as the insect sting is reported.
- 27.2.2 Of all others:
  - 27.2.2.1 If systemic reaction occurs, follow Emergency Procedure Checklist (3415P)
  - 27.2.2.2 Flick (do not squeeze) insect off the skin. They should also remove the venom sac. If the stinger, without the venom sac, is left in the skin, it should be removed carefully with a scraping motion.
  - 27.2.2.3 Cold application (ice, cold compress) at the sting site may reduce absorption.

### **28.0 Protocol: Lacerations (Cuts)**

#### Management:

- 28.1 Cuts that are clean, straight, less than 1/2 inch long, with edges separated less than 1/8 inch.
  - 28.1.1 Apply firm pressure until bleeding stops.
  - 28.1.2 Clean thoroughly with soap and water.
  - 28.1.3 Pat to dry.
  - 28.1.4 Apply plain or butterfly dressing.
- 28.2 Cuts which are contaminated, longer or wider than above, or located on face or flexor surface (knee, elbow):
  - 28.2.1 Apply firm pressure until bleeding stops.
  - 28.2.2 Notify parents and refer to physician.
- 28.3 Cuts on scalp bleed more due to large blood supply.
  - 28.3.1 Apply firm pressure until bleeding stops.
  - 28.3.2 Wash gently with soapy gauze.
  - 28.3.3 Pat to dry.
  - 28.3.4 Apply butterfly, steri-strips, or plain dressing.
  - 28.3.5 Notify parents and refer to physician.

### **29.0 Protocol: Lice**

#### 29.1 Description:

Head Lice are tiny insects that live in human hair. They hatch from small eggs, called nits, which are attached to the base of individual hairs. The nits hatch in about 10 days and reach maturity in about 2 weeks. As the louse feeds on its host, it injects saliva into the wound resulting in local irritation and itching.

#### 29.2 Physical Findings:

- 29.2.1 Presence of nits (small, round or oval, white specks) that are very firmly attached to hair shafts less than 1/2 inch from scalp.
- 29.2.2 Presence of lice on scalp and hair.
- 29.2.3 Itchiness of scalp, especially around neck and ears.
- 29.2.4 A rash may be present.

#### 29.3 Management:

Exclusion from school in children with active infestations only. Active infestations can be defined as the presence of live lice or nits found within one quarter inch of the scalp.

Any student with live lice (or nits within one quarter inch of the scalp) may remain in school until the end of the school day. Immediate treatment at home is advised. The student will be readmitted to school after treatment and examination. If, upon examination, the school-designated personnel find no live lice or viable nits on the child, the child may re-enter school.

Parents should remove nits daily and treat if live lice are observed.

For students identified during school hours to have an active case of head lice: The school nurse or school designee will contact parents directly. The student may return to class and will be sent home at the end of the school day with information regarding treatment of head lice.

Returning to school:

1. The child must go to the office upon arrival to school. It is recommended that parent/guardian accompany the student upon arrival to school.
2. Designated school personnel will re-examine the student's hair.
  - a. Student will be re-admitted if no live lice are found.
  - b. If live lice are found and not removed, the student may not be re-admitted to class.
  - c. Any student with no live lice, or nits within one quarter inch of the scalp, will be re-admitted to class.

### **30.0 Protocol: Mononucleosis (Mono)**

#### 30.1 Physical Findings:

- 30.1.1 Milder in young, more severe in high school and college age.
- 30.1.2 Fever, malaise, and fatigue.
- 30.1.3 Sore throat and enlarged, red, exuding tonsils.
- 30.1.4 Lymph nodes swollen in armpit, groin, above elbow, and especially in neck.
- 30.1.5 Enlarged spleen.
- 30.1.6 Maculopapular rash, jaundice (rare).
- 30.1.7 Fever may last 1-2 weeks; fatigue and malaise may last 4-6 weeks.

#### 30.2 Management:

- 30.2.1 Notify parents and refer to physician; laboratory tests are needed for diagnosis.
- 30.2.2 Return to school on advice of physician.
- 30.2.3 Follow physician's orders relating to all activity levels.

### **31.0 Protocol: Nosebleed**

#### Management:

- 31.1 Have child sit upright.
- 31.2 Apply pressure below bridge of nose for a minimum of 5 minutes by the clock.
- 31.3 If bleeding continues, hold closed firmly another 5 minutes.
- 31.4 If bleeding continues, notify parents and refer for immediate medical care.
- 31.5 Restrict excessive physical exertion remainder of that day only.

### **32.0 Protocol: Pink Eye or Conjunctivitis**

#### 32.1 Physical Findings:

- 32.1.1 Redness of whites of eyes
- 32.1.2 Purulent or watery discharge.

- 32.1.3 Redness and/or swelling of eyelids.
- 32.1.4 Itching and rubbing of eyes.
- 32.1.5 Crusts in inner corners of eyes, especially on waking from sleep.

32.2 Management:

- 32.2.1 Notify parents. Refer to physician for diagnosis and treatment.
- 32.2.2 If conjunctivitis, exclude from school until after treatment takes effect (follow physician orders.)
- 32.2.3 Disinfect any surfaces child may have touched.

**33.0 Protocol: Poisoning**

- 33.1 Call Poison Control Center 1-800-222-1222 and follow their instructions.
- 33.2 Follow Emergency Procedure Checklist (3415P) if appropriate.
- 33.3 Notify parents.

**34.0 Protocol: Poison Ivy/Oak: Contact Dermatitis**

34.1 Physical Findings:

- 34.1.1 Reaction begins 1-4 days after exposure.
- 34.1.2 Early: Itching, redness, small papules and vesicles.
- 34.1.3 Late: Increase of all early signs plus larger blisters and generalized weeping of skin.
- 34.1.4 Healing: Dryness, crusting and gradual shedding of crusts and scabs. May take 2-3 weeks.
- 34.1.5 Most common on hands, forearms, and face.
- 34.1.6 No fever.

34.2 Management:

- 34.2.1 Wash thoroughly after exposure (usually too late when discovered at school).
- 34.2.2 Notify parents and refer to physician.
- 34.2.3 Use medication as prescribed by physician.

**35.0 Protocol: Puncture Wounds--Pencil Leads, Splinters, Etc.**

35.1 Physical Findings:

- 35.1.1 Small skin laceration, usually 1/8 to 1/4 inch long.
- 35.1.2 Moderately severe pain.
- 35.1.3 Little to no bleeding.
- 35.1.4 Pencil lead: leaves purplish "tattoo" mark, usually permanent.
- 35.1.5 Buried wood splinter: quite painful. Student can feel it "stick" when gentle pressure is applied.

35.2 Management:

- 35.2.1 Soak foot or hand in warm water to encourage drainage.
- 35.2.2 Wash gently with soap and water.
- 35.2.3 Try to get history of what punctured the skin, e.g. rusty nail, glass, wood, etc.
- 35.2.4 Determine date of last tetanus booster.
- 35.2.5 Do not try to remove a splinter or other foreign object unless it is small and obviously visible and palpable on top of skin surface and can easily be grasped with forceps. (Do not go digging for it with needle)
- 35.2.6 Notify parents of need for physician treatment if foreign object is present or if student is in need of a tetanus booster.

**REMEMBER: Pencil leads contain no lead, only graphite, which is non-toxic.**

**36.0 Protocol: Scabies**

36.1 Physical Findings:

- 36.1.1 Typical lesion is a "burrow": a tiny, pale, irregular line which marks the path of the scabies mite.
- 36.1.2 Rash: Tiny papules, vesicles, pustule and scabs. Sometimes with tiny, linear dark scabs 0.5. - 1.0 mm long.

- 36.1.3 Location: back of hands, web of fingers, front of forearms, lower abdomen, chest, and armpit. Less common on lower legs. Rare on face, midback, palms and soles (a good diagnostic clue).
- 36.1.4 Itching is intense, especially at night.

#### 36.2 Management:

- 36.2.1 Exclude from school. Notify parent of need for physician evaluation and treatment.
- 36.2.2 Consult "Infectious Disease Control Guide for School Staff".

### **37.0 Protocol: Seizures**

#### 37.1 Physical Findings:

- 37.1.1 All Types:
  - 37.1.1.1 Distinct beginning and rapid cessation.
  - 37.1.1.2 Amnesia of seizure, sometimes including events that occurred a few seconds to minutes prior to seizure (retrograde amnesia).
  
- 37.1.2 Grand Mal
  - 37.1.2.1 Seizure may be mild or severe; begins tonic (rigid body), becomes chronic (convulsive shaking).
  - 37.1.2.2 Sometimes seizure is preceded by aura of sight, sound or smell.
  - 37.1.2.3 Post-convulsive state: drowsy to deep sleep.
  - 37.1.2.4 Frequency varies from daily, to monthly, to annually.
  
- 37.1.3 Petit Mal: (absence spells)
  - 37.1.3.1 Very brief (10-20 seconds) period or cessation of motion.
  - 37.1.3.2 Brief loss of consciousness. Does not fall to floor.
  - 37.1.3.3 May drop glass or pencil.
  - 37.1.3.4 Occasional brief muscular twitches.
  - 37.1.3.5 May occur several times a day (as often as 20).
  - 37.1.3.6 Lack of attention (e.g., staring out the window often mistaken for Petit Mal).
  
- 37.1.4 Focal: (partial)
  - 37.1.4.1 Seizure of one part of body, usually on one side only: hand, arm, face, tongue, foot or leg.
  - 37.1.4.2 May "spread" to other muscle groups.
  - 37.1.4.3 Usually no tonic or clonic convulsions.
  
- 37.1.5 Psychomotor: (complex partial)
  - 37.1.5.1 Purposeful but inappropriate motor acts, often repetitive: running motions of feet, extension of arm with slow turn of body, "fugue" or trance-like state.
  - 37.1.5.2 Often sleepy after seizure.
  - 37.1.5.3 Usually no tonic or clonic convulsions.
  
- 37.1.6 Somato-sensory: (partial)
  - 37.1.6.1 Numbness, tingling, or pain. May originate in one part of the body and spread.
  - 37.1.6.2 Visual images or sensations.
  - 37.1.6.3 Sudden tastes or smells.
  
- 37.1.7 Epileptic Equivalents: (partial)
  - 37.1.7.1 Symptoms of headache, stomachache, vomiting, diarrhea, uncontrollable laugh and other symptoms associated with autonomic nervous system.
  - 37.1.7.2 Behavior disorders and learning problems.
  - 37.1.7.3 Thought to be due to abnormal cerebral cortical discharges.
  - 37.1.7.4 The existence of this category of epilepsy is questioned; attributed to psychological origin.

- 37.1.8 Hysterical: (pseudoepilepsy)
  - 37.1.8.1 Rarely injures self.
  - 37.1.8.2 Incontinence rare.
  - 37.1.8.3 Consciousness regained quickly.
  - 37.1.8.4 Often preceded by anxiety.
  - 37.1.8.5 Cyanosis absent or momentary.

**37.2 Management:**

There is nothing you can do for Petit Mal and Psychomotor seizures except to explain the seizure to other pupils. For Grand Mal Seizures:

- 37.2.1 Keep calm. Ease the child to the floor and loosen his/her collar. You cannot stop the seizure. Let it run its course and do not try to revive the child.
- 37.2.2 Remove hard, sharp or hot objects that may injure the child, but do not interfere with his/her movements.
- 37.2.3 Do not force anything between the teeth.
- 37.2.4 Turn the head to one side for release of saliva. Place something soft under the head.
- 37.2.5 When the child regains consciousness, let him/her rest if he/she wishes.
- 37.2.6 Notify parents.
- 37.2.7 If the seizures last beyond 5 minutes, or the child seems to pass from one seizure to another without gaining consciousness, follow Emergency Procedures Checklist (3415P).
- 37.2.8 Medication changes in an epileptic child can cause behavior and/or personality changes. If you notice a child appearing over-sedated or unaware of what is happening, report this to the school nurse or directly to the parents.

**38.0 Protocol: Sprain of Ankle or Knee**

**38.1 Physical Findings:**

- 38.1.1 History of trauma, twist, or snap.
- 38.1.2 Pain
- 38.1.3 Swelling

**38.2 Management:**

- 38.2.1 Rest - walk only as necessary.
- 38.2.2 Ice - apply no more than 20 minutes at a time.
- 38.2.3 Elevate injured leg.
- 38.2.4 Notify parent and recommend physician evaluation if there is significant swelling, severe pain, point tenderness, inability to bear weight, or significant limitation of motion after first 20 minutes of rest and ice.

**39.0 Protocol: Sunburns**

Sunburn is the result of excessive exposure to sunlight.

**39.1 Physical Findings:**

- 39.1.1 Pink to scarlet hue and mild swelling. May progress to a bright red coloring.
- 39.1.2 Intense swelling and blistering.

**39.2 Preventive Measure:**

- 39.2.1 Sun-protective topical medications applied 1-2 hours before exposure and reapplied after swimming or profuse sweating.

**39.3 Management:**

- 39.3.1 Mild sunburn:
  - 39.3.1.1 Apply cool tap water compresses 20 minutes 3-4 times daily or more frequently.
  - 39.3.1.2 Lotion may help cool.



- 39.3.2 Severe sunburn: (Intense pain, inability to tolerate contact with clothing, nausea, tachycardia, chills, fever).
- 39.3.2.1 Notify parent and refer to physician.

#### **40.0 Protocol: Sun Stroke**

##### 40.1 Physical Findings:

- 40.1.1 Heat Cramps
  - 40.1.1.1 Painful spasms usually in muscles of legs and abdomen possible.
  - 40.1.1.2 Heavy sweating.
- 40.1.2 Heat Exhaustion
  - 40.1.2.1 Heavy sweating, weakness, skin cold, pale, clammy.
  - 40.1.2.2 Pulse thready.
  - 40.1.2.3 Normal temperature possible.
  - 40.1.2.4 Fainting and vomiting.
- 40.1.3 Heat Stroke
  - 40.1.3.1 High body temperature (106 F. or higher).
  - 40.1.3.2 Hot and dry skin.
  - 40.1.3.3 Rapid and strong pulse
  - 40.1.3.4 Possible unconsciousness.

##### 40.2 Management:

- 40.2.1 Heat Cramps
  - 40.2.1.1 Firm pressure on cramping muscles, or gentle massage to relieve spasm.
  - 40.2.1.2 Give sips of water. If nausea occurs, discontinue use.
- 40.2.2 Heat Exhaustion
  - 40.2.2.1 Get victim out of sun. Lay down and loosen clothing.
  - 40.2.2.2 Apply cool, wet cloths.
  - 40.2.2.3 Notify parents.
  - 40.2.2.4 Give sips of water. If nausea occurs, discontinue water.
  - 40.2.2.5 If vomiting continues follow Emergency Procedure Checklist (3416P1)
- 40.2.3 Heat Stroke (sunstroke)
  - 40.2.3.1 Get victim out of sun. Loosen clothing. Call 911.
  - 40.2.3.2 Apply cool, wet cloths.

**HEAT STROKE IS A SEVERE MEDICAL EMERGENCY. DELAY CAN BE FATAL.  
FOLLOW EMERGENCY PROCEDURES CHECKLIST (3415P).**

#### **41.0 Protocol: Tick Removal**

##### 41.1 Physical Findings:

Tick embedded in skin. Redness, could be swelling, possible fever.

##### 41.2 Management:

- 41.2.1 Remove the tick with a blunt, curved, small forceps or tweezers, using steady, firm pressure applied upward.
- 41.2.2 Put tick between tape and send home with 3410F3 (letter regarding tick bites)
- 41.2.3 Cleanse bite area with soap and water.
- 41.2.4 Notify parent.

**Approved:** October 1991

**Revised:** April 28, 2010

Revised: November 9, 2011

Revised: February 12, 2014