Chapter 1: School Health Services and School Nursing Practice

Section 1: Overview of School Nursing Services

School nursing practice is evolving as society changes and different health problems emerge. School nurses continue to take on a larger role in modeling and monitoring healthy behaviors of students and staff. School nurses can contribute to the overall educational goals by taking a leadership role in planning and promoting interventions that will directly influence the health and safety of the entire school community.

The definition of school nursing adopted by the Board of the National Association of School Nurses (NASN) in 2017 is:

"School nursing is a specialized practice of nursing that protects and promotes student health, facilitates optimal development and advances academic success. School nurses, grounded in ethical and evidence-based practice, are the leaders who bridge healthcare and education, provide care coordination, advocate for quality student-centered care, and collaborate to design systems that allow individuals and communities to develop their full potential."

Role of the 21st Century School Nurse

Background

The practice of school nursing began in the United States on Oct. 1, 1992, when Lina Rogers, the first school nurse, was hired to reduce absenteeism by intervening with students and families regarding healthcare needs related to communicable diseases. After one month of successful nursing interventions in the New York City schools, Rogers led the implementation of evidence-based nursing care across the city. Since that time, school nurses continue to provide communicable disease management, but their roles have expanded and are increasingly diverse.

A student's ability to learn is directly related to their health. Youth with unmet health needs have a difficult time engaging in the educational process. School nurses support student success by providing healthcare through assessment, intervention and follow-up for all youth within the school setting. School nurses address the physical, mental, emotional and social health needs of students and support their achievement in the learning process.

Students who are medically fragile or who deal with chronic health issues are coming to school in increasing numbers and with increasingly complex medical problems that require complicated treatments commonly provided by the school nurse.

Chronic conditions such as asthma, anaphylaxis, type 1 and type 2 diabetes, epilepsy, obesity and mental health concerns may affect the student's ability to be in school and readiness to learn.

The National Survey of Children With Special Healthcare Needs has determined that 11.2 million U.S. youth are at risk for chronic physical, developmental, behavioral or emotional conditions. These students may require health-related services in schools.

School nurses address the social determinants of health, such as income, housing, transportation, employment, access to health insurance and environmental health. Social determinants are identified to be the leading cause of health concerns. Youth from lower-income families have a more difficult time accessing medical treatment for chronic diseases.

Rationale

School nursing is a specialized practice of nursing that advances the well-being, academic success, and lifelong achievement and health of students. Keeping youth healthy, safe, in school and ready to learn should be a top priority for both healthcare and educational systems. With approximately 55.9 million students in public and private elementary and secondary schools, educational institutions are excellent locations to promote health in youth (National Center for Education Statistics, n.d.), and school nurses are uniquely positioned to meet student health needs.

Leadership

School nurses lead in the development of policies, programs and procedures for the provision of school health services at an individual or district level (NASN, 2016a), relying on student-centered, evidence-based practice and performance data to inform care (Robert Wood Johnson Foundation, 2009). Integrating ethical provisions into all areas of practice, school nurses lead in the delivery of care that preserves and protects student and family autonomy, dignity, privacy and other rights sensitive to diversity in the school setting.

As an advocate for the individual student, school nurses provide skills and education that encourage self-empowerment, problem solving, effective communication and collaboration with others. Promoting the concept of self-management is an important aspect of the school nurse role and enables the student to manage their condition and to make life decisions. School nurses advocate for safety by participating in the development of school safety plans to address bullying, school violence and the full range of emergency incidents that may occur at school.

At the policy development and implementation level, school nurses provide system-level leadership and act as change agents, promoting education and healthcare reform. According to the American Nurses Association (ANA) (2015b), registered nurses believe it is their obligation to help improve issues related to healthcare, consumer care, health and wellness. Educational preparation for school nurses should be at the baccalaureate level, and school nurses should continue to pursue professional development and continuing nursing education throughout their careers.

Community Public Health

School nursing is grounded in community/public health. The goal of community/public health moves beyond the individual to focus on community health promotion and disease prevention and is one of the primary roles of the school nurse. School nurses employ cultural competency in delivering effective care in culturally diverse communities.

The school nurse employs primary prevention by providing health education that promotes physical and mental health and informs healthcare decisions, prevents disease and enhances school performance. Addressing such topics as healthy lifestyles, risk-reducing behaviors, developmental needs, activities of daily living and preventive self-care outcomes, school nurses use teaching methods that are appropriate to the student's developmental level, learning needs, readiness and ability to learn. Screenings, referrals and follow-up are secondary prevention strategies that school nurses utilize to detect and treat health-related issues in their early stage (NASN, 2016a). School nurses provide tertiary prevention by addressing diagnosed health conditions and concerns.

Student absences due to infectious disease cause the loss of millions of school days each year. Based on standards of practice and community health perspective, the school nurse provides a safe and healthy school environment through control of infectious disease, which includes promotion of vaccines, utilization of school-wide infection control measures, and disease surveillance and reporting. Immunization compliance is much greater in schools with school nurses.

School nurses strive to promote health equity, assisting students and families in connecting with healthcare services, financial resources, shelter, food and health promotion. This role encompasses responsibility for all students within the school community, and school nurses are often the only healthcare professional aware of all the services and agencies involved in a student's care.

Care Coordination

School nurses are members of two divergent communities (educational and medical/nursing), and as such are able to communicate fluently and actively collaborate with practitioners from both fields. As a case manager, school nurses coordinate student healthcare between the medical home, family and school. School nurses are an essential member of interdisciplinary teams, bringing the health expertise necessary to develop a student's individualized education plan (IEP) or Section 504 plan designed to reduce health-related barriers to learning. Creating, updating and implementing individualized healthcare plans (IHPs) are fundamental to the school nurse role.

School nurses deliver quality healthcare and nursing intervention for actual and potential health problems. They provide for the direct care needs of the student, including medication administration and routine treatments and procedures. Education of school staff by school nurses is imperative to the successful management of a youth with a chronic condition or special healthcare need and is codified as a role of the school nurse in the Every Student Succeeds Act (2015).

Current school health practice models and school nurse workloads may require school nurses to delegate healthcare tasks to unlicensed assistive personnel (UAP) in order to support the health and safety needs of students. However, the availability of school nurses to work directly with students to assess symptoms and provide treatment increases students' time in the classroom and time at work for the parent(s)/guardian(s).

Quality Improvement

Quality improvement is a continuous and systematic process that leads to measurable improvements and outcomes and is integral to healthcare reform and standards of practice. Continuous quality improvement is the nursing process in action: assessment, identification of the issue, development of a plan of action, implementation of the plan and evaluation of the outcome. Data collection through this process is a necessary role of the school nurse.

Formal school nursing research is needed to ensure that delivery of care to students and school communities by school nurses is based on current evidence. School nurses utilize research data as they advocate and illustrate the impact of their role on meaningful health and academic outcomes.

Conclusion

It is the position of NASN that school nurses play an essential role in keeping children healthy, safe and ready to learn. School nurses are members of a unique discipline of professional nursing and are often the sole healthcare provider in an academic setting. 21st Century school nursing practice is student-centered, occurring within the context of the student's family and school community. It is essential that all students have access to a full-time school nurse all day, every day.

Printed with permission from NASN (2016). The Role of the 21st Century School Nurse. Silver Spring, MD, nasn.org/nasn-resources/framework.

The Case for School Nurses

According to the Centers for Disease Control and Prevention (CDC) (2017):

- For every dollar invested in a school nursing program, society gains an estimated $2.20.
- School nurses often lead the development and evaluation of school health policies and provide healthcare services for students who qualify under Section 504 of the Rehabilitation Act of 1973 to meet requirements of federal laws.
- School nurses assist students in learning to manage their chronic health conditions, increasing time in the classroom and decreasing absenteeism—with cost savings to the school district and increases in students' academic success.
- Smaller nurse-to-student ratios are associated with lower absenteeism rates and higher graduation rates.

Managing Chronic Health Conditions in Schools: The Role of the School Nurse. (2017). Retrieved Feb. 13, 2019, cdc.gov/healthyschools/chronic_conditions/pdfs/2017_02_15-FactSheet-RoleOfSchoolNurses_FINAL_508.pdf

Health services in schools are a key component of the Whole School, Whole Community, Whole Child Model. The healthcare needs of students with chronic health conditions may be complex and continuous. School nurses are often the only healthcare provider in schools for both emergencies and daily management of chronic health conditions. NASN and the American Academy of Pediatrics (AAP) recommend that school districts provide a full-time school nurse in every school building. A full-time school nurse and dependable funding are essential to achieve high-quality health services and to meet student health needs.

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Section 2:
National Association of School Nurses Code of Ethics

Preamble

Acknowledging the diversity of the laws and conditions under which school nurses practice, NASN believes in a commonality of moral and ethical conduct. As such, NASN adopts the American Nurses Association. The NASN Code of Ethics for Nurses With Interpretive Statements (2015), which establishes an ethical foundation for all nurses.

Furthermore, this foundation is supported by the School Nursing: Scope and Standards of Practice, 2nd Edition, and ethical guidelines provided by state boards of nursing. School nursing practice, built upon these ethical foundations, is grounded in NASN's core values of child well-being, diversity, excellence, innovation, integrity, leadership and scholarship. It is the responsibility of both the individual nurse and nursing organizations to function within these ethical provisions. For the purpose of this document, the term student also refers to families and school communities.

Organizational Ethics

NASN, a 501(c)(3) nonprofit organization established to support student health through the advancement of school nursing practice, has ethical responsibilities to its members and the communities those members serve (NASN, 2015). These organizational responsibilities include:

- Promotion of ethical work environments that support student and community health.
- Development of "...a research agenda that will lead to a culture of ethical practice in diverse settings that is evidence-based and measurable in terms of outcomes..." (Johns Hopkins School of Nursing and Johns Hopkins Berman Institute of Bioethics, 2014, p. 5).
- Development of relationships with organizations whose principles and actions are in harmony with NASN's mission and values and the termination of relationships with organizations whose known actions violate NASN's business and ethical principles.
- Support of the role of the school nurse through advocacy, integrity and participation in public policy development and social justice.

School Nurse Ethics

School nurses straddle two statutory and regulatory frameworks: health and education. Because school nurses practice nursing in an educationally focused system, they face unique legal, policy, funding and supervisory issues that may also have ethical dimensions. These issues may include:

- Unsafe school nurse-to-student ratios.
- Accountability for care delegated to UAP.
- School administrator request required to amend documentation.
- School administrator assignment of nursing tasks to UAP without the input of the school nurse.
- Parent(s)/guardian(s) request for medical treatment for their student, which is inconsistent with school nurse scope of practice (Brent, 2013).

As such, school nurses must have not only the skills to communicate within both the healthcare and education arenas, but also the requisite knowledge and skills to interpret applicable laws, regulations and professional standards, as well as apply ethical theories and principles (ANA and NASN, 2011).

Youth Well-Being

- School nurses support and promote student abilities to achieve the highest quality of life as understood by each individual and family.
- School nurses integrate and promote student abilities to achieve the highest quality of life.
- School nurses serve a unique role in transition planning to address student health needs within the school environment.
- School nurses maintain protection of, and confidentiality with, student health records according to the Health Insurance Portability and Accountability Act (HIPAA), Family Education Rights Protection Act (FERPA), other applicable federal laws, state laws and regulations, and professional standards of practice to safeguard privacy.
- School nurses utilize interventions designed to mitigate the effects of adverse childhood experiences and other social determinants of health.
- School nurses refer students to other health professionals and community health agencies as needed to promote health and well-being.

Diversity

- School nurses deliver care in a manner that promotes and preserves student autonomy, dignity and rights so that all are treated equally regardless of race, gender, or: socioeconomic status, culture, age, sexual orientation, gender identity, disability or religion.
- School nurses deliver care in an inclusive, collaborative manner that embraces diversity in the school community.
- School nurses actively promote student health, safety and self-worth.
- School nurses intervene to eliminate discrimination and bullying.

Excellence

- School nurses must have knowledge relevant to meet the needs of the student and maintain the highest level of competency by enhancing professional knowledge and skills and by collaborating with peers, other health professionals and community agencies.
- School nurses incorporate information from supervisory clinical evaluation to improve their nursing practice.
- School nurses evaluate their own nursing practice in relation to professional standards of practice and applicable laws, regulations and policies.

Innovation

- School nurses utilize available research in developing health programs, individual plans of care and interventions.
- School nurse workplace environments affect the quality of healthcare; therefore, school nurses collaborate to improve these environments.
- School nurses are aware of social determinants of health in the school community, provide healthcare to all students, support school staff, and partner with families and other community members to reduce health disparities.

Integrity

- School nurses maintain confidentiality within the legal, regulatory and ethical parameters of health and education.
- School nurses understand, follow and inform others about student health record protection according to HIPAA, FERPA, other applicable federal laws, and state laws and regulations.
- School nurses take a stand, follow and inform others about student health record protection according to HIPAA, FERPA, other applicable federal laws, and state laws and regulations.

Leadership

- School nurses are student advocates.
- School nurses support student rights in navigating the educational environment.
- Delegation or assignment of nursing tasks, including accountability for delegated tasks, may be the responsibility of the school nurse. School nurse assignments and delegations must be consistent with state nurse practice guidelines and established best practice.
- School nurses work within educational institutions to define and implement professional standards of practice and school health policy development.

Scholarship

- School nurses are lifelong learners in pursuit of knowledge, training and experiences that enhance the quality of their nursing practice.
- School nurses participate in and promote research activities as a means of advancing student health and school health services.
- School nurses conduct research as appropriate to the nurse's education, position and practice environment.
- School nurses adhere to the ethics that govern research, specifically:
  - Rights to privacy and confidentiality.
  - Voluntary and informed consent.

- Awareness of and participation in the mechanisms available to ensure the rights of human subjects, particularly vulnerable populations (e.g., minors, disabled).

Conclusion

In the course of day-to-day practice—and based upon the applicable state nurse practice act and professional scope and standards of practice—school nurses may find themselves in situations that present ethical dilemmas. School nurses and school nurse organizations have a responsibility to practice in accordance with the core values, NASN Code of Ethics and professional standards of practice. School nurse decision-making is guided by these principles that promote improved student health, academic success and excellence in school health services. NASN believes the practice of school nursing demands a vigilant focus on ethics.

School Staffing

Daily access to a registered professional school nurse can significantly improve students' health, safety and abilities to learn, according to NASN. To meet the health and safety needs of students, families and school communities, school nurse workloads should be determined at least annually, using student and community-specific health data.

School nurse-to-student ratios were first recommended in the 1970s, when laws were enacted to protect the rights for all students to attend public school, including those with significant health needs. Those laws included The Rehabilitation Act of 1973, Section 504 (2000) and Public Law 94-142, the Education for all Handicapped Children Act (1975), reauthorized in 2004 as the Individuals With Disabilities Education Improvement Act (IDEIA), (2004). Although evidence to support ratios was limited, some states and NASN recommended one school nurse to 750 students in the healthy student population; 1:225 for student populations requiring daily professional nursing services; 1:125 for student populations with complex healthcare needs; and 1:1 for individual students requiring daily, continuous professional nursing services (ANA and NASN, 2011). While a ratio of one school nurse to 750 students has been widely recommended—and was acknowledged in Healthy People 2020 (U.S. Department of Health and Human Services, 2014a) and by the AAP (2008)—a one-size-fits-all workload determination is inadequate to meet the increasingly complex health needs of students and school communities (AAP, 2008; ANA and NASN, 2011).

Appropriate school nurse staffing is related to better student attendance and academic success, according to multiple studies.

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Section 3: Unlicensed School Health Personnel

Generally, Children's Healthcare of Atlanta recommends the use of licensed registered nurses in providing direct healthcare services to children and teens in schools. UAP serve as valuable assistants to school nurses. When a school nurse is not present to administer care:

- School districts may want to consider developing a written accommodation plan that specifies responsibilities to best address student safety.
- The following documents should be followed:
  - Georgia Board of Nursing: Nurse Practice Act: sos.ga.gov/sites/default/files/forms/38%20Reference%20-%20Nurse%20Practice%20Act.pdf
  - Georgia Rules and Regulations: rules.sos.state.ga.us/gac/410
  - Professional Standards of Practice (Georgia Association of School Nurses, NASN, Georgia Nurses Association, etc.): rules.sos.ga.gov/gac/410-10
  - District policies, procedures and guidelines

Georgia Board of Nursing Position Statement on Assignment to Unlicensed Assistive Personnel

There has been a substantial increase in the use of UAP to provide direct patient care services in the changing healthcare industry. UAPs are found performing nursing activities in almost all healthcare settings. Because there is a potential that the improper utilization of unlicensed individuals may result in a risk to public safety, the Georgia Board of Nursing has promulgated rules regarding the criteria under which a registered nurse may assign certain tasks to UAP.

Other states have promulgated rules to define the parameters within which a licensed nurse may allow an unlicensed individual to provide direct care to patients. Some states chose to define task lists for UAP, often because the state directly regulates these care providers. However, by creating task lists for UAPs, an unofficial scope of practice is created. Also, there is no guarantee that a licensed healthcare professional is involved in the assessment of the patient to determine if the task can be safely provided by UAP. Therefore, the Georgia Board of Nursing has determined that development of lists of activities that may unequivocally be performed by unlicensed individuals does not result in the best protection for the public.

Many states have language in their Nurse Practice Act that specifically provides for "delegation" to unlicensed individuals.

O.C.G.A. §43-26-1, the Georgia Nurse Practice Act, does not provide for delegation of licensed activities to unlicensed individuals. Based upon well-established administrative case law, registered nurses or licensed practical nurses may not delegate activities that require professional nursing licensure to unlicensed individuals unless they have specific statutory authority to do so. If the care and activities under the specific circumstances do require the knowledge and skills of a registered nurse or licensed practical nurse, and if a registered nurse or licensed practical nurse permits an unlicensed individual to engage in these activities, it is inappropriate delegation of licensed activities. This inappropriate delegation has regulatory consequences. However, registered nurses may delegate professional nursing activities to other licensed individuals where there is statutory authority within their practice act to perform such acts (i.e., Licensed Practical Nurses who are under the "direction and supervision" of a Registered Professional Nurse).

The Georgia Board of Nursing has determined that certain tasks can be individually assigned to unlicensed individuals and has generated rules to this end. The rules have their statutory basis in O.C.G.A.§43-26-12(a)(3) and O.C.G.A. §43-26-12(a)(5). The exemptions for the requirement of licensure as a registered nurse are that:

(a) No provision in this article shall be construed to require licensure in Georgia as a registered professional nurse in:

(5) The performance of auxiliary services in the care of patients when such care and activities do not require the knowledge and skill required of a person practicing nursing as a registered professional nurse and when such care and activities are performed under orders or direction of a licensed physician, licensed dentist, licensed podiatrist or person licensed to practice nursing as a registered professional nurse.

Registered nurses have always utilized unlicensed individuals to assist in the provision of nursing care. O.C.G.A. §43-26-1 et seq. acknowledged that practice by incorporating certain exemptions from the requirement of professional nursing licensure within the Nurse Practice Act. O.C.G.A. §43-

26-12(5) provides an exemption to licensure for the performance of auxiliary services in the care of patients when such care and activities do not require the knowledge and skills required of a person practicing nursing as a registered professional nurse and when such care and activities are performed under orders or direction of a licensed physician, licensed dentist, licensed podiatrist or person licensed to practice nursing as a registered professional nurse. Therefore, if the care and activities meet all the above criteria for the exemption, it is an unlicensed activity and can be assigned.

The Georgia Board of Nursing has generated rules and a decision-making tool to assist registered nurses and nurse employers to make appropriate decisions regarding whether to assign a task to an unlicensed person. The tool, RN Assignment Decision Tree, will assist the registered nurse to evaluate patient care tasks on an individual patient basis. It guides the nurse to assign only those tasks that can be safely performed by trained UAP.

Resources

- Unlicensed Assistive Personnel: Their Role on the School Health Services Team: Position Statement. NASN School Nurse. 2016;31(5):299-301. doi:10.1177/1942602X16661192 https://files.eric.ed.gov/fulltext/ED558481.pdf
- RN Decision Tree for Assignment to Unlicensed Assistive Personnel: sos.ga.gov/sites/default/files/forms/38%20Reference%20-%20RN%20Decision%20Tree%20for%20Assignment%20to%20Unlicensed%20Assistive%20Personnel.pdf
- Georgia Board of Nursing Position Statement: Assignment to Unlicensed Assistive Personnel: sos.ga.gov/sites/default/files/forms/38%20Reference%20-%20Position%20Statement%20-%20Assignment%20to%20Unlicensed%20Assistive%20Personnel.pdf
- Nursing Delegation in the School Setting from NASN: nasn.org/nasn-resources/resources-by-topic/delegation

Section 4: Advocacy

Georgia data and current trends:

- From 2021 to 2022, there were more than 1.6 million total public school students in 2,305 Georgia schools across 159 counties:
  - Elementary school students: 44%
  - Middle school students: 24.5%
  - High school students: 31.5%
  - Of these students:
    - 56.2% were eligible for free/reduced lunch
    - 12.1% were served under Special Education
    - 8.9% have limited English proficiency
    - 55.3% were transported by school bus and 0.8% were enrolled in Georgia Virtual School
    - The gender number percentage was 51% male and female 49%
- Georgia ranks 38th in the nation in child and family well-being for the fourth consecutive year, according to the 2022 KIDS COUNT Data Book, released by the Annie E. Casey Foundation. According to the annual report, "For the first time in 33 years, focuses on youth mental health, concurring with the U.S. surgeon general's recent assessment that conditions amount to a 'youth mental health pandemic.'" The Data Book reveals that youth across the country are amid a mental health crisis, struggling with anxiety and depression at unprecedented levels. Additionally, in Georgia, 10.4% of youth ages 3 to 17 reported anxiety or depression in 2020, up from 8.5% in 2016.
- Overall, Georgia improved in all four economic measures, including child poverty and children whose parents lack secure employment. The state also improved in fourth grade reading proficiency and eighth grade math proficiency, as well as high school students who graduate on time.
- Georgia ranked 45th among states for health. Indicators where the state did worse include youths who are overweight or obese, deaths among children and teens, and low-birth-weight babies—which Rice said affects 10% of infants.
- Per the CDC, in the U.S., more than 40% of school-aged children and adolescents have at least one chronic health condition, such as asthma, diabetes, seizure disorders, food allergies or poor oral health. For these students, school nurses—who are often the only healthcare provider in a school—play a large role in the daily management of their conditions. School nurses or other school health services staff may also be the first to identify chronic health conditions in students through routine health exams.
- The benefits of school nurses reach beyond the school walls. School nurses not only make a big difference in student health and academic achievement, but they can also save money. Research shows that for every $1 spent on school nurses, society saves $2.20. These savings come from preventing costly emergency room visits and parents/guardians missing time at work to care for sick children.
- **According to NASN, a school nurse in the building saves:**
  - Principals almost an hour a day.
  - Teachers almost 20 minutes a day.
  - Clerical staff over 45 minutes a day.
- Both NASN and the AAP recommend that school districts provide a full-time school nurse in every school building.

cdc.gov/healthyschools/features/school_nurse.htm#:~:text=The%20benefits%20of%20school%20nurses%20reach%20beyond%20the%20school%20walls.&text=Research%20shows%20that%2C%20for%20every,school%20nursing%2C%20society%20saves%20%242.20.&text=These%20savings%20come%20from%20preventing,to%20care%20for%20sick%20children

nasn.org/nasn-resources/fact-sheets-infographics

These data points and trends are important to note because school nurses play pivotal roles in improving the health status of students and are integral in helping to advocate for students' health, support eliminating health disparities, and foster school health programs and services.

Advocacy and School Nurses

According to NASN, "Advocacy is the deliberate process of influencing those who make decisions." NASN's definition of school nursing includes and highlights the importance of advocacy. According to NASN, school

nursing is a specialized practice of nursing that protects and promotes student health, facilitates optimal development, and advances academic success. School nurses, grounded in ethical and evidence-based practice, are the leaders who bridge healthcare and education, provide care coordination, advocate for quality student-centered care, and collaborate to design systems that allow individuals and communities to develop their full potential.

Adopted by NASN Board of Directors, February 2017.

Why school nurses should be advocates?

School nurses are healthcare professionals in an educational setting and frequently practice as the only healthcare professional in the setting. The role of the school nurse is not always understood by teachers, administrators, parents/guardians, elected officials and the community at large. Only school nurses have the insight to educate stakeholders, so they know the role of the school nurse and the difference school nurses make in the lives of students. Stakeholders need to know why school nurses are important.

School nurses serve students and families and should proactively engage their school community.

School nurses are expected to advocate for policies and procedures that support student health, safety and school attendance. (journals.sagepub.com/doi/abs/10.1177/1059840518814294)

Advocacy can begin with telling your story. Start a log to document stories describing how you interceded to help a student at school. Anecdotes connect your efforts to improved student health and academic achievement.

Put your expertise on display. Some ways to share your stories and work include:

- Creating a newsletter or web page.
- Sending health and wellness email updates to school officials, administrators and parents/guardians.
- Offering to make a presentation on health issues at a PTA/PTO or board of education meeting.
- Allowing local leaders to see you as a valuable resource for students.
- Writing letters to the editor.
- Building relationships with stakeholders.
- Regularly attending PTA/PTO and board of education meetings.
- Attending local community events.
- Finding opportunities to meet with elected officials, including school board members, city councilors, mayors, and state and federal legislators.

When telling your stories, remember to ensure confidentiality and speak broadly about topics and issues. Use only data that is not identifiable. (nasn.org/nasn-resources/advocacy-tools)

School nurses are key members of the education team and leaders of school health who keep students healthy, safe and ready to learn.

Every Student Counts

For school nurses to be effective in advocacy, it is critical to include data in messaging, stories, presentations and other communication forums. NASN's National School Health Data Set: Every Student Counts! is designed to encourage robust national school health data that can be used for advocacy. The National Data Set is designed to:

- Influence local, state and national student health policy.
- Identify best practices in school health.
- Better understand child health.

This design will lead to policies that better support the needs of students, increase evidence-based school nursing practice and better youth health outcomes.

Data helps build bridges that connect school nursing to the rest of the healthcare system. This initiative provides the support and structure for the collection and use of data by every school nurse. Read the complete initiative vision document at higherlogicdownload.s3.amazonaws.com/NASN/8575d1b7-94ad-45ab-808e-d45019cc5c08/UploadedImages/PDFs/Research/ESC_Vision.pdf.

The purpose of the data set is for all school nurses to collect the same data in the same way across the U.S., and to influence local, state and national policies that:

- Support student needs.
- Increase evidence-based school nursing practice.
- Improve health outcomes.

The current data points are:

- Chronic health conditions (diagnosed)
- Allergies (life-threatening)
- Asthma
- Diabetes (type 1 and type 2)
- Seizures
- ME/CFS myalgic encephalomyelitis/chronic fatigue syndrome
- Chronic absenteeism
- School staffing (workforce capacity)
- RN, LPN, clinic aides, 1:1 nurses
- Disposition (count) health office visits

Georgia's Every Student Counts Task Force is an official task force that reports to the Georgia Association of School Nurses. The task force is led by Georgia's State Data Champion, who provides oversight for Georgia School Nurse's data collection. The Georgia State Data Champion works under the direction of NASN's Every Student Counts National Data Committee.

How school nurses can collect this data:

- First, you may already be collecting this information. Review your documentation and software capabilities.
- Report confirmed data so that you can be accurate in your data submission. Do not guesstimate.
- Preferably, it is ideal for each school district/system to collect the district-level data and report it pursuant to the instructions and reporting platform from Georgia's Every Student Counts Task Force.
- Every year, Georgia's Every Student Task Force will share and distribute the annual data survey once it is released from NASN.

How the data will be used:

- To protect the confidentiality of individual students, the data will not be identifiable by student name and will only be used in group (aggregate) form.
- To allow accurate reflection of the variety of models of school nursing practice across the nation, the results of this data collection will be reported as it relates to the school nurse service delivery models. Models of school nursing practice vary based on the size of the nurse's caseload, their full-time equivalent and the acuity of the students in that caseload. Collecting data in this way allows a comparison of the models of care versus individual nurse outcomes.
- The data will be used at state and national levels to demonstrate the value of school health services led by a professional school nurse.
- The data will be reported at state conferences and nationally so that you can see the results.

Content provided with permission from NASN.

Resources

- Quick Facts on Georgia Education 2021-2022 from the Georgia Department of Education: gadoe.org/External-Affairs-and-Policy/communications/Pages/Quick-Facts-on-Georgia-Education.aspx
- "Georgia Ranks 38th in the Nation for Child and Family Well-Being" from the Georgia Family Connection Partnership: gafcp.org/2022/08/08/georgia-ranks-38th-in-the-nation-for-child-and-family-well-being-4/
- Children's Health from the Georgia Department of Public Health: dph.georgia.gov/childrens-health
- Advocacy tools from NASN: nasn.org/nasn-resources/advocacy-tools
- "School Nurse Advocacy for Student Health, Safety, and School Attendance: Impact of an Educational Activity" from the Journal of School Nursing: journals.sagepub.com/doi/abs/10.1177/1059840518814294

- Fact Sheets, Education Briefs and Infographics from NASN: nasn.org/nasn-resources/fact-sheets-infographics
- National School Health Data Set: Every Student Counts from NASN: nasn.org/research/everystudentcounts
- "School Nurses Help Keep Students Healthy" from the CDC: cdc.gov/healthyschools/features/school_nurse.htm

Section 5:
School Health Clinic Management

This information is provided to assist with areas of concern that confront school health personnel in the daily operation of the school health clinic. If a question or situation arises that is not addressed by general guidelines, local policies or procedures, or evidence-based best practice, remember that the school principal has the ultimate responsibility for the health and well-being of staff, students and visitors during school hours and school-sponsored activities. Nurses and other school health personnel should work within the guidelines established by school board policy and procedures and local school procedures and in partnership with the principal.

The Georgia School Health Resource Manual serves as a resource for the development of district and school policies, procedures and guidelines and for up-to-date best practice guidelines. The forms and letters (with the exception of state-mandated forms) are provided as a resource and may be downloaded and customized to reflect the procedures and practices of local schools and school districts.

Duties and Responsibilities of the School Nurse

Below is a list of areas to consider when developing school nurse job descriptions and daily duties/responsibilities. This list is not exhaustive, and individual schools and school districts may not support all the listed duties/responsibilities. School nurses should be familiar with their district's job description and job expectations.

- Maintain confidentiality of student information at all times in compliance with school requirements, FERPA and, if applicable, HIPAA requirements. Be mindful of confidentiality when providing care in the clinic, during telephone conversations and when handling student health records.
- Provide appropriate direct health services and demonstrate care and concern for students.
- Notify principal and parent(s)/guardian(s) of recommendations for further evaluation or treatment. Contact parent(s)/guardian(s) regarding student health issues as appropriate.
- Report communicable disease concerns to the school principal and to the public health department as required or deemed necessary. Collaborate with the local public health department to implement recommendations. Assist with immunization compliance as requested.
- Maintain a current list of students with chronic health conditions/concerns and develop IHPs and emergency plans as needed.
- Communicate pertinent student health information/concerns in a timely and confidential manner to appropriate school personnel (principal/designee) and/or other necessary school staff in compliance with confidentiality requirements.
- Maintain documentation of clinic records accurately and completely.
- Develop effective working relationships with school personnel and parents/guardians.
- Administer student medications in accordance with school system guidelines, the Georgia Nurse Practice Act (including rules and regulations of the Georgia Board of Nursing best practice) and utilizing professional nursing judgment.
- Provide special healthcare procedures to students, as prescribed by the healthcare provider.
- Coordinate mandated school screenings and ensure necessary follow-up care.
- Maintain an orderly health clinic. Maintain and restock supplies per school policy.
- Maintain current CPR and basic first aid certification as required by your district.
- Maintain current knowledge of school health practices, trends and procedures through relevant best practice professional development.
- Promote a healthy and safe environment within the school.
- Provide employee wellness education and services to school staff.
- Provide or assist with classroom health education as requested.
- Participate in school committees as appropriate, providing appropriate health information on individual students or for the general student population (i.e., Crisis Team, SST/IEP, Coordinated School Health Program, etc.). Provide accurate, appropriate and relevant health data to school/district administrators to inform policy, procedures and practices for school health.

Recommendations for School Clinic Procedures

School districts and local schools should develop standardized procedures for the daily activities of the school clinics. Procedures should utilize evidence-based best practices for school health. Resources for best practice standards, in addition to this resource manual, are listed below. Some recommended procedures include, but are not limited to, the following:

- Develop a clinic pass with basic information regarding the student's concern/complaint and ensure that staff sending youth to the clinic utilize this system of communication.
- School clinics should also develop and implement a documentation system (paper or electronic) to document the details of the visit. At minimum, the information should include the date and time of the visit, student's name, complaint, treatment or intervention, and the disposition. Documentation should also include any communication with the parent(s)/guardian(s).
- School clinic staff should listen carefully to the student's complaint and take a focused health history as appropriate to the youth's age and developmental level while ensuring confidentiality.
- Staff should check the clinic health information card and, if applicable, the IHP for each student to raise awareness of the youth's health history, such as allergies and other chronic medical conditions.
- School clinic staff should assess the student, take vital signs if indicated, and provide care following district and school procedures and best practice guidelines.
- It is important to follow procedures for contacting the parent(s)/guardian(s) and/or consulting with a school nurse supervisor or school administrator, as appropriate.
- School clinics should have a communication procedure, especially for medical emergencies, and a direct or dedicated telephone line in the clinic.
- School clinics should have established procedures for releasing a student from the clinic. These procedures should include procedures for returning to class, release to the parent(s)/guardian(s) or other authorized adult, or to emergency medical services (EMS) for transport.
- Procedures for the administration of medication should be developed in a manner that is designed to avoid medication errors.
- Schools should consider the need for a student health record. The health record can be utilized to record any pertinent information/observations, which can assist with continuity of care that may not be maintained by a daily clinic log.
- Schools should develop a plan for student health services when the school nurse or clinic personnel is unavailable.
- Schools should develop written procedures to include standard precautions and infection control procedures designed to prevent exposure to infectious diseases. All staff working with students should be trained to these procedures per Georgia state law.
- School clinic staff should consider the use of IHPs for students with chronic health conditions. The parent(s)/guardian(s), healthcare provider and school nurse should collaborate in the development of the plan for students. Schools should develop a procedure so that staff working with the student is familiar with the IHP and their role in the implementation of the plan.
- In collaboration with school administrators, school nurses should develop emergency medical plans and should be active participants in the development of school-wide safety plans.
- Clinic procedures should include guidelines with regard to laws, regulations, policies and procedures, and best practices (including those contained in this manual) on those procedures that should not be performed in the school clinic. These may include such activities as performing invasive procedures, transporting students, or administering medications or other substances without parental permission.

Recommended School Clinic Supply List

Permanent Equipment

- 2 beds with adjustable headrests
- Toilet facility
- 4 chairs
- Biohazard (sharps) container
- Clock with second hand
- Desk with chair
- Thermometer
- Thermometer covers (if needed)
- Bookcase or shelf
- Flashlight
- Bandage scissors
- Computer
- Bulletin board
- Tweezers
- Locked medication cabinets
- Gooseneck lamp (for head checks)
- File cabinet with lock
- Weight scale and stadiometer (measures height)
- Telephone
- Small refrigerator
- Sink with hot and cold water
- Soap dispensers
- Privacy screen
- Vision testing equipment
- Covered trash can
- Pure tone audiometer
- Transport chair
- Sphygmomanometer with cuffs
- Disposable mouth barrier for CPR (recommendations for one per CPR provider in the school)

First Aid Supplies

- Non-latex, hypoallergenic tape (assorted sizes)
- Tongue depressors
- Adhesive bandages, assorted sizes
- Emesis basins
- Pint-sized bags for ice, frozen sponge
- Elastic bandages
- Non-sterile gauze (2-by-2 inches and 4-by-4 inches)
- Dental wax and floss
- Sterile gauze (2-by-2 inches and 4-by-4 inches)
- Non-stick gauze (4-by-4-inch squares, such as Telfa)
- Rolled non-sterile gauze
- Normal saline eyewash
- Cold packs (small and medium)
- Eye pads/dressing/shield
- Arm splints, slings
- Cotton-tipped applicators
- Portable first aid kit for field trips
- Cotton balls
- Disposable diapers (may be used for compression)

General Supplies

- Alcohol prep pads
- Blanket
- Facial tissues

- School-approved cleaning agents/supplies
- Paper towels with dispenser plastic bags
- Table paper for bed (disposable)
- Bed pillow, plastic cover
- 3-oz. paper cups
- Glucose gel
- Medicine cups
- Non-latex gloves (disposable)
- General office supplies
- Feminine hygiene pads
- Unscented hand lotion
- Vaseline for chapped lips
- Liquid soap in dispenser
- Cooler for ice (if no freezer)
- Pediculosis sticks (optional)
- Magnifying glass
- Donated/thrift store clothing for younger students (pre-K to second grade sizes) for changes due to "accidents," including socks and underwear
- Quart-sized bags
- Marker
- Bottled water

Setting Up the Health Clinic

- An organized workspace is critical to the success of a school clinic. Some clinics have multiple work stations, each with the supplies and resources needed for that task readily available (e.g., first aid, medication administration, phone, paperwork and referrals).
- Maintain student health information cards or files alphabetically or by grade. Health information cards should be easily accessible while ensuring confidentiality. Color-coded flags or dots can be used to designate the cards of those students with chronic health concerns. School nurses should consider creating a duplicate file for those students who have specific instructions, treatments, procedures and/or emergency plans along with a portable kit containing required medications, equipment and supplies that can be easily transported when the student leaves the school campus.
- A system should be developed for filing medication authorization forms. Some school nurses file the forms in a notebook with tabs for daily and PRN (updated weekly as needed). Forms can also be kept with the medication.
- A system for documentation of medication administration, paper or electronic, should also be maintained. Medication documentation should occur at the time that the medication is given. School nurses should adopt a system so that medications are kept in a locked and stationary cabinet with limited key access.
  - One system that is used frequently is to keep the medications and authorization forms for each student in a file folder with sides stapled or an accordion file. These folders should be labeled and alphabetized.
  - It can be helpful to separate medications by daily and PRN.
  - School nurses should consider keeping emergency medications, such as asthma inhalers and epinephrine auto-injectors, separately so that they can be quickly taken out in the event of an evacuation.
  - School nurses can also consider keeping emergency medications in an evacuation cart. Remember that some medications require storage in a refrigerator.
  - School nurses should ensure that there is a system in place to identify medication expiration dates in order to allow time for the parent(s)/guardian(s) to provide additional medication for their student.
  - See chapter 3 about medication administration for additional information.
- Suggestions for resources that can be posted in the school clinic include: communicable disease information chart, list of staff currently certified in CPR/first aid or First Responder/AED, emergency numbers (including poison control), CPR poster and handwashing reminders. Also consider

posting by the clinic phone the school's phone number, fax number and address; valuable time can be lost if these are not readily available during an emergency.

- Develop and post in a prominent place a folder for substitute clinic personnel containing essential information for the daily operation of the clinic.
  - It is important to identify someone within the school building, such as a front office clerk or other available personnel, who can assist a clinic substitute with information (e.g., the location of health information cards, the AEDs in the building, medications, and forms and IHPs).
  - Simple things, such as where to locate ice and first aid supplies, can often be overlooked.
- A bulletin board in the school health clinic or in the hall is an excellent tool for health education. Refer to chapter 9 about school-wide health promotion for information to post.
- In addition to a documentation system for clinic activity, school nurses can also keep a phone logbook for easy reference and/or a spiral notebook for notes written throughout the day.
- School clinics should consider a go (evacuation) bag, rolling cart or evacuation cart in the event of an emergency. The evacuation cart should contain first aid supplies, a blanket, a Stop-the-Bleed kit (if available), an AED and medications that may be required by students with chronic health conditions during an evacuation.

Questions for Parent(s)/Guardian(s) of a New Student

It is important to obtain as much health information as possible from the parent(s)/guardian(s) when a student enrolls in school. The following are suggested questions that can be asked in an interview with the parent(s)/guardian(s) at the time of registration of the new student or by telephone. This is also a time when school nurses can briefly explain the school health program in school, the role of the school nurse and how the clinic may be contacted.

- Will your student need to take any medications in school? If yes, provide required forms for medication administration in the school along with relevant policies and procedures. School nurses should make sure that the medications are required to be given during school hours in order to minimize time out of class.
- Does your student have any health concerns for school, such as asthma, allergies or any other health conditions? If yes, does your student have an IHP for school, such as a seizure action plan, allergy action plan, asthma action plan, diabetes management plan or sickle cell care plan?
  - If the student has a chronic health condition but does not have an IHP for school, school nurses should follow their school procedure for providing a form to the parent(s)/guardian(s) to complete or obtaining the necessary information in order to develop the plan. This is a good time for school nurses to determine the parent(s')/guardian(s') and student's level of understanding of the condition and initiate health education if needed.
- Does your student have any activity restrictions for PE or recess?
- Is there anything that causes your student to miss school frequently?
- Does your student have any vision or hearing problems? Corrected?
- Have you completed the emergency contact cards with all of the information I may need to reach you if necessary?
- Does your student have a healthcare provider for regular check-ups and illnesses? If not, do you need referral information (PeachCare, Medicaid, local practitioners)?
- Is your student current on immunizations?
  - If no, offer the parent(s)/guardian(s) information on required vaccines and resources for obtaining vaccinations if needed.
- Is there anything else about your student's health that you would like to share with me?

If possible, school nurses should find a time to introduce themselves to the student and show them the location of the school clinic.

Communicating With Families

Communication with families is an important component of school health services. Because of societal changes and work situations, parents/guardians may be difficult to contact. In some cases, school nurses will be communicating with grandparents, guardians, foster parents or social

workers. It is important for school nurses to know who is authorized to provide and receive information about the student.

Sending a letter or form home with information about clinic visits can assist with keeping the lines of communication open (see "Clinic Visit Report to Parent" at the end of this chapter). The school nurse should document and maintain a record of communication with the parent(s)/guardian(s). Helping the parent(s)/guardian(s) understand, during registration and interviews with families new to the school, that the nurse is there to be an advocate for their student can help the nurse obtain good contact information and pave the way for good communication.

The approach of pediatrician T. Berry Brazelton, MD, for working with parents/guardians promotes a positive attitude of "enlisting parents as partners in the healthcare process." School nurses can be a part of the supportive network for families who may be undergoing stresses of all types as their children grow. Dr. Brazelton's Touchpoints Project was developed as an interdisciplinary relational model to help healthcare providers create a supportive model of family interaction.

This relationship is built on mutual respect, care and acknowledgement of the care and concern the parent(s)/guardian(s) have for their student(s). The seven basic principles of the Touchpoints Project for healthcare providers are to:

1. Recognize what you bring to the interaction.
2. Look for opportunities to support mastery.
3. Use the behavior of the student as your language.
4. Value and understand the relationship between you and the student's parent(s)/guardian(s).
5. Be willing to discuss matters that go beyond your traditional role.
6. Focus on the parent-student relationship.
7. Value passion wherever you find it.

For more information, visit brazeltontouchpoints.org/about/brazelton-touchpoints

Section 6: Collaborating With All School Employees

School nurses have a responsibility for monitoring and maintaining a healthy school environment in which students can learn. To accomplish this goal, collaboration with other school employees is key.

- The principal is the leader of the school team. The principal should be made aware of any obstacles or problems that occur in the school health clinic, such as the following:
  - If a student is seriously ill or injured.
  - If emergency services need to be called.
  - If there is a concern with communication with a parent/guardian.
  - If there is a pattern of illness, infection, injury or infestation.
  - If there is suspected child abuse or neglect.
  - If there is a concern about the safety or health of the school environment.
  - Any time there is a situation with which the school nurse or clinic worker needs assistance.
- The school administrative staff can provide information on the students and families, class scheduling, building concerns, problems that may be occurring in other schools and community resources.
- Teachers can be your best observers. They will most likely be the first ones to notice students' physical symptoms, patterns of illness, health complaints and psychological changes. Special education teachers and paraprofessionals also have a wealth of knowledge and experience in dealing with students with special needs.
- The school social worker, guidance counselor, student support team leader and other allied health professionals (speech therapist, etc.) can be your best allies in gathering information about students and families and available resources. District-level personnel, such as audiologists and school psychologists, are also important contacts.
- The cafeteria staff can be helpful with snacks and ice for students, and observation of a student's eating patterns. The district-level nutrition director can also provide assistance to students with special nutrition needs.
- The custodial staff can help with infection control issues, clean-up of spills and building safety issues.
- The media center staff can help with researching a health issue and finding resources for health education.
- Interpreters are becoming more and more important as populations become more diverse.
- The technical support staff at your school or district can help with computer software needs and problems.
- School nurses may be asked to help with a staff member's health concern as well. You may be able to provide first aid, assist with referrals, help with health education curriculum and ideas for bulletin boards, etc.
- Children's Healthcare of Atlanta's Regional School Nurse Coordinator is available to offer continuing education and educational resources. The School Nurse Coordinator can be reached at 404-785-8927, or by visiting choa.org/medical-professionals/nursing-resources/school-health-resources.
- The Deputy Chief Nurse of School Health at the Georgia Department of Public Health can provide leadership, training and consultation as it relates to school nursing practice and public health to all health districts and school districts, including private and parochial schools, as well as nurses employed as school nurses. The Deputy Chief Nurse can be reached at 404-656-4456 or by visiting dph.georgia.gov/school-health.
- The Program Manager: School Nurse Support at the Georgia Department of Education provides leadership and technical assistance, as well as facilitating the development of student health services programs for local school districts. The School Nurse Specialist can be reached at 404-657-8023, or by visiting gadoe.org/wholechild/Pages/school-nurse-resources.aspx.
- Children's Healthcare of Atlanta also has a 24-hour nurse advice line (404-785-KIDS) for questions about healthcare, a specific illness or injury or referral information.

- The Georgia Association of School Nurses was organized in 1991 to unite the state's school nurses committed to providing quality healthcare services to students. The Georgia Association of School Nurses remains dedicated to promoting excellence in school health through its continued education programs and advocacy. Learn more at gasn.org.
- NASN has a board of directors composed of elected officers and one representative of each affiliate member organization who serves as a state director. Georgia's NASN state director can be found at nasn.org/about-nasn/leaders/directors.

Additional Resources

- The School Health Services Team: Supporting Student Outcomes from NASN: nasn.org/nasn-resources/professional-practice-documents/position-statements/ps-team
- IDEIA and Section 504 Teams: The School Nurse as an Essential Team Member from NASN: nasn.org/nasn-resources/professional-practice-documents/position-statements/ps-ideia

Section 7:
School Health Records

Confidentiality: FERPA and HIPAA

FERPA is a federal law that protects the privacy of student education records. The law applies to all schools that receive funds under an applicable program of the U.S. Department of Education. FERPA gives parent(s)/guardian(s) certain rights with respect to their student's education records. Although most elementary and secondary schools are not generally subject to HIPAA, there are exceptions. School nurses should follow all applicable confidentiality laws and regulations regarding educational records and protected health information.

View a complete copy of the law and additional information:
www2.ed.gov/policy/gen/guid/fpco/ferpa/index.html

Further Reading

- astho.org/advocacy/state-health-policy/legal-preparedness-series/public-health-and-schools-toolkit/
- nasn.org/nasn-resources/resources-by-topic/school-health-documentation/hipaa-ferpa

School Nurse Role in Electronic School Health Records

In 2011, 74 percent of school nurses reported using electronic health records (NASN, 2011). Therefore, it is important for school districts to have policies and procedures in place regarding the types, maintenance, protection, access, retention, destruction and confidentiality of student health records. Information technology professionals with school districts may require expert assistance in addressing the requirements for health documentation standards; thus, school nurses should participate in the selection of documentation systems as well as the development of appropriate policies and procedures.

Further Reading

- nasn.org/nasn-resources/professional-practice-documents/position-statements/ps-electronic-health-records

Documentation

Parents/guardians should complete a health or clinic card for every student at the beginning of the school year or upon registration, which includes:

- All emergency contact information (including cell phone numbers)
- Pertinent health history
- Primary care provider/insurance information
- All medications taken
- Allergies
- Persons to whom student may be released
- Signed permission to release medical information or contact the primary care provider

Ideally, this form (or a copy or computer version) should be available in the school clinic, with each student name filed alphabetically by grade. It should be updated annually (consider the beginning of each school year), especially for emergency contact and health history information.

- Some schools put space on the back of the form to record specific student health information as it occurs, such as clinic visits, immunizations given and screening reports.
- Some schools have incorporated this information into a health folder, which can then be filed and used to hold other pertinent health information for this student.

The student's complete school health record includes all the following (those marked with * are required for all students, and the rest are required inclusions as needed):

- Immunization certificate (form 3231) and supporting documents, including Georgia Registry of Immunization Transactions and Services records*
- Vision, hearing, dental and nutrition screening (form 3300)*
- Medication authorization forms
- Correspondence from physicians and the parent(s)/guardian(s)
- Treatment authorization forms
- Results from school screenings, referral letters sent
- Clinic visit reports, nurse's notes

- Student accident forms
- Any other documentation related to the student's health in school

Some schools may choose to keep all information in one record in the office, but keeping health information filed separately in the health clinic is better for logistics and confidentiality.

- Wherever this information is kept, it must be locked and accessible only to authorized persons to maintain confidentiality.
- Orders for medications and treatments should be written and signed per local district policy. Acceptance of verbal or faxed orders should be addressed in school policy.
- Two people should always listen to a telephone verbal order from a healthcare provider, and both should sign the order.
- Verbal orders, if taken, should always be followed by an order in writing within a specified time period, usually 48 to 72 hours.
- Personal health information that is faxed should come in and be sent out with a cover sheet, clearly marking the information as confidential.

Standards of documentation for the school health record are similar to any other nursing documentation.

- All written materials should be accurate, objective, concise, complete, timely and well-organized.
- Entries should be legible, in ink, with each entry timed and dated. Subjective student data should be recorded in the student's own words.
- Assessment data should include significant findings, both positive and negative.
- Nursing actions should be documented completely; personal judgments and opinions should be omitted.
- An accepted method of error correction is one single line drawn through the entry, the word "error" and the nurse's signature written above it.
- Avoid late entries; however, if necessary, make the entry with the correct date and time and mark as "late entry."

Special Education Abbreviations Commonly Used in Schools

AB	Adaptive Behavior	LEA	Local Education Agency or Limited English Proficiency
ADA	Americans with Disabilities Act	LRE	Least Restrictive Environment
ADD	Attention Deficit Disorder	MilD	Mild Intellectual Disability
ADHD	Attention Deficit Hyperactivity Disorder	MoID	Moderate Intellectual Disability
APE	Adaptive Physical Education	OCR	Office for Civil Rights
BD	Behavior Disorder	OHI	Other Health Impaired
CST	Child Study Team	OSEP	Office of Special Education Programs
DFCS	Department of Family and Child Services	Para	Paraprofessional
DHHS	Department of Health and Human Services	PD	Physical Disability
DHR	Department of Human Resources	PI	Physically Impaired
DOE	Department of Education	PID	Profound Intellectual Disability
EBD	Emotional Behavior Disorders	RS	Rehabilitation Services
EIP	Early Intervention Program	SDD	Significantly Developmentally Delayed
ESY	Extended School Year	SEA	State Education Agency
FAPE	Free and Appropriate Public Education	SED	Serious Emotional Disturbances
FERPA	Family Educational Rights and Privacy Act of 1974	SI	Speech Impaired or Sensory Integration
HI	Hearing Impaired	SID	Significantly or Severe Intellectual Disability
HIPAA	Health Insurance Portability and Accountability Act	SLD	Specific Learning Disabilities
HB	Home Bound	SST	Student Study Team
IDEA	Individuals with Disabilities Education Act	TBI	Traumatic Brain Injury
IEP	Individualized Education Plan	VI	Visual Impaired
IHP	Individualized Health Plan	504	A Civil Rights Law
LD	Learning Disabilities		

Additional Acronym Resources

- Disability and special education acronyms from the Center of Parent Information and Resources: parentcenterhub.org/repository/acronyms/
- Commonly used acronyms and abbreviations within Georgia's Behavioral Health and Development Disabilities System: dbhdd.georgia.gov/sites/dbhdd.georgia.gov/files/imported/DBHDD/Files/DBHDD%20Acronyms%20%26%20Abbreviations%20-%20Updated%20December%206%2C%202011.pdf

Section 8:
Required Health Certificates

Required health certificates for school include:

- Georgia Department of Public Health Form 3300 Certificate of Vision, Hearing, Dental and Nutrition Screening (O.C.G.A. 20-2-770 Rules and Regulations for Nutritional Screening and Eye, Ear and Dental Examinations of Students)
- Georgia Department of Public Health Form 3231 Certificate of Immunization or Georgia Department of Public Health Form 2208 Affidavit of Religious Exemption (if applicable)
- Form 4400: Scoliosis Screening Form

For the most current versions of these health certificates and additional information regarding immunization requirements from the Georgia Department of Public Health, visit dph.georgia.gov/schools-and-childcare.

Resources

- Information regarding immunizations including vaccine requirements, vaccination schedules, sample forms and audit information from the Georgia Department of Public Health: dph.georgia.gov/schools-and-childcare
- Information regarding Vision, Hearing, Dental and Nutrition Screening: gadoe.org/wholechild/Documents/SchoolNurse/Form-3300-School-Health-Leaders.pdf
- Information on required health records to attend school in Georgia: georgia.gov/get-required-health-records-attend-school

Section 9:
Healthy School Environment

Indoor Air Quality

Exposure to air pollution is a health concern for everyone, especially those with asthma and other chronic respiratory conditions. In the school setting, outdoor air pollution and high levels of ozone are problematic when P.E., sports activities, field days and field trips are held outside. Indoor air quality can be even more of a concern with construction of tightly sealed buildings; reduced ventilation rates to save energy; use of synthetic materials in construction, furnishings and carpets; and chemicals in consumer products.

Some of the consequences of poor air quality in schools are:

- Increased long- and short-term health problems for students and staff.
- Spread of airborne infectious diseases.
- Degraded student learning environment, affecting comfort and attendance.
- Reduced productivity of teachers and staff due to discomfort, sickness and absenteeism.
- Deterioration of the school building and equipment.

Maintaining a healthy school environment involves creating a safe work and study area and a healthy atmosphere that is physically, emotionally and psychologically supportive. Optimum indoor air quality, elimination of safety hazards and adequate lighting are important factors to be considered in achieving this goal.

In a 2002 position paper, NASN stated that the school nurse is in a unique position to work with administration, maintenance personnel and other health professionals in detecting, monitoring and eliminating sources of indoor air contaminants, as well as proactively educating students, staff and parents/guardians on indoor air quality issues.

The Environmental Protection Agency developed the Indoor Air Quality (IAQ) Tools for Schools Action Kit, which guides school staff in how to improve the air quality environment in the school. This kit is recommended by the National Safety Council, the American Lung Association, the National Education Association and the National Parent Teacher Association.

Checklists included in the kit allow staff to pinpoint areas of concern and potential solutions.

Through simple, low-cost measures, schools can:

- Reduce IAQ-related health risks and triggers for asthma.
- Identify sources of mold.
- Improve comfort and performance levels.
- Avoid costly repairs.
- Avoid negative publicity and loss of parent/guardian and community trust.
- Avoid liability problems.

Resources

- Coalition for Healthier Schools from the Healthy Schools Network: healthyschools.org/Coalition/
- Environmental Health Position Statement from NASN: nasn.org/nasn-resources/professional-practice-documents/position-statements/ps-environmental-health
- Indoor Air Quality Tools for Schools Action Kit from the Environmental Protection Agency: epa.gov/iaq-schools
- Indoor Air Quality from the Environmental Protection Agency: epa.gov/indoor-air-quality-iaq
- Healthy Schools Network: healthyschools.org/

School Health Index

The CDC Adolescent and School Health section developed the School Health Index, a self-assessment and planning tool for elementary and secondary schools that enables schools to:

- Identify the strengths and weaknesses of their health, physical activity and nutrition policies and programs.
- Develop an action plan for improving student health.
- Involve teachers, parents/guardians, students and the community in improving school health services.

The School Health Index currently addresses five health topic areas:

- Physical activity
- Healthy eating
- Tobacco-use prevention
- Unintentional injury and violence prevention (safety)
- Asthma

The School Health Index also includes cross-cutting questions, which address policies and practices that apply to all five health topic areas.

"The School Health Index is available at no cost and can be completed in approximately five hours. Many of the improvements that a school may want to make after completing the index can be done with existing staff and resources. A small investment of time can pay big dividends in improving students' well-being, readiness to learn and prospects for a healthy life."

For more information about the School Health Index, visit cdc.gov/healthyschools/shi/index.htm.

Resources

Division of Adolescent and School Health from the CDC: cdc.gov/HealthyYouth/index.htm

Section 10:
Child Abuse Prevention, Recognition and Reporting

Child abuse and neglect is a serious and costly public health issue that affects youth victims, their families, and society as a whole. According to the latest Annie E. Casey Foundation KIDS COUNT assessment, Georgia ranked 38th in the nation for child well-being. There are 163,000 reports made to Georgia Division of Family and Children Services each year. Educators and school personnel can help in prevention efforts.

Education and Assistance for Students and Families

- Provide training on life skills, such as communication, problem-solving, coping, personal safety and parenting.
- Use teaching styles that promote assertiveness, decision-making skills, positive peer relations and self-esteem.
- Make sure students know where they can go to get help or talk to a trusted adult.
- Offer after-school care or programs for youth of working parents/guardians or parents/guardians who need respite from childcare responsibilities.
- Make parents/guardians aware of child protection policies and procedures in place to protect youth, encourage them to ask questions and to find out if other organizations with which their students are involved have similar policies.
- Encourage parents/guardians to know where their students are at all times, to minimize one-adult/one-youth activities (especially if not visible to others or easily interruptible), and to be vigilant about leaving youth only with trusted caregivers.
- Counsel parents/guardians and students about child sexual abuse and exploitation prevention, possible indicators of abuse/exploitation, and common grooming or recruitment techniques.
- Know what to do if abuse, neglect or exploitation is suspected (be aware of mandatory reporting laws, agencies to contact and community resources to seek).
- Invite parents/guardians to get involved in school activities where they can observe positive models for interactions with youth.
- Provide referrals to families facing domestic violence, drug and alcohol abuse, or unemployment, as well as those with food, housing, mental health or healthcare needs.
- Have clear and consistent codes of conduct.
- Send positive feedback to the parent(s)/guardian(s) about their students.
- Set realistic goals and celebrate small successes.

Training for School Staff and Organizational Change

- Require all staff and volunteers to participate in training on child abuse, exploitation and neglect, and encourage them to reach out to students at risk.
- Promote school as a safe place; have policies that prohibit corporal punishment on campus.
- Develop comprehensive child protection policies, such as those that reduce one-adult/one-youth interactions at school and make those interactions observable and interruptible.
- Assist the school with requiring the staff to read and sign off on code of conduct annually.
- Educate staff on the importance of all activities with students be observable and interruptible by others.
- Make school facilities available for parenting support meetings and workshops. Use school resources (e.g., newsletters, bulletin boards, newspapers) to broadcast prevention messages, such as positive parenting and appropriate discipline techniques.
- Form partnerships with law enforcement, social services and other community organizations that deal with child abuse.
- Support and participate in advocacy efforts at the community, state and federal levels for more funding for prevention programs.

Prevention Programs in Georgia

Prevention Programs in Georgia that Reduce Risk Factors and Strengthen Protective Factors			
Program Name	**Target Audience**	**Sponsoring Organization**	**Description**
Speak-Up, Be Safe (SUBS)	Youth in pre-K to 6th grade	School-based; created by Childhelp	Body safety and violence prevention education for youth
FindHelpGA	Anyone in Georgia (both professionals and parents/guardians)	Prevent Child Abuse Georgia	Provides information on a variety of resources available to parents/guardians statewide
First Steps	New parents	Varies depending on location	Support, information and referrals; phone-based after initial face-to-face visit
Healthy Families Georgia	New parents	University of Georgia Center for Family Research	Long-term voluntary home visitation for more vulnerable families of newborns
HELPLINE: 1-800-4CHILD	Parents/guardians, caregivers, anyone who works with youth	Childhelp USA National Child Abuse Hotline	Toll-free, confidential source of support, information and referrals
Stop It Now!	Adults	Georgia State University Center for Healthy Development	Public health campaign on adult responsibility for preventing child sexual abuse
Stewards of Children	Adults; staff of youth- serving organizations	Darkness to Light and Georgia Center for Child Advocacy	Training program on adult responsibility for preventing child sexual abuse
Educational brochures, classes and reporting info	Parents/guardians, caregivers, anyone who works with youth	Children Without a Voice USA	Free information for adults interacting with children to learn about prevention
Period of PURPLE Crying	Parents of infants	Children's Healthcare of Atlanta and the National Center on Shaken Baby Syndrome	Training for parents and adults on Shaken Baby Syndrome, and Shaken Baby Syndrome prevention
Multidisciplinary Webinar Program	Parents/guardians, caregivers, anyone who works with youth	Stephanie V. Blank Center for Safe and Healthy Children at Children's Healthcare of Atlanta	Training for professionals and volunteers on topics relating to child maltreatment and prevention
Strengthening Families Protective Factor Framework	Adults working and volunteering in child-serving agencies	Strengthening Families Georgia	Protective factors are "promotive" factors that build family strengths and a family environment that promotes optimal child and youth development

Chart above provided by the Stephanie V. Blank Center for Safe and Healthy Children at Children's Healthcare of Atlanta.

Protective Factors for Maltreatment

Everyone is exposed to risk at some point. Because risk cannot be entirely eliminated, it is important to build up protective factors, those strengths that can be built upon to increase a family's safety and well-being.

Parents/Guardians/Family	Service Provider	Community	Society
Develops close bonding with a youth	Expresses positive expectations	Leaders prioritize community health, safety and quality of life for families	Values youth contribution
Those who are nurturing and protective	Encourages pro-social development	Engage supportive neighbors	Values collaboration
Values and encourages education	Provides opportunities for leadership and participation	Develop neighborhood watch groups, mentoring groups	Laws that hold perpetrators accountable
Manages stress	Staff view themselves as caring people	Ensure safe neighborhoods free from violence	Emphasis on academics
Makes spending time with their youth a priority	Supports families when they recognize signs of stress or need	Provide supportive social and health networks	Family-friendly atmosphere
Seeks professional help when needed	Has family-friendly information available, which includes information on child development, bonding, parenting	Community organizations have written child protection policies in hiring and monitoring staff, as well as reporting abuse	
Has appropriate community resource referrals available			
Understands child development			

The chart above provided by the Stephanie V. Blank Center for Safe and Healthy Children at Children's Healthcare of Atlanta.

Strengthening Families Georgia: 5 Protective Factors Framework

Parental Resilience: Parents Work Through Challenges	Parents' capacity for resilience affects how they deal with stress. Resilience is the ability to better handle all types of challenges that emerge in a family's life. It means finding ways to solve problems, building and sustaining trusting relationships including with youth, and knowing how to seek help when necessary.
Social Connections: Parents Have Friends	Friends, family members, neighbors and community members provide emotional support, help solve problems, offer parenting advice and give concrete assistance to parents. Networks of support are essential to parents and offer opportunities for people to "give back" as a way to build self-esteem as well as benefit the community. Isolated families may need extra help in reaching out to build positive relationships.
Knowledge of Parenting and Child Development: Parents Know How Youth Grow and Learn	Accurate information about child development and appropriate expectations for youth's behavior at every age help parents see their children and youth in a positive light and promote their healthy development. Information is most effective when it comes at the precise time parents need it to understand their own youth. Parents who experienced harsh discipline or other negative childhood experiences may need extra help to change the parenting patterns they learned growing up.
Concrete Support in Times of Need: Parents Know Where to Turn for Help	Meeting basic economic needs, like food, shelter, clothing and healthcare, is essential for families to thrive. Likewise, when families encounter a crisis, such as domestic violence, mental illness or substance abuse, adequate services and supports need to be in place to provide stability, treatment and help for family members to get through the crisis.
Social and Emotional Competence of Children: Youth Learn to Talk About and Handle Feelings	A child or youth's ability to interact positively with others, self-regulate their behavior and effectively communicate their feelings has a positive impact on their relationships with their family, other adults and peers. Challenging behaviors or delayed development create extra stress for families, so early identification and assistance for both parents and children can head off negative results and keep development on track.

Chart above adapted from the Strengthening Families Georgia Protective Factors Framework.
https://abuse.publichealth.gsu.edu/strengthening-families-georgia/

Recognition of Child Abuse

Types of Abuse

- Emotional abuse is a repeated pattern of caregiver behavior or extreme incident(s) that harm a youth's self-worth or emotional well-being or convey to youth that they are worthless, flawed, unloved, unwanted, endangered or only of value in meeting another's needs.
- Neglect is (A) The failure to provide proper parental care or control, subsistence, education as required by law, or other care or control necessary for a youth's physical, mental or emotional health or morals; (B) The failure to provide a youth with adequate supervision necessary for such youth's well-being; or (C) The abandonment of a youth by his or her parent, guardian or legal custodian. OCGA 19-7-5.
- Munchausen by Proxy Syndrome is a form of child abuse in which a parent or guardian presents a youth for medical or behavioral health attention with symptoms that may have been fabricated and/or directly created by the parent, guardian or caretaker, and that subjects the youth to unnecessary or potentially harmful medications or medical procedures. The parent, guardian or caretaker (typically a mother) may display considerable medical knowledge and may have worked in a healthcare setting.
- Child endangerment is defined as one of the following: youth is living in a home where methamphetamine is being produced; youth is living in a home where domestic violence is occurring; youth under the age of 14 is riding in the car with someone who is under the influence; or there is evidence of prenatal substance abuse (presence of substances in meconium or youth is experiencing withdrawals).
- Physical abuse is non-accidental physical injury or death inflicted upon a youth by a parent or a caretaker. In Georgia, physical forms of discipline (such as spanking) may be used by a parent as long as there is no physical injury to the youth (typically determined as marks lasting longer than 24 hours).
- Sexual abuse is when an adult, or older or larger child, employs, uses, persuades, induces, entices or coerces any minor to engage in any sexual act. Sexual abuse includes contact and non-contact acts, such as exhibitionism, voyeurism, and pornography exposure or involvement.
- Sexual exploitation (often referred to as "commercial sexual exploitation" or CSEC) involves engaging a youth younger than 18 years of age in a commercial sex act of any kind (sexual act performed in exchange for something of perceived value).
- The exchange could involve money, clothing, shelter, drugs, electronics, other consumer goods or other items of value. It may involve prostitution (with or without a third party controlling the situation), production of child sexual abuse images (pornography) or engaging a youth in work at a sex-related venue (e.g., strip club).

Indicators of Abuse and Neglect

The information below provides some potential indicators of different types of maltreatment. This list is by no means exhaustive, nor are the indicators listed for each type of abuse mutually exclusive. Students experiencing abuse may show signs from more than one category. However, if you see a student, parent/guardian or caregiver exhibiting the signs/symptoms listed below, it is worth considering the possibility of maltreatment. If you have a reasonable suspicion that a student is being abused, sexually exploited or neglected, Mandated Reporting statute 19-7-5 requires that you report that suspicion to the designated reporter in your organization or directly to the Division of Family and Children's Services. Failure to report abuse or neglect is a crime. See the next section on reporting child maltreatment for more information.

Free training opportunities to learn more on how to recognize and respond to various types of child abuse are available at choa.org/cptraining.

Potential Signs of Physical Abuse

- Unexplained burns, bites, bruises, broken bones or black eyes.
- Injuries in ordinarily protected locations, such as the torso, upper arms, neck, inner thighs and genitalia.
- Fading bruises or other marks in ordinarily protected locations noticeable after an absence from school.
- Youth seems frightened of their parent(s)/guardian(s) or caregivers and protests or cries when it is time to go home.

- Youth shrinks at the approach of adults.
- Youth reports injury by their parent(s)/guardian(s) or another adult caregiver.

Consider the possibility of physical abuse when a parent/guardian or other adult caretaker:

- Offers conflicting, unconvincing or no explanation for the youth's injury.
- Offers an explanation for the injury that is inconsistent with the developmental capabilities of the youth.
- Describes the youth as "evil," or in some other very negative way.
- Uses harsh physical discipline with the youth.

Potential Signs of Neglect

Note that many of these do not rise to the level of neglect unless it is happening on a consistent basis. For example, a student consistently comes to school hungry or inappropriately dressed.

- Frequently absent from school.
- Dresses inappropriately for school, such as inadequate clothing to protect from the cold in winter.
- Begs or steals food or money.
- Hordes food for themselves or their siblings.
- Lacks needed medical or dental care, immunizations or glasses.
- Consistently dirty or unhygienic and has severe body odor.
- Consistent bad breath due to unbrushed or rotting teeth.
- Abuses alcohol or other drugs.
- States that there is no one at home to provide care.
- States that their father (or stepfather/mom's boyfriend) hits (or beats/screams at/abuses) their mother. Keep in mind that domestic violence can also occur in same-sex couples, and females can be abusive toward males.

Consider the possibility of neglect when a parent/guardian or other adult caretaker:

- Appears to be indifferent to the youth's well-being.
- Seems apathetic or depressed.
- Behaves irrationally or in a bizarre manner.
- Abuses alcohol or other drugs.
- Shows signs that they are the victim or perpetrator of domestic violence.

Potential Signs of Sexual Abuse/Exploitation

- Sudden changes in behavior or performance. For example, getting failing grades when the youth used to do well in school, or the youth begins to stay late after school to help out the teacher because they do not feel like going home yet.
- Regresses to behaviors they have previously outgrown. For example, urinating or defecating in their clothes, bed-wetting or thumb-sucking.
- Suddenly refuses to change for gym or to participate in physical activities.
- Reports nightmares or bed-wetting.
- Displays a sudden change in appetite.
- Unusual knowledge and/or interest in sex given the age of the youth.
- Has poor peer relationships.
- Makes frequent trips to school nurse/medical for stomach/headaches or other psychosomatic ailments.
- Complains of pain, itching, bleeding and/or discharge in private area.
- Becomes pregnant.
- Contracts a sexual transmitted infection/disease, particularly if pre-pubescent.
- Runs away from home, especially more than once.
- Is frequently truant from school.
- Appears scared or uncomfortable around one particular adult or older/larger youth.
- Discloses/reports sexual abuse by a parent/guardian or another adult caregiver, even another youth.

- Has money and/or new and expensive items of unclear source.
- Shows signs of depression, anxiety, mood swings, hypervigilance or dissociation.

Consider the possibility of sexual abuse when a parent/guardian or other adult or older/larger youth:

- Uses inappropriate language and topics around youth.
- Has a secretive relationship with youth.
- Spends so much time with a youth that they are isolated from others.
- Jealous or controlling of a youth.
- Does not respect a youth's personal boundaries.

Potential Signs of Emotional Abuse

- Shows extremes in behavior, such as overly compliant or demanding behavior, extreme passivity or aggression.
- Either inappropriately adult, such as parenting other youth, or inappropriately infantile, such as frequently rocking or head-banging.
- Delayed in physical or emotional development.
- Has attempted suicide.
- Exhibits lack of attachment to their parent.

Consider the possibility of emotional abuse when a parent/guardian or other adult caregiver:

- Constantly blames, belittles or berates the youth.
- Appears unconcerned about the youth and refuses to consider offers of help for the youth's problems.
- Overtly rejects the youth.

What to Do if a Child Discloses Abuse

- Remain calm. If you act overly upset or shaken, it may cause the youth to backtrack, or not share any more information.
- Make sure the youth knows that it is OK to talk with you about these things.
- Listen carefully and do not interrupt.
- Do not interrogate or interview the youth. If you must ask questions, make sure they are open-ended questions, such as, "What happened next?"
- Avoid leading questions about details. This can contaminate the youth's memory of the events or cause them to answer in a way that they think you want to hear.
- Minimize the number of questions you ask the youth. Ask only the questions you need in order to determine:
  - Do you have concerns of abuse/neglect/exploitation?
  - Will the youth be safe in the immediate future?
  - Will the youth be safe if they go home after school?
  - Does the youth need immediate medical attention?
- You do not need to be certain that abuse/neglect/exploitation has occurred before making your report. You just need to have a reasonable concern that this is a possibility.
- Reassure the youth that what happened is not their fault, such as, "When things like this happen to kids and teens, it is never their fault."
- Let the youth know you believe and support them.
- Thank the youth for telling you and praise the youth's courage for sharing with you.
- Assure the youth that you want to do everything you can to protect them, but do not make any promises to the youth.
- Be honest. If the youth asks you keep their disclosure a secret, let them know you have to make a report. You can say, "I cannot promise not to tell, because I need help to make sure that you are safe and no one is hurting you, because I care about you."
- Believe the youth. It is not the reporter's job to decide truthfulness. Believe the youth and report their disclosure. Let authorities make the decisions regarding truthfulness of the disclosure.

Reporting of Child Abuse and Neglect

Section § 19-7-5 of the Official Code of Georgia mandates that any staff or volunteers of any type of organization or business that provides youth with "care, treatment, education, training, supervision, coaching, counseling, recreational programs or shelter" make a report when they have reasonable cause to suspect that a youth has been abused. Mandated reporters can include volunteers, nurses, school teachers, school administrators, school guidance counselors, social workers, school psychologists, etc. Reporters do not have to be certain that maltreatment has occurred; only a reasonable suspicion is needed. All reports are kept confidential. The law provides immunity from criminal or civil liability for reporting abuse and/or neglect when the report is made in good faith. Knowingly and willingly failing to report child abuse, such as when a youth discloses abuse or abuse is witnessed, is a crime, and you can be found guilty of a misdemeanor. Note that the report to Division of Family and Children Services should be made as soon as possible but must be made within 24 hours of the disclosure/discovery of abuse.

If a student is in immediate danger, always dial 911. In all other cases, a report should be made as soon as possible to the Division of Family and Children Services. Some schools may designate a particular staff member to receive notifications of suspected abuse and to make a report to Division of Family and Children Services on behalf of the school. In this case, it is important to know that this delegate can in no way exercise any control, restraint, modification or any change whatsoever to the information provided by the reporter. Response time ranges from within 24 hours to five days, depending on the county, age of the youth, and the nature and severity of the allegation(s). Division of Family and Children Services is now required to provide notification to school employees of receipt of suspected abuse report within 24 hours. It must provide notice of completion of the investigation within five days to the school counselor to disclose whether or not the abuse was confirmed or unconfirmed. If the school does not have a school counselor, the principal is notified of the outcome.

When you suspect abuse:

- Act on your suspicions. Remember that it is OK to be wrong, but it is not OK to allow youth to continue to suffer abuse in silence.
  - You may discuss your concerns with another adult in your organization or with a child abuse-focused organization, maintaining confidentiality as appropriate. However, if you have reasonable suspicion that abuse or neglect has occurred, you must make a report to authorities within 24 hours—the sooner, the better.
- Call a helpline if you have questions or are unsure about your suspicions. Remember, calling a help line does not meet the requirements for mandated reporting of suspected abuse. Remember the rules of confidentiality.
  - Childhelp National Child Abuse Hotline: 800-4-A-CHILD (800-422-4453)
  - Prevent Child Abuse Georgia Helpline: 1-800-CHILDREN
- Determine the youth's immediate needs (e.g., safety, medical attention).
- Talk to the youth's non-offending parent/guardian, and do what you can to connect them to needed services—including a child advocacy center. You may wish to work with a counselor or a Division of Family and Children Services caseworker to help the student obtain these services.
  - To find a child advocacy center near you, contact Children's Advocacy Centers of Georgia at cacga.org or 770-319-6888.
- Report according to school policy and your legal requirement as a mandated reporter within 24 hours.
  - Follow up with any other school staff delegated to make the official report within 24 hours of the report being made. If it has not been made, make it yourself; remember, it is your responsibility.

How to Report Child Abuse and Neglect

- Call the statewide, 24-hour Mandated Reporting Line at 1-855-GA-CHILD. Note: This is the preferred option.
- Email the Division of Family and Children Services Reporting Form to cpsintake@dhs.ga.gov.

- Fax the Division of Family and Children Services Reporting Form to 229-317-9663. To access the Mandated Reporter form, visit https://www.gadoe.org/Curriculum-Instruction-and-Assessment/Curriculum-and-Instruction/Documents/MANDATED%20REPORTER%20INTAKE%20FORM%207%2010%2014.pdf.
  - If you email or fax a form, you will receive an autoreply stating that the report has been received. Include a phone number on the report where you can be reached. You will receive a return phone call within two hours to acknowledge your report and collect any additional information needed. This return phone call satisfies the legal requirement to speak with a Department of Human Services employee.
- Complete the digital form: dfcs.dhs.georgia.gov/child-abuse-neglect. A private code is needed to access the digital form. This code will only be given upon completion of the mandated reporter training: prosolutionstraining.com/hostedcourses/hostcode.cfm?hostid=18.

Supporting Children and Families

It is vital to support as well as report. The attitude of school personnel can make a difference in the progress a family makes once a report of abuse or neglect is made. For instance, a school nurse who is supportive and available to the family throughout the investigation, treatment and rehabilitation process not only protects the student, but also helps the family maintain dignity and move forward.

When a student who has experienced abuse returns to the classroom:

- Create a supportive and safe environment for the student.
- Make sure the student feels like they are valued and accepted as part of the classroom and school.
- Provide structure with consistent routines, clear instructions and predictable behavior.
- Be available to talk to the student about their concerns, but do not question them about events.
- Do not discuss the abuse with any other student in the school or any adults who are not involved in getting the student help.
- Build the student's self-worth and sense of identity with praise and friendly nonverbal communication. Tell the student what you like about them and what makes them special and unique.
- Collaborate and communicate with Department of Family and Children Services (DFCS), law enforcement, foster parents, non-offending caregivers and others involved in the student's life.
- Meet with your school or community child protection or crisis team to plan how best to protect and help the student.
- Work with others to coordinate any support services that the student may need.

Remember that traumatic stress may manifest in a variety of behaviors, including difficulties with attention, aggression, withdrawal, dissociation, mood swings and hyperactivity. These behaviors may serve the function of self-protection, may be a response to anxiety associated with emotional triggers in the environment, may express a need of the student to connect with a trusted person or may serve some other function. Try to understand the function behind the behavior and make efforts to encourage the student's sense of safety.

Resources

- Child Abuse and Neglect from the AAP: aap.org/en/patient-care/child-abuse-and-neglect
- Professional Society on the Abuse of Children: apsac.org
- Bright from the Start from the Georgia Department of Early Care and Learning: decal.ga.gov/
- Violence Prevention from the CDC: cdc.gov/ViolencePrevention/index.html
- Child Welfare Information Gateway: childwelfare.gov
- Children's Advocacy Centers of Georgia: cacga.org
- Children's Defense Fund/Parent Resource Network: childrensdefense.org
- Children's Safety Network: childrenssafetynetwork.org

- Darkness to Light (child sexual abuse prevention program for adults – Stewards of Children): darkness2light.org
- Division of Family and Children Services from the Georgia Department of Human Services: dfcs.dhr.georgia.gov
- Georgia Coalition Against Domestic Violence: gcadv.org
- National Alliance for Drug Endangered Children: nationaldec.org
- National Center for Missing and Exploited Children: missingkids.com
- National Center on Shaken Baby Syndrome: dontshake.com
- National Children's Advocacy Center: nationalcac.org
- National Children's Alliance: nationalchildrensalliance.org
- National Council on Child Abuse and Family Violence: preventfamilyviolence.org
- Prevent Child Abuse America: preventchildabuse.org
- Prevent Child Abuse Georgia: abuse.publichealth.gsu.edu/
- Stephanie V. Blank Center for Safe and Healthy Children at Children's Healthcare of Atlanta: choa.org/childprotection and choa.org/cptraining
- Stop It Now!: stopitnow.org
- The Bureau for At-Risk Youth: at-risk.com
- The National Child Traumatic Stress Network: nctsn.org

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Section 11:
Cultural Diversity

Impact on Student Health in the Schools

According to an article published in the Journal of School Nursing, school nurses are among the professional specialty disciplines in the school environment that have the unique opportunity of exploring and building upon effective practices when working and providing service to diverse populations. As such, school nurses must not only acquire the skills to survive in the culture of education; they must also develop cultural competence by engaging in self-identity and reflection, understanding cultural differences, being culturally responsive, identifying social injustices and engaging in life-long learning experiences.

Source: Carr, B., & Knutson, S. (2015). Culturally Competent School Nurse Practice. NASN School Nurse, 30(6), 336-342.

Section 12:
Source Material and References for Chapter 1

Some sections of chapter 1 were adapted from other materials. A complete list is provided below. All material was used with permission. References can be accessed online at the links below.

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Section 13:
Chapter 1 Appendix

Accident/Incident Report Form

(Please print clearly)

Injured Person Information: ☐**Visitor** ☐**Employee** ☐**Student**
Name:_____Age:__Sex: ☐**Male** ☐ **Female**

Address:____Grade: _____ **Teacher: ___**

_____ Phone #'s: __

School: ____ **Date of Accident: ___** (Mo. Day Year) **Time of Accident: ___** (Hr. Min. AM or PM)

Location	Type of Injury	Body Part Injured			
☐Classroom or Auditorium	☐Abrasion	☐Head			
☐Cafeteria	☐Bite	☐Eye	R	L	B
☐Corridor	☐Blister	☐Ear	R	L	B
☐Commons Area	☐Bruise	☐Mouth			
☐Stairs (inside)	☐Burn	☐Teeth			
☐Bathroom	☐Cut/Laceration	☐Neck			
☐Showers or dressing room	☐Poisoning	☐Chest			
☐Parking area	☐Puncture	☐Shoulder	R	L	B
☐Driveway	☐Scratch	☐Arm	R	L	B
☐Shops	☐Sprain	☐Elbow		R	L B
☐Labs	☐Tooth Damage	☐Wrist	R	L	B
☐Homemaking	☐Other: _____	☐Hand	R	L	B
☐Playground		☐Abdomen			
☐Street, Highway	Possible Injury:	☐Hip	R	L	B
☐Athletic Field	☐Concussion	☐Leg	R	L	B
☐Other: _____	☐Dislocation	☐Knee	R	L	B
	☐Fracture or Break	☐Ankle		R	L B
	☐Internal Injury	☐Foot	R	L	B

☐**Strain or Sprain** ☐**Toe(s)** **R/L: __**
Degree of Injury ☐**Other: ____**
☐**Non-disabling**
☐**Temporary (lost time from school)** **Accident / Incident Description (include cause):**
☐**Permanent disability**
☐**Death**

Witness(es): **Who gave First Aid, if any?**

Describe aid given:

Parent(s) notified? ☐**Yes** ☐**No** **MD notified:** ☐**Yes** ☐**No** **MD name:** **Principal notified?** ☐**Yes** ☐**No**
MD phone: **Released to:** ☐**Parent** ☐**EMS/Hospital** ☐**Back to class Accompanied by:**

Title: **Date:**

Report Prepared by:

 # Days Lost From School: __

(Continue on back of page as needed)

School _____ Date: _____

Student Name:____Teacher: _

Date of Accident ___ Time of Accident___AM/PM

Your child was seen in the clinic today for: _

We noticed the following:

First aid or treatment given:

Your child returned to class and reported no further problems.

We attempted to call you at___Time: _

Please help us assist your child further by doing the following:

Continue to observe at home.

Watch for signs of infection (pain, swelling, redness, heat).

Rccommend healthcare provider follow-up for further recommendations or treatment.

Other: _____

Please feel free to call the school if you have any further questions or concerns relating to this visit. I can be reached at:___(Phone #)

Sincerely,

_____ Title: _____
(Reported by)

Chronic Health Concerns Data

Name of Chronic Health Concern	Number of Students with this Concern
ADD/ADHD	
Autism/Asperger's Syndrome	
Allergies:	
Food (peanut, milk, etc.)	
Environmental and Seasonal	
Bee or Insect Stings/ # Epinephrine pens	
Anxiety/ Depression	
Arthritic conditions or Bone Disorders	
Asthma / # with Inhalers	
Cancer	
Cerebral Palsy	
Cystic Fibrosis	
Diabetes / Hypoglycemia	
Down's Syndrome	
G.I. disorders (Crohn's, Reflux, etc.)	
Hearing or Visual disturbances	
Heart condition or Bleeding disorder	
Lupus	
Mental Health concern (Bipolar, EBD,	
Compulsion disorder, etc.	
Migraines	
Muscular Dystrophy / Spina Bifida	
Nosebleeds	
Scoliosis	
Seizure disorders	
Sickle Cell Anemia	
Thyroid disorders	
Tourette's Syndrome	
Other:	
Other:	
Other:	

# Meds administered Daily	
# Meds administered PRN (as needed)	

Please fill out the chart using the School Health Clinic Information Card.

Clinic Visit to Report to Parent

School: _____ **Date:** _____

Student Name: _____ **Teacher:**____**Grade:**_____

Your child was seen in the clinic today for:

_____

_____

We noticed the following:

_____

_____

_____

First aid or treatment given:

_____

_____

☐ **Your child returned to class and reported no further problems.**

☐ **We attempted to call you at:** _____ **Time:** _____

Please help us assist your child further by doing the following:

Continue to observe at home.
Watch for signs of infection (pain, swelling, redness, heat).
Recommend healthcare provider follow-up for further recommendations or treatment.
Return to school when fever free for 24 hours.
To prevent possible spread of infection in the school, we will need a note from your healthcare provider before your child returns to school.

☐ Other: _____

Please feel free to call the school if you have any further questions or concerns relating to this visit. I can be reached at:__**(Phone #)**

Sincerely,

_____ _____

Reported by Title

Informe para los padres de la visita del estudiante a la clínica

Escuela: _____ **Fecha:** _____

Estudiante: _ **Profesor:**____**Grado:** _____

En la clínica se examinó a su niño hoy debido a:

_____

_____

Notamos lo siguiente:

_____

_____

_____

Primeros auxilios o tratamiento dado:

_____

_____

Su niño regresó a la clase y no reportó problemas adicionales.
Tratamos de llamarlo al: ____

Por favor ayúdenos a darle asistencia adicional a su niño, haciendo lo siguiente:

Continúe observándolo en casa.
Observe si tiene señales de infección (dolor, hinchazón, enrojecimiento, se siente caliente).
Se recomienda cita de control con el proveedor de atención médica para instrucciones adicionales o tratamiento.
Regrese a la escuela 24 horas después de que le pase la fiebre
Para prevenir la posible diseminación de la infección en la escuela, necesitamos que traiga una nota del proveedor de atención médica antes de regresar a la escuela.

☐ Otro: _____

Por favor siéntase con toda libertad de llamar a la escuela, si tiene más preguntas o preocupaciones sobre esta visita. Puede llamarme al teléfono # _

Atentamente,

_____ **Título:** _____

(Informe presentado por)

Information Card - School Health Clinic **(School Year: 20___ to 20___)**

School: _____ Grade: _____ Teacher/HR: _____

Name: _____ Sex: M F D.O.B. _____

Address: _____ Phone: _____ (H) _____ (C) _____ (W)

Health Insurance: Yes No (If no, talk with your school nurse about available resources)

HEALTH HISTORY (Answer Yes or No, and give information as needed.)

Allergies (Specify) _____ Diabetes _____
Asthma _____ Physical Disabilities _____
ADHD/ADD _____ Sickle Cell _____
Cancer _____ Seizure Disorder _____
Other physical or mental health issues which may be a concern at school: (continue on back as needed)

_____
_____

____Does your child require special seating in the classroom? Specify: _____
____Does your child have any condition that would limit physical education activities? List: _____
____Does your child take any prescribed medications routinely? List: _____
____Does your child take any non-prescription medications? List: _____
____Did your child receive any immunizations this past year? List type, date: _____
____Date of last tetanus shot?

List name(s) of school-age siblings:
1. _____ Grade/School: _____
2. _____ Grade/School: _____
3. _____ Grade/School: _____

EMERGENCY CONTACT INFORMATION

Father/Guardian _____ Phone (H) _____ (C) _____
Name
Phone (W) _____ Pgr _____

Mother/Guardian _____ Phone (H) _____ (C) _____
Name
Phone (W) _____ Pgr _____

If parents cannot be reached, list two nearby persons who will assume care of your child.
Name _____ Relationship _____ Phone _____
Name _____ Relationship _____ Phone _____
Child's Healthcare Provider _____ Phone _____

I give permission to give my child medicine for fever or headache, like Tylenol or Advil (or generic equivalent) according to label instructions after contacting me (Parent/Guardian) by phone. Yes ___ No ___

I give permission to contact my child's healthcare provider for further medical information. Yes ___ No ___

I also understand that in the event of an emergency and I cannot be reached that the school will have my child transported to the hospital via the EMS/911 service to receive appropriate treatment.

Parent Signature _____ Date _____

Tarjeta de información de la clínica de la escuela **(Año escolar: 20__ al 20__)**

Escuela: _____ Grado: ____ Profesor/Salón de clase: _____

Nombre: _____ Sexo: M F Fecha de nacimiento: _____

Dirección: _____ Tel. #: _____ (Vivienda) _____ (Cel.) _____
(Trabajo)

HISTORIA CLÍNICA (Conteste Sí o No, y dé la información según sea necesario.)

Alergias (especifique) _____ Diabetes _____
Asma _____ Discapacidades físicas _____
Trastorno por déficit de atención e hiperactividad (ADHD) /Trastorno por déficit de atención (ADD) _____
Anemia drepanocítica _____
Cáncer _____ Trastorno convulsivo _____
Otras afecciones de salud física o mental que puedan ser preocupación en la escuela: (continúe en la parte posterior, según sea necesario)

_____
_____

_____¿Requiere su niño asiento especial en el salón de clase? Especifique: _____
_____¿Tiene su niño alguna afección médica que lo limite para hacer educación física? Especifique: _____
_____¿Toma su niño regularmente algún medicamento recetado? Especifique: _____
_____¿Toma su niño algún medicamento de venta sin receta? Especifique: _____
_____¿Recibió su niño alguna vacuna este último año? Especifique el tipo y la fecha: _____
_____¿Fecha en que recibió la última vacuna contra el tétano?

Escriba los nombres de los hermanos en edad escolar:
1. _____ Escuela/Grado: _____
2. _____ Escuela/Grado: _____
3. _____ Escuela/Grado: _____

INFORMACIÓN DE CONTACTO EN CASO DE EMERGENCIA

Padre/Representante legal _____ Teléfono (Vivienda) _____ (Cel.) _____
Nombre
Teléfono (Trabajo) _____ Pager _____

Madre/Representante legal _____ Teléfono (Vivienda) _____ (Cel.) _____
Nombre
Teléfono (Trabajo) _____ (Cel.) _____

Si no se puede contactar a los padres, dénos el nombre de dos personas cercanas que asumirán el cuidado del niño
Nombre _____ Parentesco _____ Teléfono _____
Nombre _____ Parentesco _____ Teléfono _____
Proveedor de atención médica del niño _____ Teléfono _____

Doy permiso para que se le dé a mi niño un medicamento para la fiebre o el dolor de cabeza, tal como Tylenol o Advil (o su marca genérica equivalente), siguiendo las instrucciones de la etiqueta, y después de que se me comunique por teléfono (padre/representante legal) Sí ___ No ___
Doy permiso para que se comunique con el proveedor de atención médica de mi niño para obtener información médica adicional. Sí _____ No _____
También entiendo que, en caso de una emergencia, y no se puede comunicar conmigo, la escuela hará que mi niño sea transportado al hospital a través del servicio 911/EMS (# 911/Servicios Médicos de Emergencia) para recibir un tratamiento adecuado.

Health Notes

School Name______ School Year_ Page_of____

Student Name______ DOB_

Teacher_____Grade_ Physician___

Date	Vital Signs	Health Notes (Sign after each entry)

Information Letter for Parent School Year: 20___-20___

Dear Parent/ Guardian:
We need your assistance and cooperation in preparing for the possibility that your child might need to take medication, become ill or have an accident during school hours. We hope this letter will explain our procedures.

Emergency Information

Emergency contact information should be updated annually by sending the information to the school or calling the school office. When you receive a Student Contact Form, please update it and return it to the school within five (5) days. Current, accurate information will enable us to contact you. If any information changes during the school year, contact the school immediately.

Prescription/Non-Prescription Medication

Medication time schedules should be set so that, when possible, medicine is taken at home rather than at school. However, if medication must be taken at school, the following procedures apply.

1. Medication Authorization Form – The parent/legal guardian must complete an authorization and instruction form entitled "Authorization to Give Medication At School." For prescription medication your healthcare provider must also sign the form. A copy of this form is on the back of this letter. You can make copies yourself or request additional forms from the school. ***The completed form must accompany the medication, so be sure to take this form to your physician whenever your child is ill.***

The medicine, in the original container (along with authorization form), must be taken to the school office/clinic for central storage. The parent/guardian should take the medication to school; however, if this is not possible, your child should be instructed to take the medication and the authorization form directly to the school office/clinic. Under no circumstances should medication be shown or shared with other students.

At the designated time, the student will go to the office/ clinic to take the medication. Assistance/ supervision will be given in accordance with the instructions on the authorization form. Medication is a parental responsibility; school employees will not assume any liability for supervising or assisting in the administration of medication.

Unused medication should be retrieved from the school office/ clinic within one week after medication is discontinued; otherwise the school will dispose of the medication.

Student Illness/ Injury

Sick students who are contagious must not be sent to school. When a student becomes ill at school, the parent must arrange for the student to be taken home. By working together, we can strive to ensure the health and well-being of every student so that he/she can benefit from the educational program.

Principal ___ School Clinic Personnel _____ **Date: _____**

Carta informativa de la enfermería escolar para los padres Año escolar 20__-20__

Apreciados padres/representante legal:

Necesitamos su ayuda y cooperación en preparación para la eventualidad de que su niño llegare a necesitar algún medicamento, se enfermara o tuviera un accidente durante el horario escolar. Esperamos que esta carta les explique nuestros procedimientos.

Información de emergencia

La información de los contactos en caso de emergencia debe actualizarse anualmente, enviándola a la escuela o llamando a la oficina. Cuando reciba el Formulario Salud del Estudiante (*Student Health Form)*, por favor actualícelo y devuélvalo a la escuela en los cinco días siguientes. Esta información, actualizada y exacta, nos permitirá comunicarnos con usted cada vez que sea necesario. Si en algún momento durante el año escolar esta información cambia, comuníquese inmediatamente con la escuela.

Medicamentos recetados/medicamentos de venta sin receta

El horario para tomar los medicamentos debe programarse de tal manera que, de ser posible, se tomen en casa en lugar de hacerlo en la escuela. Sin embargo, si deben tomarse en la escuela, se aplican los siguientes procedimientos.

1. Forma para Autorización de Medicamentos – Los padres/representante legal deben llenar una forma de autorización e instrucción titulada "Autorización de los padres/representante legal para administrar medicamentos en la escuela" (*Paren/Guardian Authorization to Give Medication at School*). En el caso de medicamentos de **venta con receta, su médico también debe firmar** dicha forma. Al reverso de esta carta, usted encontrará una copia de dicha forma. Usted le puede sacar copias o solicitar formas adicionales en la escuela. **La forma, debidamente llena, debe entregarse junto con el medicamento; así que asegúrese de llevarle esta forma al proveedor de atención médica, cuando su niño se enferme.**
2. El medicamento en su envase original (junto con la forma de autorización), debe entregarse en la enfermería/oficina de la escuela para su almacenamiento central. Los padres/representante legal deben llevar personalmente el medicamento a la escuela; sin embargo, si esto no es posible, debe instruir a su niño para que lleve el medicamento y la forma de autorización directamente a la enfermería/oficina de la escuela. Bajo ninguna circunstancia se debe mostrar el medicamento a otros estudiantes o compartirlo.
3. A la hora designada, el estudiante irá a la enfermería/oficina a tomarse el medicamento. Se dará asistencia/supervisión, siguiendo las instrucciones que aparecen en la forma de autorización. El medicamento es responsabilidad de los padres; los empleados de la escuela no asumen ninguna responsabilidad por supervisar o asistir en la administración del mismo.
4. El medicamento no utilizado se debe retirar de la enfermería/oficina de la escuela, dentro de la semana siguiente de haberse suspendido su administración; de otro modo la escuela lo desechará.

Enfermedad/lesión de un estudiante
Los estudiantes con enfermedades contagiosas no deben ir a la escuela. Cuando un

estudiante se enferme en la escuela, los padres deben hacer los arreglos necesarios para llevarlo a casa.
Trabajando juntos, trataremos de garantizar la salud y el bienestar de cada estudiante para que él/ella pueda beneficiarse de los programas educativos.

Director
Principal _____ Fecha _____

Personal de enfermería _____ Fecha _____
School Clinic Personnel

Sample Forms

EMPLOYEE NAME:

JOB DESCRIPTION

POSITION TITLE: School Nurse	**FLSA:** Non-Exempt
DIVISION:	**PAY GRADE:** LPN or RN
DEPARTMENT:	**SALARY SCHEDULE:** School Nurse
REPORTS TO: Principal	**WORK DAYS:** 183 Days
PRIMARY FUNCTION: Applies appropriate theories from nursing to meet the unique and diverse health needs of the school community under the guidance of the Nursing Supervisor.	

REQUIREMENTS:

1. Educational Level: Graduate of an accredited nursing education program required
2. Certification/License Required: Valid RN/LPN licensure in the State of Georgia; Certification in CPR/AED required; Certification in American Red Cross Standard First Aid required; must successfully complete the CCSD training course and pass all written tests; must fulfill continuing competency requirements
3. Experience: Minimum of 1 year nursing experience required; 2 years of professional nursing experience preferred
4. Physical Activities: Routine physical activities that are required to fulfill job responsibilities
5. Knowledge, Skills, & Abilities: Written and oral communication; strong motivation for community health; ability to maintain a positive working relationship with school personnel, students, and families; competency in computer applications, record keeping, and organizational abilities; interpersonal skills necessary for overseeing the clinic; knowledge of fundamental nursing concepts, practices, and procedures is essential

ESSENTIAL DUTIES:

1. Demonstrates prompt and regular attendance.
2. Presents professional and well-groomed appearance according to District Dress Code.
3. Attends mandatory Clinic Orientation and Training, Pre-Planning, Professional Learning Days, and other district required trainings.
4. Adheres to District Administrative Rules; uses a distinct clinical knowledge base for decision making in nursing practice; delivers nursing services consistent with Georgia Board of Nursing rules and regulations; nursing procedures are efficient, safe, and effective; maintains accurate documentation of clinic services, including emergency situations; demonstrates ethical and professional behavior, including maintenance of confidentiality at all times.
5. Administers and documents medications to students according to approved clinic policies, procedures, protocols and written physician directions to include injectable medications and emergency medication with appropriate documented records.
6. Organizes and maintains a clean, orderly clinic to ensure a safe physical environment including locked medication cabinets, practicing standard precautions at all times, and maintaining sharps containers in appropriate locations; maintains adequate clinic supplies.
7. Provides privacy and a caring environment; displays and models respect towards students and others; serves as a student advocate and establishes and communicates clear behavior expectation in the clinic to students and staff.
8. Identifies and manages individuals with suspected infectious illnesses and helps prevent transmission to others through exclusion and education; reports required information to the Nursing Supervisor.
9. Evaluates student responses to prescribed interventions and the efficacy of the interventions and executes and documents the nursing interventions noted in an Individual Health Care Plan (IHCP), Section 504 Plan, or Individual Educational Plan (IEP).
10. Collaborates with the Nursing Supervisor in the development and implementation of the IHCP or 504 Plan as appropriate to the student's needs.
11. Communicates and collaborates with school personnel, nursing administration, students and families in a professional manner and with appropriate frequency about school health issues.
12. Performs other duties as assigned by appropriate administrator.

Signature of Employee_____ Date _____

Signature of Supervisor_____ Date _____

GSHRM Chapter 1 Page 46

Post-Hospitalization and/or Outpatient Care Report to School

Student's name:____DOB__

School District_____School_Grade_

Reason for hospitalization or diagnosis:____

Date student may return to school (if applicable):___

Need for homebound instruction or modified day (How long?):____

Recommendations for health management at school:
Symptoms you may observe, related to student's condition:

Observation Action (CP-Call Parent, EAP-See Emergency Plan, N-None needed)

Medications: (It is helpful for the school nurse to know all meds, in case side effects occur.) None
List: Medication name, Dose, Route, Time(s) to be given, Special instructions:

Other Recommendations:_____ Special diet:_____ Need for extra hydration:_____

Activity restrictions:_____ PE:__Positioning:_____Special Toileting needs:_____

Treatments/ Procedures (if done at school, please attach signed orders, with specifics):_____

Special equipment Other

School Nurse (Name, phone #) _____

Healthcare provider (Name, phone #) _____

Date: _____

Social Services Referral Form

Student Name: _____ **Student ID:** _____

Date:_____ School:____ Grade:____

DOB (Age) / / ( ) **Teacher:**

Mother/Guardian: _____ **Mother's Home Phone ( ) _____**
Mother's Work Phone ( ) _____ Mother's Cell ( ) _____

Father/Guardian: _____ **Father's Home Phone ( ) _____ Father's Cell ( ) _____**
Father's Work Phone ( ) _____

Street Address:_____Apt:__

City:_____State:___ **Zip Code:_____**

Emergency Contact Name:_____ **Emergency Phone: ( ) _____**

Attendance: As of___/_____/____
Number of Excused: ____
Number of Unexcused:____
Number of Tardies:____

CHECK ALL THAT APPLY:

- ☐ **Abuse Services**
- ☐ **Academic Services**
- ☐ **Discipline Services**
- ☐ **Special Education**
- ☐ **Homeless**
- ☐ **Pregnancy**
- ☐ **Verification of Residence**
- ☐ **Family/Health/Personal/Social Services**

Problem Seen by Referring Person and Attempts Made by School to Remedy:

Referred by: _____ **Title:** _____

Reviewed by: _____ **Date:** _____

_____
Social Worker Signature

Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger

UNITED STATES 2024

Vaccines and Other Immunizing Agents in the Child and Adolescent Immunization Schedule*

Monoclonal antibody	Abbreviation(s)	Trade name(s)
Respiratory syncytial virus monoclonal antibody (Nirsevimab)	**RSV-mAb**	Beyfortus™
Vaccine	**Abbreviation(s)**	**Trade name(s)**
COVID-19	**1vCOV-mRNA**	Comirnaty®/Pfizer-BioNTech COVID-19 Vaccine Spikevax®/Moderna COVID-19 Vaccine
	1vCOV-aPS	Novavax COVID-19 Vaccine
Dengue vaccine	**DEN4CYD**	Dengvaxia®
Diphtheria, tetanus, and acellular pertussis vaccine	**DTaP**	Daptacel® Infanrix®
Haemophilus influenzae type b vaccine	**Hib (PRP-T)** **Hib (PRP-OMP)**	ActHIB® Hiberix® PedvaxHIB®
Hepatitis A vaccine	**HepA**	Havrix® Vaqta®
Hepatitis B vaccine	**HepB**	Engerix-B® Recombivax HB®
Human papillomavirus vaccine	**HPV**	Gardasil 9®
Influenza vaccine (inactivated)	**IIV4**	Multiple
Influenza vaccine (live, attenuated)	**LAIV4**	FluMist® Quadrivalent
Measles, mumps, and rubella vaccine	**MMR**	M-M-R II® Priorix®
Meningococcal serogroups A, C, W, Y vaccine	**MenACWY-CRM** **MenACWY-TT**	Menveo® MenQuadfi®
Meningococcal serogroup B vaccine	**MenB-4C** **MenB-FHbp**	Bexsero® Trumenba®
Meningococcal serogroup A, B, C, W, Y vaccine	**MenACWY-TT/ MenB-FHbp**	Penbraya™
Mpox vaccine	**Mpox**	Jynneos®
Pneumococcal conjugate vaccine	**PCV15** **PCV20**	Vaxneuvance™ Prevnar 20®
Pneumococcal polysaccharide vaccine	**PPSV23**	Pneumovax 23®
Poliovirus vaccine (inactivated)	**IPV**	Ipol®
Respiratory syncytial virus vaccine	**RSV**	Abrysvo™
Rotavirus vaccine	**RV1** **RV5**	Rotarix® RotaTeq®
Tetanus, diphtheria, and acellular pertussis vaccine	**Tdap**	Adacel® Boostrix®
Tetanus and diphtheria vaccine	**Td**	Tenivac® Tdvax™
Varicella vaccine	**VAR**	Varivax®
Combination vaccines *(use combination vaccines instead of separate injections when appropriate)*		
DTaP, hepatitis B, and inactivated poliovirus vaccine	**DTaP-HepB-IPV**	Pediarix®
DTaP, inactivated poliovirus, and *Haemophilus influenzae* type b vaccine	**DTaP-IPV/Hib**	Pentacel®
DTaP and inactivated poliovirus vaccine	**DTaP-IPV**	Kinrix® Quadracel®
DTaP, inactivated poliovirus, *Haemophilus influenzae* type b, and hepatitis B vaccine	**DTaP-IPV-Hib-HepB**	Vaxelis®
Measles, mumps, rubella, and varicella vaccine	**MMRV**	ProQuad®

*Administer recommended vaccines if immunization history is incomplete or unknown. Do not restart or add doses to vaccine series for extended intervals between doses. When a vaccine is not administered at the recommended age, administer at a subsequent visit. The use of trade names is for identification purposes only and does not imply endorsement by the ACIP or CDC.

11/16/2023

How to use the child and adolescent immunization schedule

1. Determine recommended vaccine by age **(Table 1)**
2. Determine recommended interval for catch-up vaccination **(Table 2)**
3. Assess need for additional recommended vaccines by medical condition or other indication **(Table 3)**
4. Review vaccine types, frequencies, intervals, and considerations for special situations **(Notes)**
5. Review contraindications and precautions for vaccine types **(Appendix)**
6. Review new or updated ACIP guidance **(Addendum)**

Recommended by the Advisory Committee on Immunization Practices (www.cdc.gov/vaccines/acip) and approved by the Centers for Disease Control and Prevention (www.cdc.gov), American Academy of Pediatrics (www.aap.org), American Academy of Family Physicians (www.aafp.org), American College of Obstetricians and Gynecologists (www.acog.org), American College of Nurse-Midwives (www.midwife.org), American Academy of Physician Associates (www.aapa.org), and National Association of Pediatric Nurse Practitioners (www.napnap.org).

Report

- Suspected cases of reportable vaccine-preventable diseases or outbreaks to your state or local health department
- Clinically significant adverse events to the Vaccine Adverse Event Reporting System (VAERS) at www.vaers.hhs.gov or 800-822-7967

Questions or comments

Contact www.cdc.gov/cdc-info or 800-CDC-INFO (800-232-4636), in English or Spanish, 8 a.m.–8 p.m. ET, Monday through Friday, excluding holidays

Download the CDC Vaccine Schedules app for providers at www.cdc.gov/vaccines/schedules/hcp/schedule-app.html

Helpful information

- Complete Advisory Committee on Immunization Practices (ACIP) recommendations: www.cdc.gov/vaccines/hcp/acip-recs/index.html
- ACIP Shared Clinical Decision-Making Recommendations: www.cdc.gov/vaccines/acip/acip-scdm-faqs.html
- *General Best Practice Guidelines for Immunization* (including contraindications and precautions): www.cdc.gov/vaccines/hcp/acip-recs/general-recs/index.html
- Vaccine information statements: www.cdc.gov/vaccines/hcp/vis/index.html
- Manual for the Surveillance of Vaccine-Preventable Diseases (including case identification and outbreak response): www.cdc.gov/vaccines/pubs/surv-manual

Scan QR code for access to online schedule

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

CS310020-D

Table 1 Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger, United States, 2024

These recommendations must be read with the notes that follow. For those who fall behind or start late, provide catch-up vaccination at the earliest opportunity as indicated by the green bars.
To determine minimum intervals between doses, see the catch-up schedule (Table 2).

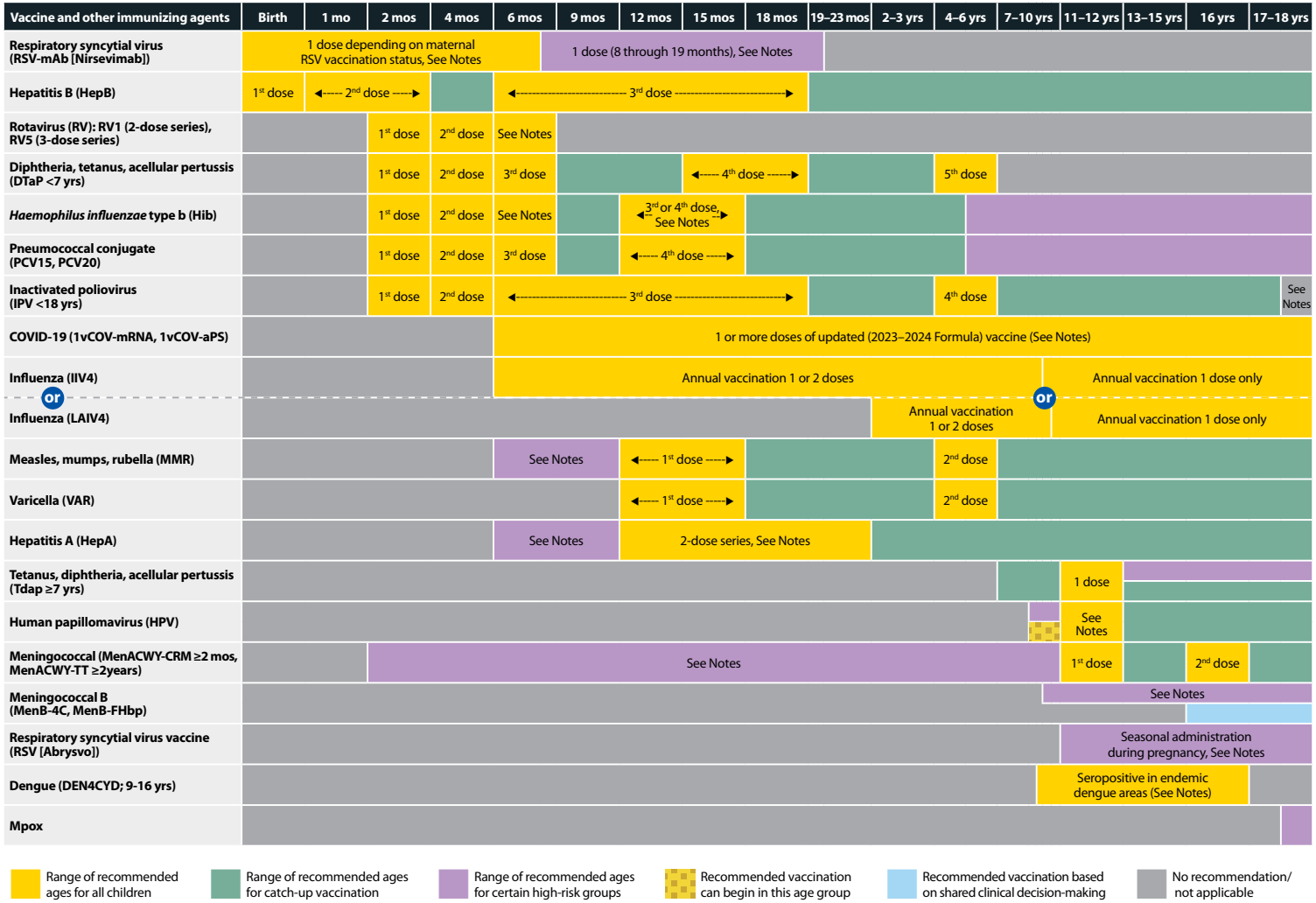

Table 2 Recommended Catch-up Immunization Schedule for Children and Adolescents Who Start Late or Who Are More than 1 Month Behind, United States, 2024

The table below provides catch-up schedules and minimum intervals between doses for children whose vaccinations have been delayed. A vaccine series does not need to be restarted, regardless of the time that has elapsed between doses. Use the section appropriate for the child's age. **Always use this table in conjunction with Table 1 and the Notes that follow.**

Children age 4 months through 6 years					
Vaccine	**Minimum Age for Dose 1**	**Minimum Interval Between Doses**			
		Dose 1 to Dose 2	**Dose 2 to Dose 3**	**Dose 3 to Dose 4**	**Dose 4 to Dose 5**
Hepatitis B	Birth	**4 weeks**	**8 weeks *and* at least 16 weeks after first dose** minimum age for the final dose is 24 weeks		
Rotavirus	6 weeks Maximum age for first dose is 14 weeks, 6 days.	**4 weeks**	**4 weeks** maximum age for final dose is 8 months, 0 days		
Diphtheria, tetanus, and acellular pertussis	6 weeks	**4 weeks**	**4 weeks**	**6 months**	**6 months** A fifth dose is not necessary if the fourth dose was administered at age 4 years or older ***and*** at least 6 months after dose 3
Haemophilus influenzae type b	6 weeks	**No further doses needed** if first dose was administered at age 15 months or older. **4 weeks** if first dose was administered before the 1st birthday. **8 weeks (as final dose)** if first dose was administered at age 12 through 14 months.	**No further doses needed** if previous dose was administered at age 15 months or older **4 weeks** if current age is younger than 12 months ***and*** first dose was administered at younger than age 7 months ***and*** at least 1 previous dose was PRP-T (ActHib®, Pentacel®, Hiberix®), Vaxelis® or unknown **8 weeks *and* age 12 through 59 months (as final dose)** if current age is younger than 12 months ***and*** first dose was administered at age 7 through 11 months; **OR** if current age is 12 through 59 months ***and*** first dose was administered before the 1st birthday ***and*** second dose was administered at younger than 15 months; **OR** if both doses were PedvaxHIB® and were administered before the 1st birthday	**8 weeks (as final dose)** This dose only necessary for children age 12 through 59 months who received 3 doses before the 1st birthday.	
Pneumococcal conjugate	6 weeks	**No further doses needed** for healthy children if first dose was administered at age 24 months or older **4 weeks** if first dose was administered before the 1st birthday **8 weeks (as final dose for healthy children)** if first dose was administered at the 1st birthday or after	**No further doses needed** for healthy children if previous dose was administered at age 24 months or older **4 weeks** if current age is younger than 12 months ***and*** previous dose was administered at <7 months old **8 weeks (as final dose for healthy children)** if previous dose was administered between 7–11 months (wait until at least 12 months old); **OR** if current age is 12 months or older ***and*** at least 1 dose was administered before age 12 months	**8 weeks (as final dose)** This dose is only necessary for children age 12 through 59 months regardless of risk, or age 60 through 71 months with any risk, who received 3 doses before age 12 months.	
Inactivated poliovirus	6 weeks	**4 weeks**	**4 weeks** if current age is <4 years **6 months (as final dose)** if current age is 4 years or older	**6 months (minimum age 4 years for final dose)**	
Measles, mumps, rubella	12 months	**4 weeks**			
Varicella	12 months	**3 months**			
Hepatitis A	12 months	**6 months**			
Meningococcal ACWY	2 months MenACWY-CRM 2 years MenACWY-TT	**8 weeks**	See Notes	See Notes	
Children and adolescents age 7 through 18 years					
Meningococcal ACWY	Not applicable (N/A)	**8 weeks**			
Tetanus, diphtheria; tetanus, diphtheria, and acellular pertussis	7 years	**4 weeks**	**4 weeks** if first dose of DTaP/DT was administered before the 1st birthday **6 months (as final dose)** if first dose of DTaP/DT or Tdap/Td was administered at or after the 1st birthday	**6 months** if first dose of DTaP/DT was administered before the 1st birthday	
Human papillomavirus	9 years	**Routine dosing intervals are recommended.**			
Hepatitis A	N/A	**6 months**			
Hepatitis B	N/A	**4 weeks**	**8 weeks *and* at least 16 weeks after first dose**		
Inactivated poliovirus	N/A	**4 weeks**	**6 months** A fourth dose is not necessary if the third dose was administered at age 4 years or older ***and*** at least 6 months after the previous dose.	A fourth dose of IPV is indicated if all previous doses were administered at <4 years **OR** if the third dose was administered <6 months after the second dose.	
Measles, mumps, rubella	N/A	**4 weeks**			
Varicella	N/A	**3 months** if younger than age 13 years. **4 weeks** if age 13 years or older			
Dengue	9 years	**6 months**	6 months		

Table 3 Recommended Child and Adolescent Immunization Schedule by Medical Indication, United States, 2024

Always use this table in conjunction with Table 1 and the Notes that follow. Medical conditions are often not mutually exclusive. If multiple conditions are present, refer to guidance in all relevant columns. See Notes for medical conditions not listed.

Vaccine and other immunizing agents	Pregnancy	Immunocompromised (excluding HIV infection)	HIV infection CD4 percentage and count[a]		CSF leak or cochlear implant	Asplenia or persistent complement component deficiencies	Heart disease or chronic lung disease	Kidney failure, End-stage renal disease or on Dialysis	Chronic liver disease	Diabetes
			<15% or <200mm	≥15% and ≥200mm						
RSV-mAb (nirsevimab)		2nd RSV season		1 dose depending on maternal RSV vaccination status, See Notes			2nd RSV season for chronic lung disease (See Notes)	1 dose depending on maternal RSV vaccination status, See Notes		
Hepatitis B										
Rotavirus		SCID[b]								
DTaP/Tdap	DTaP Tdap: 1 dose each pregnancy									
Hib		HSCT: 3 doses	See Notes			See Notes				
Pneumococcal										
IPV										
COVID-19		See Notes								
IIV4										
LAIV4							Asthma, wheezing: 2–4 years[c]			
MMR	*									
VAR	*									
Hepatitis A										
HPV	*	3 dose series. See Notes								
MenACWY										
MenB										
RSV (Abrysvo)	Seasonal administration, See Notes									
Dengue										
Mpox	See Notes									

Recommended for all age-eligible children who lack documentation of a complete vaccination series

Not recommended for all children, but is recommended for some children based on increased risk for or severe outcomes from disease

Recommended for all age-eligible children, and additional doses may be necessary based on medical condition or other indications. See Notes.

Precaution: Might be indicated if benefit of protection outweighs risk of adverse reaction

Contraindicated or not recommended
*Vaccinate after pregnancy, if indicated

No Guidance/ Not Applicable

a. For additional information regarding HIV laboratory parameters and use of live vaccines, see the General Best Practice Guidelines for Immunization, "Altered Immunocompetence," at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/immunocompetence.html and Table 4-1 (footnote J) at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html.

b. Severe Combined Immunodeficiency

c. LAIV4 contraindicated for children 2–4 years of age with asthma or wheezing during the preceding 12 months

Notes

Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger, United States, 2024

For vaccination recommendations for persons ages 19 years or older, see the Recommended Adult Immunization Schedule, 2024.

Additional information

- For calculating intervals between doses, 4 weeks = 28 days. Intervals of ≥4 months are determined by calendar months.
- Within a number range (e.g., 12–18), a dash (–) should be read as "through."
- Vaccine doses administered ≤4 days before the minimum age or interval are considered valid. Doses of any vaccine administered ≥5 days earlier than the minimum age or minimum interval should not be counted as valid and should be repeated as age appropriate. **The repeat dose should be spaced after the invalid dose by the recommended minimum interval.** For further details, see Table 3-2, Recommended and minimum ages and intervals between vaccine doses, in *General Best Practice Guidelines for Immunization* at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/timing.html.
- Information on travel vaccination requirements and recommendations is available at www.cdc.gov/travel/.
- For vaccination of persons with immunodeficiencies, see Table 8-1, Vaccination of persons with primary and secondary immunodeficiencies, in *General Best Practice Guidelines for Immunization* at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/immunocompetence.html, and Immunization in Special Clinical Circumstances (In: Kimberlin DW, Barnett ED, Lynfield Ruth, Sawyer MH, eds. *Red Book: 2021–2024 Report of the Committee on Infectious Diseases*. 32nd ed. Itasca, IL: American Academy of Pediatrics; 2021:72–86).
- For information about vaccination in the setting of a vaccine-preventable disease outbreak, contact your state or local health department.
- The National Vaccine Injury Compensation Program (VICP) is a no-fault alternative to the traditional legal system for resolving vaccine injury claims. All vaccines included in the child and adolescent vaccine schedule are covered by VICP except dengue, PPSV23, RSV, Mpox and COVID-19 vaccines. Mpox and COVID-19 vaccines are covered by the Countermeasures Injury Compensation Program (CICP). For more information, see www.hrsa.gov/vaccinecompensation or www.hrsa.gov/cicp.

COVID-19 vaccination

(minimum age: 6 months [Moderna and Pfizer-BioNTech COVID-19 vaccines], 12 years [Novavax COVID-19 Vaccine])

Routine vaccination

Age 6 months–4 years

- **Unvaccinated:**
  - 2-dose series of updated (2023–2024 Formula) Moderna at 0, 4-8 weeks
  - 3-dose series of updated (2023–2024 Formula) Pfizer-BioNTech at 0, 3-8, 11-16 weeks
- **Previously vaccinated* with 1 dose of any Moderna:** 1 dose of updated (2023–2024 Formula) Moderna 4-8 weeks after the most recent dose.
- **Previously vaccinated* with 2 or more doses of any Moderna:** 1 dose of updated (2023–2024 Formula) Moderna at least 8 weeks after the most recent dose.
- **Previously vaccinated* with 1 dose of any Pfizer-BioNTech:** 2-dose series of updated (2023–2024 Formula) Pfizer-BioNTech at 0, 8 weeks (minimum interval between previous Pfizer-BioNTech and dose 1: 3-8 weeks).
- **Previously vaccinated* with 2 or more doses of any Pfizer-BioNTech:** 1 dose of updated (2023–2024 Formula) Pfizer-BioNTech at least 8 weeks after the most recent dose.

Age 5–11 years

- **Unvaccinated:** 1 dose of updated (2023–2024 Formula) Moderna or Pfizer-BioNTech vaccine.
- **Previously vaccinated* with 1 or more doses of Moderna or Pfizer-BioNTech:** 1 dose of updated (2023–2024 Formula) Moderna or Pfizer-BioNTech at least 8 weeks after the most recent dose.

Age 12–18 years

- **Unvaccinated:**
  - 1 dose of updated (2023–2024 Formula) Moderna or Pfizer-BioNTech vaccine
  - 2-dose series of updated (2023–2024 Formula) Novavax at 0, 3-8 weeks
- **Previously vaccinated* with any COVID-19 vaccine(s):** 1 dose of any updated (2023–2024 Formula) COVID-19 vaccine at least 8 weeks after the most recent dose.

Special situations

Persons who are moderately or severely immunocompromised**

Age 6 months–4 years

- **Unvaccinated:**
  - 3-dose series of updated (2023–2024 Formula) Moderna at 0, 4, 8 weeks
  - 3-dose series of updated (2023–2024 Formula) Pfizer-BioNTech at 0, 3, 11 weeks.
- **Previously vaccinated* with 1 dose of any Moderna:** 2-dose series of updated (2023–2024 Formula) Moderna at 0, 4 weeks (minimum interval between previous Moderna and dose 1: 4 weeks).
- **Previously vaccinated* with 2 doses of any Moderna:** 1 dose of updated (2023–2024 Formula) Moderna at least 4 weeks after the most recent dose.
- **Previously vaccinated* with 3 or more doses of any Moderna:** 1 dose of updated (2023–2024 Formula) Moderna at least 8 weeks after the most recent dose.
- **Previously vaccinated* with 1 dose of any Pfizer-BioNTech:** 2-dose series of updated (2023–2024 Formula) Pfizer-BioNTech at 0, 8 weeks (minimum interval between previous Pfizer-BioNTech and dose 1: 3 weeks).
- **Previously vaccinated* with 2 or more doses of any Pfizer-BioNTech:** 1 dose of updated (2023–2024 Formula) Pfizer-BioNTech at least 8 weeks after the most recent dose.

Age 5–11 years

- **Unvaccinated:**
  - 3-dose series of updated (2023–2024 Formula) Moderna at 0, 4, 8 weeks
  - 3-dose series updated (2023–2024 Formula) Pfizer-BioNTech at 0, 3, 7 weeks.
- **Previously vaccinated* with 1 dose of any Moderna:** 2-dose series of updated (2023–2024 Formula) Moderna at 0, 4 weeks (minimum interval between previous Moderna and dose 1: 4 weeks).
- **Previously vaccinated* with 2 doses of any Moderna:** 1 dose of updated (2023–2024 Formula) Moderna at least 4 weeks after the most recent dose.
- **Previously vaccinated* with 1 dose of any Pfizer-BioNTech:** 2-dose series of updated (2023–2024 Formula) Pfizer-BioNTech at 0, 4 weeks (minimum interval between previous Pfizer-BioNTech and dose 1: 3 weeks)
- **Previously vaccinated* with 2 doses of any Pfizer-BioNTech:** 1 dose of 2023–2024 Pfizer-BioNTech at least 4 weeks after the most recent dose.

Notes

Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger, United States, 2024

- **Previously vaccinated* with 3 or more doses of any Moderna or Pfizer-BioNTech:** 1 dose of updated (2023–2024 Formula) Moderna or Pfizer-BioNTech at least 8 weeks after the most recent dose.

Age 12–18 years

- **Unvaccinated:**
  - 3-dose series of updated (2023–2024 Formula) Moderna at 0, 4, 8 weeks
  - 3-dose series of updated (2023–2024 Formula) Pfizer-BioNTech at 0, 3, 7 weeks
  - 2-dose series of updated (2023–2024 Formula) Novavax at 0, 3 weeks
- **Previously vaccinated* with 1 dose of any Moderna:** 2-dose series of updated (2023–2024 Formula) Moderna at 0, 4 weeks (minimum interval between previous Moderna dose and dose 1: 4 weeks).
- **Previously vaccinated* with 2 doses of any Moderna:** 1 dose of updated (2023–2024 Formula) Moderna at least 4 weeks after the most recent dose.
- **Previously vaccinated* with 1 dose of any Pfizer-BioNTech:** 2-dose series of updated (2023–2024 Formula) Pfizer-BioNTech at 0, 4 weeks (minimum interval between previous Pfizer-BioNTech dose and dose 1: 3 weeks).
- **Previously vaccinated* with 2 doses of any Pfizer-BioNTech:** 1 dose of updated (2023–2024 Formula) Pfizer-BioNTech at least 4 weeks after the most recent dose.
- **Previously vaccinated* with 3 or more doses of any Moderna or Pfizer-BioNTech:** 1 dose of any updated (2023–2024 Formula) COVID-19 vaccine at least 8 weeks after the most recent dose.
- **Previously vaccinated* with 1 or more doses of Janssen or Novavax or with or without dose(s) of any Original monovalent or bivalent COVID-19 vaccine:** 1 dose of any updated (2023–2024 Formula) COVID-19 vaccine at least 8 weeks after the most recent dose.

There is no preferential recommendation for the use of one COVID-19 vaccine over another when more than one recommended age-appropriate vaccine is available.

Administer an age-appropriate COVID-19 vaccine product for each dose. For information about transition from age 4 years to age 5 years or age 11 years to age 12 years during COVID-19 vaccination series, see Tables 1 and 2 at www.cdc.gov/vaccines/covid-19/clinical-considerations/interim-considerations-us.html#covid-vaccines.

Current COVID-19 schedule and dosage formulation available at www.cdc.gov/covidschedule. For more information on Emergency Use Authorization (EUA) indications for COVID-19 vaccines, see www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/covid-19-vaccines

***Note:** Previously vaccinated is defined as having received any Original monovalent or bivalent COVID-19 vaccine (Janssen, Moderna, Novavax, Pfizer-BioNTech) prior to the updated 2023–2024 formulation.

****Note:** Persons who are moderately or severely immunocompromised have the option to receive one additional dose of updated (2023–2024 Formula) COVID-19 vaccine at least 2 months following the last recommended updated (2023–2024 Formula) COVID-19 vaccine dose. Further additional updated (2023–2024 Formula) COVID-19 vaccine dose(s) may be administered, informed by the clinical judgement of a healthcare provider and personal preference and circumstances. Any further additional doses should be administered at least 2 months after the last updated (2023–2024 Formula) COVID-19 vaccine dose. Moderately or severely immunocompromised children 6 months–4 years of age should receive homologous updated (2023–2024 Formula) mRNA vaccine dose(s) if they receive additional doses.

Dengue vaccination (minimum age: 9 years)

Routine vaccination

- Age 9–16 years living in areas with endemic dengue **AND** have laboratory confirmation of previous dengue infection
  - 3-dose series administered at 0, 6, and 12 months
- Endemic areas include Puerto Rico, American Samoa, US Virgin Islands, Federated States of Micronesia, Republic of Marshall Islands, and the Republic of Palau. For updated guidance on dengue endemic areas and pre-vaccination laboratory testing see www.cdc.gov/mmwr/volumes/70/rr/rr7006a1.htm?s_cid=rr7006a1_w and www.cdc.gov/dengue/vaccine/hcp/index.html
- Dengue vaccine should not be administered to children traveling to or visiting endemic dengue areas.

Diphtheria, tetanus, and pertussis (DTaP) vaccination (minimum age: 6 weeks [4 years for Kinrix® or Quadracel®])

Routine vaccination

- 5-dose series (3-dose primary series at age 2, 4, and 6 months, followed by a booster doses at ages 15–18 months and 4–6 years
  - **Prospectively:** Dose 4 may be administered as early as age 12 months if at least 6 months have elapsed since dose 3.
  - **Retrospectively:** A 4th dose that was inadvertently administered as early as age 12 months may be counted if at least 4 months have elapsed since dose 3.

Catch-up vaccination

- Dose 5 is not necessary if dose 4 was administered at age 4 years or older and at least 6 months after dose 3.
- For other catch-up guidance, see Table 2.

Special situations

- **Wound management** in children less than age 7 years with history of 3 or more doses of tetanus-toxoid-containing vaccine: For all wounds except clean and minor wounds, administer DTaP if more than 5 years since last dose of tetanus-toxoid-containing vaccine. For detailed information, see www.cdc.gov/mmwr/volumes/67/rr/rr6702a1.htm.

Haemophilus influenzae type b vaccination (minimum age: 6 weeks)

Routine vaccination

- **ActHIB®, Hiberix®, Pentacel®, or Vaxelis®:** 4-dose series (3-dose primary series at age 2, 4, and 6 months, followed by a booster dose* at age 12–15 months)
  - *Vaxelis® is not recommended for use as a booster dose. A different Hib-containing vaccine should be used for the booster dose.
- **PedvaxHIB®:** 3-dose series (2-dose primary series at age 2 and 4 months, followed by a booster dose at age 12–15 months)

Catch-up vaccination

- **Dose 1 at age 7–11 months:** Administer dose 2 at least 4 weeks later and dose 3 (final dose) at age12–15 months or 8 weeks after dose 2 (whichever is later).
- **Dose 1 at age 12–14 months:** Administer dose 2 (final dose) at least 8 weeks after dose 1.
- **Dose 1 before age 12 months and dose 2 before age 15 months:** Administer dose 3 (final dose) at least 8 weeks after dose 2.
- **2 doses of PedvaxHIB® before age 12 months:** Administer dose 3 (final dose) at age12–59 months and at least 8 weeks after dose 2.
- **1 dose administered at age 15 months or older:** No further doses needed
- **Unvaccinated at age 15–59 months:** Administer 1 dose.

Notes

Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger, United States, 2024

- **Previously unvaccinated children age 60 months or older who are not considered high risk:** Do not require catch-up vaccination

For other catch-up guidance, see Table 2. Vaxelis® can be used for catch-up vaccination in children less than age 5 years. Follow the catch-up schedule even if Vaxelis® is used for one or more doses. For detailed information on use of Vaxelis® see www.cdc.gov/mmwr/volumes/69/wr/mm6905a5.htm.

Special situations

- **Chemotherapy or radiation treatment:**
  Age 12–59 months
  - Unvaccinated or only 1 dose before age 12 months: 2 doses, 8 weeks apart
  - 2 or more doses before age 12 months: 1 dose at least 8 weeks after previous dose

  Doses administered within 14 days of starting therapy or during therapy should be repeated at least 3 months after therapy completion.
- **Hematopoietic stem cell transplant (HSCT):**
  - 3-dose series 4 weeks apart starting 6 to 12 months after successful transplant, regardless of Hib vaccination history
- **Anatomic or functional asplenia (including sickle cell disease):**
  Age 12–59 months
  - Unvaccinated or only 1 dose before age 12 months: 2 doses, 8 weeks apart
  - 2 or more doses before age 12 months: 1 dose at least 8 weeks after previous dose

  Unvaccinated* persons age 5 years or older
  - 1 dose
- **Elective splenectomy:**
  Unvaccinated* persons age 15 months or older
  - 1 dose (preferably at least 14 days before procedure)
- **HIV infection:**
  Age 12–59 months
  - Unvaccinated or only 1 dose before age 12 months: 2 doses, 8 weeks apart
  - 2 or more doses before age 12 months: 1 dose at least 8 weeks after previous dose

  Unvaccinated* persons age 5–18 years
  - 1 dose
- **Immunoglobulin deficiency, early component complement deficiency:**
  Age 12–59 months
  - Unvaccinated or only 1 dose before age 12 months: 2 doses, 8 weeks apart
  - 2 or more doses before age 12 months: 1 dose at least 8 weeks after previous dose

Unvaccinated* = Less than routine series (through age 14 months) **OR no doses (age 15 months or older)*

Hepatitis A vaccination
(minimum age: 12 months for routine vaccination)

Routine vaccination

- 2-dose series (minimum interval: 6 months) at age 12–23 months

Catch-up vaccination

- Unvaccinated persons through age 18 years should complete a 2-dose series (minimum interval: 6 months).
- Persons who previously received 1 dose at age 12 months or older should receive dose 2 at least 6 months after dose 1.
- Adolescents age 18 years or older may receive the combined HepA and HepB vaccine, **Twinrix®**, as a 3-dose series (0, 1, and 6 months) or 4-dose series (3 doses at 0, 7, and 21–30 days, followed by a booster dose at 12 months).

International travel

- Persons traveling to or working in countries with high or intermediate endemic hepatitis A (www.cdc.gov/travel/):
  - **Infants age 6–11 months**: 1 dose before departure; revaccinate with 2 doses (separated by at least 6 months) between age 12–23 months.
  - **Unvaccinated age 12 months or older**: Administer dose 1 as soon as travel is considered.

Hepatitis B vaccination
(minimum age: birth)

Routine vaccination

- 3-dose series at age 0, 1–2, 6–18 months **(use monovalent HepB vaccine for doses administered before age 6 weeks)**
  - Birth weight ≥2,000 grams: 1 dose within 24 hours of birth if medically stable
  - Birth weight <2,000 grams: 1 dose at chronological age 1 month or hospital discharge (whichever is earlier and even if weight is still <2,000 grams).
- Infants who did not receive a birth dose should begin the series as soon as possible (see Table 2 for minimum intervals).
- Administration of 4 doses is permitted when a combination vaccine containing HepB is used after the birth dose.
- **Minimum intervals (see Table 2):** when 4 doses are administered, substitute "dose 4" for "dose 3" in these calculations
- **Final (3rd or 4th) dose:** age 6–18 months **(minimum age 24 weeks)**
- **Mother is HBsAg-positive**
  - **Birth dose (monovalent HepB vaccine only):** administer **HepB vaccine** and **hepatitis B immune globulin (HBIG)** (in separate limbs) within 12 hours of birth, regardless of birth weight.
  - **Birth weight <2000 grams:** administer 3 additional doses of HepB vaccine beginning at age 1 month (total of 4 doses)
  - **Final (3rd or 4th) dose:** administer at age 6 months **(minimum age 24 weeks)**
  - Test for HBsAg and anti-HBs at age 9–12 months. If HepB series is delayed, test 1–2 months after final dose. Do not test before age 9 months.
- **Mother is HBsAg-unknown**

  If other evidence suggestive of maternal hepatitis B infection exists (e.g., presence of HBV DNA, HBeAg-positive, or mother known to have chronic hepatitis B infection), manage infant as if mother is HBsAg-positive
  - **Birth dose (monovalent HepB vaccine only):**
    - Birth weight ≥2,000 grams: administer **HepB vaccine** within 12 hours of birth. Determine mother's HBsAg status as soon as possible. If mother is determined to be HBsAg-positive, administer **HBIG** as soon as possible (in separate limb), but no later than 7 days of age.
    - Birth weight <2,000 grams: administer **HepB vaccine** and **HBIG** (in separate limbs) within 12 hours of birth. Administer 3 additional doses of **HepB vaccine** beginning at age 1 month (total of 4 doses)
  - **Final (3rd or 4th) dose:** administer at age 6 months **(minimum age 24 weeks)**
  - If mother is determined to be HBsAg-positive or if status remains unknown, test for HBsAg and anti-HBs at age 9–12 months. If HepB series is delayed, test 1–2 months after final dose. Do not test before age 9 months.

Catch-up vaccination

- Unvaccinated persons should complete a 3-dose series at 0, 1–2, 6 months. See Table 2 for minimum intervals
- Adolescents age 11–15 years may use an alternative 2-dose schedule with at least 4 months between doses (adult formulation **Recombivax HB®** only).
- Adolescents age 18 years may receive:
  - **Heplisav-B®:** 2-dose series at least 4 weeks apart
  - **PreHevbrio®:** 3-dose series at 0, 1, and 6 months
  - Combined HepA and HepB vaccine, **Twinrix®:** 3-dose series (0, 1, and 6 months) or 4-dose series (3 doses at 0, 7, and 21–30 days, followed by a booster dose at 12 months).

Notes

Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger, United States, 2024

Special situations

- Revaccination is not generally recommended for persons with a normal immune status who were vaccinated as infants, children, adolescents, or adults.
- **Post-vaccination serology testing and revaccination** (if anti-HBs <10mIU/mL) is recommended for certain populations, including:
  - Infants born to HBsAg-positive mothers
  - Persons who are predialysis or on maintenance dialysis
  - Other immunocompromised persons
  - For detailed revaccination recommendations, see www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/hepb.html.

Note: Heplisav-B and PreHevbrio are not recommended in pregnancy due to lack of safety data in pregnant persons

Human papillomavirus vaccination
(minimum age: 9 years)

Routine and catch-up vaccination

- HPV vaccination routinely recommended at **age 11–12 years (can start at age 9 years)** and catch-up HPV vaccination recommended for all persons through age 18 years if not adequately vaccinated
- 2- or 3-dose series depending on age at initial vaccination:
  - **Age 9–14 years at initial vaccination**: 2-dose series at 0, 6–12 months (minimum interval: 5 months; repeat dose if administered too soon)
  - **Age 15 years or older at initial vaccination**: 3-dose series at 0, 1–2 months, 6 months (minimum intervals: dose 1 to dose 2: 4 weeks / dose 2 to dose 3: 12 weeks / dose 1 to dose 3: 5 months; repeat dose if administered too soon)
- No additional dose recommended when any HPV vaccine series **of any valency** has been completed using recommended dosing intervals.

Special situations

- **Immunocompromising conditions, including HIV infection:** 3-dose series, even for those who initiate vaccination at age 9 through 14 years.
- **History of sexual abuse or assault:** Start at age 9 years
- **Pregnancy:** Pregnancy testing not needed before vaccination; HPV vaccination not recommended until after pregnancy; no intervention needed if vaccinated while pregnant

Influenza vaccination
(minimum age: 6 months [IIV], 2 years [LAIV4], 18 years [recombinant influenza vaccine, RIV4])

Routine vaccination

- Use any influenza vaccine appropriate for age and health status annually:
  - **Age 6 months–8 years** who have received **fewer** than 2 influenza vaccine doses before July 1, 2023, or whose influenza vaccination history is unknown: 2 doses, separated by at least 4 weeks. Administer dose 2 even if the child turns 9 years between receipt of dose 1 and dose 2.
  - **Age 6 months–8 years** who have received **at least** 2 influenza vaccine doses before July 1, 2023: 1 dose
  - **Age 9 years or older:** 1 dose
- For the 2023-2024 season, see www.cdc.gov/mmwr/volumes/72/rr/rr7202a1.htm.
- For the 2024–25 season, see the 2024–25 ACIP influenza vaccine recommendations.

Special situations

- **Close contacts (e.g., household contacts) of severely immunosuppressed persons who require a protected environment:** should not receive LAIV4. If LAIV4 is given, they should avoid contact with for such immunosuppressed persons for 7 days after vaccination.

Note: Persons with an egg allergy can receive any influenza vaccine (egg-based and non-egg-based) appropriate for age and health status.

Measles, mumps, and rubella vaccination
(minimum age: 12 months for routine vaccination)

Routine vaccination

- 2-dose series at age 12–15 months, age 4–6 years
- MMR or MMRV* may be administered

Note: For dose 1 in children age 12–47 months, it is recommended to administer MMR and varicella vaccines separately. MMRV* may be used if parents or caregivers express a preference.

Catch-up vaccination

- Unvaccinated children and adolescents: 2-dose series at least 4 weeks apart*
- The maximum age for use of MMRV* is 12 years.

Special situations

- **International travel**
  - **Infants age 6–11 months:** 1 dose before departure; revaccinate with 2-dose series at age 12–15 months (12 months for children in high-risk areas) and dose 2 as early as 4 weeks later.*
  - **Unvaccinated children age 12 months or older:** 2-dose series at least 4 weeks apart before departure*
- In mumps outbreak settings, for information about additional doses of MMR (including 3rd dose of MMR), see www.cdc.gov/mmwr/volumes/67/wr/mm6701a7.htm

***Note:** If MMRV is used, the minimum interval between MMRV doses is 3 months

Meningococcal serogroup A,C,W,Y vaccination
(minimum age: 2 months [MenACWY-CRM, Menveo], 2 years [MenACWY-TT, MenQuadfi]), 10 years [MenACWY-TT/MenB-FHbp, Penbraya])

Routine vaccination

- 2-dose series at age 11–12 years; 16 years

Catch-up vaccination

- Age 13–15 years: 1 dose now and booster at age 16–18 years (minimum interval: 8 weeks)
- Age 16–18 years: 1 dose

Special situations

Anatomic or functional asplenia (including sickle cell disease), HIV infection, persistent complement component deficiency, complement inhibitor (e.g., eculizumab, ravulizumab) use:

- **Menveo®***
  - Dose 1 at age 2 months: 4-dose series (additional 3 doses at age 4, 6, and 12 months)
  - Dose 1 at age 3–6 months: 3- or 4-dose series (dose 2 [and dose 3 if applicable] at least 8 weeks after previous dose until a dose is received at age 7 months or older, followed by an additional dose at least 12 weeks later and after age 12 months)
  - Dose 1 at age 7–23 months: 2-dose series (dose 2 at least 12 weeks after dose 1 and after age 12 months)
  - Dose 1 at age 24 months or older: 2-dose series at least 8 weeks apart
- **MenQuadfi®**
  - Dose 1 at age 24 months or older: 2-dose series at least 8 weeks apart

Notes

Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger, United States, 2024

Travel to countries with hyperendemic or epidemic meningococcal disease, including countries in the African meningitis belt or during the Hajj (www.cdc.gov/travel/)**:**

- Children less than age 24 months:
  - **Menveo®* (age 2–23 months)**
    - Dose 1 at age 2 months: 4-dose series (additional 3 doses at age 4, 6, and 12 months)
    - Dose 1 at age 3–6 months: 3- or 4-dose series (dose 2 [and dose 3 if applicable] at least 8 weeks after previous dose until a dose is received at age 7 months or older, followed by an additional dose at least 12 weeks later and after age 12 months)
    - Dose 1 at age 7–23 months: 2-dose series (dose 2 at least 12 weeks after dose 1 and after age 12 months)
- Children age 2 years or older: 1 dose Menveo®* or MenQuadfi®

First-year college students who live in residential housing (if not previously vaccinated at age 16 years or older) or military recruits:

- 1 dose **Menveo®*** or **MenQuadfi®**

Adolescent vaccination of children who received MenACWY prior to age 10 years:

- **Children for whom boosters are recommended** because of an ongoing increased risk of meningococcal disease (e.g., those with complement component deficiency, HIV, or asplenia): Follow the booster schedule for persons at increased risk.
- **Children for whom boosters are not recommended** (e.g., a healthy child who received a single dose for travel to a country where meningococcal disease is endemic): Administer MenACWY according to the recommended adolescent schedule with dose 1 at age 11–12 years and dose 2 at age 16 years.

**Menveo has two formulations: lyophilized and liquid. The liquid formulation should not be used before age 10 years. See www.cdc.gov/vaccines/vpd/mening/downloads/menveo-single-vial-presentation.pdf.*

Note: For MenACWY **booster dose recommendations** for groups listed under "Special situations" and in an outbreak setting and additional meningococcal vaccination information, see www.cdc.gov/mmwr/volumes/69/rr/rr6909a1.htm.

Children age 10 years or older may receive a single dose of Penbraya™ as an alternative to separate administration of MenACWY and MenB when both vaccines would be given on the same clinic day (see "Meningococcal serogroup B vaccination" section below for more information).

Meningococcal serogroup B vaccination (minimum age: 10 years [MenB-4C, Bexsero®; MenB-FHbp, Trumenba®; MenACWY-TT/MenB-FHbp, Penbraya™])

Shared clinical decision-making

- **Adolescents not at increased risk** age 16–23 years (preferred age 16–18 years) based on shared clinical decision-making:
  - **Bexsero®:** 2-dose series at least 1 month apart
  - **Trumenba®:** 2-dose series at least 6 months apart (if dose 2 is administered earlier than 6 months, administer a 3rd dose at least 4 months after dose 2)

For additional information on shared clinical decision-making for MenB, see www.cdc.gov/vaccines/hcp/admin/downloads/isd-job-aid-scdm-mening-b-shared-clinical-decision-making.pdf

Special situations

Anatomic or functional asplenia (including sickle cell disease), persistent complement component deficiency, complement inhibitor (e.g., eculizumab, ravulizumab) use:

- **Bexsero®:** 2-dose series at least 1 month apart
- **Trumenba®:** 3-dose series at 0, 1–2, 6 months (if dose 2 was administered at least 6 months after dose 1, dose 3 not needed; if dose 3 is administered earlier than 4 months after dose 2, a 4th dose should be administered at least 4 months after dose 3)

Note: Bexsero® and **Trumenba®** are not interchangeable; the same product should be used for all doses in a series.

For MenB **booster dose recommendations** for groups listed under "Special situations" and in an outbreak setting and additional meningococcal vaccination information, see www.cdc.gov/mmwr/volumes/69/rr/rr6909a1.htm.

Children age 10 years or older may receive a dose of Penbraya™ as an alternative to separate administration of MenACWY and MenB when both vaccines would be given on the same clinic day. For age-eligible children not at increased risk, if Penbraya™ is used for dose 1 MenB, MenB-FHbp (Trumenba) should be administered for dose 2 MenB. For age-eligible children at increased risk of meningococcal disease, Penbraya™ may be used for additional MenACWY and MenB doses (including booster doses) if both would be given on the same clinic day **and** at least 6 months have elapsed since most recent Penbraya™ dose.

Mpox vaccination (minimum age: 18 years [Jynneos®])

Special situations

- **Age 18 years and at risk for Mpox infection:** 2-dose series, 28 days apart.

  Risk factors for Mpox infection include:
  - Persons who are gay, bisexual, and other MSM, transgender or nonbinary people who in the past 6 months have had:
    - A new diagnosis of at least 1 sexually transmitted disease
    - More than 1 sex partner
    - Sex at a commercial sex venue
    - Sex in association with a large public event in a geographic area where Mpox transmission is occurring
  - Persons who are sexual partners of the persons described above
  - Persons who anticipate experiencing any of the situations described above
- **Pregnancy:** There is currently no ACIP recommendation for Jynneos use in pregnancy due to lack of safety data in pregnant persons. Pregnant persons with any risk factor described above may receive Jynneos.

For detailed information, see: www.cdc.gov/vaccines/acip/meetings/downloads/slides-2023-10-25-26/04-MPOX-Rao-508.pdf

Pneumococcal vaccination (minimum age: 6 weeks [PCV15], [PCV 20]; 2 years [PPSV23])

Routine vaccination with PCV

- 4-dose series at 2, 4, 6, 12–15 months

Catch-up vaccination with PCV

- Healthy children ages 2–4 years with any incomplete* PCV series: 1 dose PCV
- For other catch-up guidance, see Table 2.

Note: For children **without** risk conditions, PCV20 is not indicated if they have received 4 doses of PCV13 or PCV15 or another age appropriate complete PCV series.

Notes

Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger, United States, 2024

Special situations

Children and adolescents with cerebrospinal fluid leak; chronic heart disease; chronic kidney disease (excluding maintenance dialysis and nephrotic syndrome); chronic liver disease; chronic lung disease (including moderate persistent or severe persistent asthma); cochlear implant; or diabetes mellitus:

Age 2–5 years

- Any incomplete* PCV series with:
  - 3 PCV doses: 1 dose PCV (at least 8 weeks after the most recent PCV dose)
  - Less than 3 PCV doses: 2 doses PCV (at least 8 weeks after the most recent dose and administered at least 8 weeks apart)
- Completed recommended PCV series but have not received PPSV23
  - Previously received at least 1 dose of PCV20: no further PCV or PPSV23 doses needed
  - Not previously received PCV20: administer 1 dose PCV20 OR 1 dose PPSV23 administer at least 8 weeks after the most recent PCV dose.

Age 6–18 years

- Not previously received any dose of PCV13, PCV15, or PCV20: administer 1 dose of PCV15 or PCV20. If PCV15 is used and no previous receipt of PPSV23, administer 1 dose of PPSV23 at least 8 weeks after the PCV15 dose.**
- Received PCV before age 6 years but have not received PPSV23
  - Previously received at least 1 dose of PCV20: no further PCV or PPSV23 doses needed
  - Not previously received PCV20: 1 dose PCV20 OR 1 dose PPSV23 administer at least 8 weeks after the most recent PCV dose.
- Received PCV13 only at or after age 6 years: administer 1 dose PCV20 OR 1 dose PPSV23 at least 8 weeks after the most recent PCV13 dose.
- Received 1 dose PCV13 and 1 dose PPSV23 at or after age 6 years: no further doses of any PCV or PPSV23 indicated.

Children and adolescents on maintenance dialysis, or with immunocompromising conditions such as nephrotic syndrome; congenital or acquired asplenia or splenic dysfunction; congenital or acquired immunodeficiencies; diseases and conditions treated with immunosuppressive drugs or radiation therapy, including malignant neoplasms, leukemias, lymphomas, Hodgkin disease, and solid organ transplant; HIV infection; or sickle cell disease or other hemoglobinopathies:

Age 2–5 years

- Any incomplete* PCV series:
  - 3 PCV doses: 1 dose PCV (at least 8 weeks after the most recent PCV dose)
  - Less than 3 PCV doses: 2 doses PCV (at least 8 weeks after the most recent dose and administered at least 8 weeks apart)
- Completed recommended PCV series but have not received PPSV23
  - Previously received at least 1 dose of PCV20: no further PCV or PPSV23 doses needed
  - Not previously received PCV20: administer 1 dose PCV20 OR 1 dose PPSV23 at least 8 weeks after the most recent PCV dose. If PPSV23 is used, administer 1 dose of PCV20 or dose 2 PPSV23 at least 5 years after dose 1 PPSV23.

Age 6–18 years

- Not previously received any dose of PCV13, PCV15, or PCV20: administer 1 dose of PCV15 or 1 dose of PCV20. If PCV15 is used and no previous receipt of PPSV23, administer 1 dose of PPSV23 at least 8 weeks after the PCV15 dose.**
- Received PCV before age 6 years but have not received PPSV23
  - Previously received at least 1 dose of PCV20: no additional dose of PCV or PPSV23
  - Not previously received PCV20: administer 1 dose PCV20 OR 1 dose PPSV23 at least 8 weeks after the most recent PCV dose. If PPSV23 is used, administer either PCV20 or dose 2 PPSV23 at least 5 years after dose 1 PPSV23.
- Received PCV13 only at or after age 6 years: administer 1 dose PCV20 OR 1 dose PPSV23 at least 8 weeks after the most recent PCV13 dose. If PPSV23 is used, administer 1 dose of PCV20 or dose 2 PPSV23 at least 5 years after dose 1 PPSV23.
- Received 1 dose PCV13 and 1 dose PPSV23 at or after age 6 years: administer 1 dose PCV20 OR 1 dose PPSV23 at least 8 weeks after the most recent PCV13 dose and at least 5 years after dose 1 PPSV23.

**Incomplete series* = Not having received all doses in either the recommended series or an age-appropriate catch-up series. See Table 2 in ACIP pneumococcal recommendations at stacks.cdc.gov/view/cdc/133252

***When both PCV15 and PPSV23 are indicated, administer all doses of PCV15 first. PCV15 and PPSV23 should not be administered during the same visit.*

For guidance on determining which pneumococcal vaccines a patient needs and when, please refer to the mobile app, which can be downloaded here: www.cdc.gov/vaccines/vpd/pneumo/hcp/pneumoapp.html

Poliovirus vaccination
(minimum age: 6 weeks)

Routine vaccination

- 4-dose series at ages 2, 4, 6–18 months, 4–6 years; administer the final dose on or after age 4 years and at least 6 months after the previous dose.
- 4 or more doses of IPV can be administered before age 4 years when a combination vaccine containing IPV is used. However, a dose is still recommended on or after age 4 years and at least 6 months after the previous dose.

Catch-up vaccination

- In the first 6 months of life, use minimum ages and intervals only for travel to a polio-endemic region or during an outbreak.
- **Adolescents age 18 years known or suspected to be unvaccinated or incompletely vaccinated:** administer remaining doses (1, 2, or 3 IPV doses) to complete a 3-dose primary series.* Unless there are specific reasons to believe they were not vaccinated, most persons aged 18 years or older born and raised in the United States can assume they were vaccinated against polio as children.

Series containing oral poliovirus vaccine (OPV), either mixed OPV-IPV or OPV-only series:

- Total number of doses needed to complete the series is the same as that recommended for the U.S. IPV schedule. See www.cdc.gov/mmwr/volumes/66/wr/mm6601a6.htm?s_%20cid=mm6601a6_w.
- Only trivalent OPV (tOPV) counts toward the U.S. vaccination requirements.
  - Doses of OPV administered before April 1, 2016, should be counted (unless specifically noted as administered during a campaign).
  - Doses of OPV administered on or after April 1, 2016, should not be counted.
  - For guidance to assess doses documented as "OPV," see www.cdc.gov/mmwr/volumes/66/wr/mm6606a7.htm?s_cid=mm6606a7_w.
- For other catch-up guidance, see Table 2.

Notes

Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger, United States, 2024

Special situations

- **Adolescents aged 18 years at increased risk of exposure to poliovirus and completed primary series*:** may administer one lifetime IPV booster

***Note:** Complete primary series consist of at least 3 doses of IPV or trivalent oral poliovirus vaccine (tOPV) in any combination.

For detailed information, see: www.cdc.gov/vaccines/vpd/polio/hcp/recommendations.html

Respiratory syncytial virus immunization (minimum age: birth [Nirsevimab, RSV-mAb (Beyfortus™)

Routine immunization

- **Infants born October – March in most of the continental United States***
  - Mother did not receive RSV vaccine OR mother's RSV vaccination status is unknown: administer 1 dose nirsevimab within 1 week of birth in hospital or outpatient setting
  - Mother received RSV vaccine **less than 14 days** prior to delivery: administer 1 dose nirsevimab within 1 week of birth in hospital or outpatient setting
  - Mother received RSV vaccine **at least 14 days** prior to delivery: nirsevimab not needed but can be considered in rare circumstances at the discretion of healthcare providers (see special populations and situations at www.cdc.gov/vaccines/vpd/rsv/hcp/child-faqs.html)
- **Infants born April–September in most of the continental United States***
  - Mother did not receive RSV vaccine OR mother's RSV vaccination status is unknown: administer 1 dose nirsevimab shortly before start of RSV season*
  - Mother received RSV vaccine **less than 14 days** prior to delivery: administer 1 dose nirsevimab shortly before start of RSV season*
  - Mother received RSV vaccine **at least 14 days** prior to delivery: nirsevimab not needed but can be considered in rare circumstances at the discretion of healthcare providers(see special populations and situations at www.cdc.gov/vaccines/vpd/rsv/hcp/child-faqs.html)

Infants with prolonged birth hospitalization** (e.g., for prematurity) discharged October through March should be immunized shortly before or promptly after discharge.

Special situations

- **Ages 8–19 months with chronic lung disease of prematurity requiring medical support (e.g., chronic corticosteroid therapy, diuretic therapy, or supplemental oxygen) any time during the 6-month period before the start of the second RSV season; severe immunocompromise; cystic fibrosis with either weight for length <10th percentile or manifestation of severe lung disease (e.g., previous hospitalization for pulmonary exacerbation in the first year of life or abnormalities on chest imaging that persist when stable)**:**
  - 1 dose nirsevimab shortly before start of second RSV season*
- **Ages 8–19 months who are American Indian or Alaska Native:**
  - 1 dose nirsevimab shortly before start of second RSV season*
- **Age-eligible and undergoing cardiac surgery with cardiopulmonary bypass**:** 1 additional dose of nirsevimab after surgery. For additional details see special populations and situations at www.cdc.gov/vaccines/vpd/rsv/hcp/child-faqs.html

***Note:** While the timing of the onset and duration of RSV season may vary, nirsevimab may be administered October through March in most of the continental United States. Providers in jurisdictions with RSV seasonality that differs from most of the continental United States (e.g., Alaska, jurisdiction with tropical climate) should follow guidance from public health authorities (e.g., CDC, health departments) or regional medical centers on timing of administration based on local RSV seasonality. Although optimal timing of administration is just before the start of the RSV season, nirsevimab may also be administered during the RSV season to infants and children who are age-eligible.

****Note:** Nirsevimab can be administered to children who are eligible to receive palivizumab. Children who have received nirsevimab should not receive palivizumab for the same RSV season.

For further guidance, see www.cdc.gov/mmwr/volumes/72/wr/mm7234a4.htm and www.cdc.gov/vaccines/vpd/rsv/hcp/child-faqs.html

Respiratory syncytial virus vaccination (RSV [Abrysvo™])

Routine vaccination

- **Pregnant at 32 weeks 0 days through 36 weeks and 6 days gestation from September through January in most of the continental United States*:** 1 dose RSV vaccine (Abrysvo™). Administer RSV vaccine regardless of previous RSV infection.
  - Either maternal RSV vaccination or infant immunization with nirsevimab (RSV monoclonal antibody) is recommended to prevent respiratory syncytial virus lower respiratory tract infection in infants.
- **All other pregnant persons:** RSV vaccine not recommended.

There is currently no ACIP recommendation for RSV vaccination in subsequent pregnancies. No data are available to inform whether additional doses are needed in later pregnancies.

***Note:** Providers in jurisdictions with RSV seasonality that differs from most of the continental United States (e.g., Alaska, jurisdiction with tropical climate) should follow guidance from public health authorities (e.g., CDC, health departments) or regional medical centers on timing of administration based on local RSV seasonality.

Rotavirus vaccination (minimum age: 6 weeks)

Routine vaccination

- **Rotarix®:** 2-dose series at age 2 and 4 months
- **RotaTeq®:** 3-dose series at age 2, 4, and 6 months
- If any dose in the series is either **RotaTeq®** or unknown, default to 3-dose series.

Catch-up vaccination

- Do not start the series on or after age 15 weeks, 0 days.
- The maximum age for the final dose is 8 months, 0 days.
- For other catch-up guidance, see Table 2.

Notes

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Tetanus, diphtheria, and pertussis (Tdap) vaccination
(minimum age: 11 years for routine vaccination, 7 years for catch-up vaccination)

Routine vaccination

- **Age 11–12 years:** 1 dose Tdap (adolescent booster)
- **Pregnancy:** 1 dose Tdap during each pregnancy, preferably in early part of gestational weeks 27–36.

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

Catch-up vaccination

- **Age 13–18 years who have not received Tdap:** 1 dose Tdap (adolescent booster)
- **Age 7–18 years not fully vaccinated* with DTaP:** 1 dose Tdap as part of the catch-up series (preferably the first dose); if additional doses are needed, use Td or Tdap.
- **Tdap administered at age 7–10 years:**
  - **Age 7–9 years** who receive Tdap should receive the adolescent Tdap booster dose at age 11–12 years.
  - **Age 10 years** who receive Tdap do not need the adolescent Tdap booster dose at age 11–12 years.
- **DTaP inadvertently administered on or after age 7 years**:
  - **Age 7–9 years**: DTaP may count as part of catch-up series. Administer adolescent Tdap booster dose at age 11–12 years.
  - **Age 10–18 years**: Count dose of DTaP as the adolescent Tdap booster dose.
- For other catch-up guidance, see Table 2.

Special situations

- **Wound management** in persons age 7 years or older with history of 3 or more doses of tetanus-toxoid-containing vaccine: For clean and minor wounds, administer Tdap or Td if more than 10 years since last dose of tetanus-toxoid-containing vaccine; for all other wounds, administer Tdap or Td if more than 5 years since last dose of tetanus-toxoid-containing vaccine. Tdap is preferred for persons age 11 years or older who have not previously received Tdap or whose Tdap history is unknown. If a tetanus-toxoid-containing vaccine is indicated for a pregnant adolescent, use Tdap.
- For detailed information, see www.cdc.gov/mmwr/volumes/69/wr/mm6903a5.htm.

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

Varicella vaccination
(minimum age: 12 months)

Routine vaccination

- 2-dose series at age 12–15 months, 4–6 years
- VAR or MMRV may be administered*
- Dose 2 may be administered as early as 3 months after dose 1 (a dose inadvertently administered after at least 4 weeks may be counted as valid)

***Note**: For dose 1 in children age 12–47 months, it is recommended to administer MMR and varicella vaccines separately. MMRV may be used if parents or caregivers express a preference.

Catch-up vaccination

- Ensure persons age 7–18 years without evidence of immunity (see *MMWR* at www.cdc.gov/mmwr/pdf/rr/rr5604.pdf) have a 2-dose series:
  - **Age 7–12 years**: Routine interval: 3 months (a dose inadvertently administered after at least 4 weeks may be counted as valid)
  - **Age 13 years and older**: Routine interval: 4–8 weeks (minimum interval: 4 weeks)
  - The maximum age for use of *MMRV* is 12 years.

Appendix

Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger, United States, 2024

Guide to Contraindications and Precautions to Commonly Used Vaccines

Adapted from Table 4-1 in Advisory Committee on Immunization Practices (ACIP) General Best Practice Guidelines for Immunization: Contraindication and Precautions, Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of the Advisory Committee on Immunization Practices—United States, 2023–24 Influenza Season | MMWR (cdc.gov), Contraindications and Precautions for COVID-19 Vaccination, and Contraindications and Precautions for JYNNEOS Vaccination

Vaccines and other Immunizing Agents	Contraindicated or Not Recommended[1]	Precautions[2]
COVID-19 mRNA vaccines [Pfizer-BioNTech, Moderna]	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a component of an mRNA COVID-19 vaccine[4]	• Diagnosed non-severe allergy (e.g., urticaria beyond the injection site) to a component of an mRNA COVID-19 vaccine[4]; or non-severe, immediate (onset less than 4 hours) allergic reaction after administration of a previous dose of an mRNA COVID-19 vaccine • Myocarditis or pericarditis within 3 weeks after a dose of any COVID-19 vaccine • Multisystem inflammatory syndrome in children (MIS-C) or multisystem inflammatory syndrome in adults (MIS-A) • Moderate or severe acute illness, with or without fever
COVID-19 protein subunit vaccine [Novavax]	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a component of a Novavax COVID-19 vaccine[4]	• Diagnosed non-severe allergy (e.g., urticaria beyond the injection site) to a component of Novavax COVID-19 vaccine[4]; or non-severe, immediate (onset less than 4 hours) allergic reaction after administration of a previous dose of a Novavax COVID-19 vaccine • Myocarditis or pericarditis within 3 weeks after a dose of any COVID-19 vaccine • Multisystem inflammatory syndrome in children (MIS-C) or multisystem inflammatory syndrome in adults (MIS-A) • Moderate or severe acute illness, with or without fever
Influenza, egg-based, inactivated injectable (IIV4)	• Severe allergic reaction (e.g., anaphylaxis) after previous dose of any influenza vaccine (i.e., any egg-based IIV, ccIIV, RIV, or LAIV of any valency) • Severe allergic reaction (e.g., anaphylaxis) to any vaccine component[3] (excluding egg)	• Guillain-Barré syndrome (GBS) within 6 weeks after a previous dose of any type of influenza vaccine • Moderate or severe acute illness with or without fever
Influenza, cell culture-based inactivated injectable (ccIIV4) [Flucelvax Quadrivalent]	• Severe allergic reaction (e.g., anaphylaxis) to any ccIIV of any valency, or to any component[3] of ccIIV4	• Guillain-Barré syndrome (GBS) within 6 weeks after a previous dose of any type of influenza vaccine • Persons with a history of severe allergic reaction (e.g., anaphylaxis) after a previous dose of any egg-based IIV, RIV, or LAIV of any valency. If using ccIV4, administer in medical setting under supervision of health care provider who can recognize and manage severe allergic reactions. May consult an allergist. • Moderate or severe acute illness with or without fever
Influenza, recombinant injectable (RIV4) [Flublok Quadrivalent]	• Severe allergic reaction (e.g., anaphylaxis) to any RIV of any valency, or to any component[3] of RIV4	• Guillain-Barré syndrome (GBS) within 6 weeks after a previous dose of any type of influenza vaccine • Persons with a history of severe allergic reaction (e.g., anaphylaxis) after a previous dose of any egg-based IIV, ccIIV, or LAIV of any valency. If using RIV4, administer in medical setting under supervision of health care provider who can recognize and manage severe allergic reactions. May consult an allergist. • Moderate or severe acute illness with or without fever
Influenza, live attenuated (LAIV4) [Flumist Quadrivalent]	• Severe allergic reaction (e.g., anaphylaxis) after previous dose of any influenza vaccine (i.e., any egg-based IIV, ccIIV, RIV, or LAIV of any valency) • Severe allergic reaction (e.g., anaphylaxis) to any vaccine component[3] (excluding egg) • Children age 2–4 years with a history of asthma or wheezing • Anatomic or functional asplenia • Immunocompromised due to any cause including, but not limited to, medications and HIV infection • Close contacts or caregivers of severely immunosuppressed persons who require a protected environment • Pregnancy • Cochlear implant • Active communication between the cerebrospinal fluid (CSF) and the oropharynx, nasopharynx, nose, ear or any other cranial CSF leak • Children and adolescents receiving aspirin or salicylate-containing medications • Received influenza antiviral medications oseltamivir or zanamivir within the previous 48 hours, peramivir within the previous 5 days, or baloxavir within the previous 17 days	• Guillain-Barré syndrome (GBS) within 6 weeks after a previous dose of any type of influenza vaccine • Asthma in persons age 5 years old or older • Persons with underlying medical conditions other than those listed under contraindications that might predispose to complications after wild-type influenza virus infection, e.g., chronic pulmonary, cardiovascular (except isolated hypertension), renal, hepatic, neurologic, hematologic, or metabolic disorders (including diabetes mellitus) • Moderate or severe acute illness with or without fever

1. When a contraindication is present, a vaccine should **NOT** be administered. Kroger A, Bahta L, Hunter P. ACIP General Best Practice Guidelines for Immunization.
2. When a precaution is present, vaccination should generally be deferred but might be indicated if the benefit of protection from the vaccine outweighs the risk for an adverse reaction. Kroger A, Bahta L, Hunter P. ACIP General Best Practice Guidelines for Immunization.
3. Vaccination providers should check FDA-approved prescribing information for the most complete and updated information, including contraindications, warnings, and precautions. See Package inserts for U.S.-licensed vaccines.
4. See package inserts and FDA EUA fact sheets for a full list of vaccine ingredients. mRNA COVID-19 vaccines contain polyethylene glycol (PEG).

Appendix

Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger, United States, 2024

Vaccines and other Immunizing Agents	Contraindicated or Not Recommended[1]	Precautions[2]
Dengue (DEN4CYD)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • Severe immunodeficiency (e.g., hematologic and solid tumors, receipt of chemotherapy, congenital immunodeficiency, long-term immunosuppressive therapy or patients with HIV infection who are severely immunocompromised) • Lack of laboratory confirmation of a previous Dengue infection	• Pregnancy • HIV infection without evidence of severe immunosuppression • Moderate or severe acute illness with or without fever
Diphtheria, tetanus, pertussis (DTaP)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • For DTaP only: Encephalopathy (e.g., coma, decreased level of consciousness, prolonged seizures) not attributable to another identifiable cause within 7 days of administration of previous dose of DTP or DTaP	• Guillain-Barré syndrome (GBS) within 6 weeks after previous dose of tetanus-toxoid–containing vaccine • History of Arthus-type hypersensitivity reactions after a previous dose of diphtheria-toxoid–containing or tetanus-toxoid–containing vaccine; defer vaccination until at least 10 years have elapsed since the last tetanus-toxoid–containing vaccine • For DTaP only: Progressive neurologic disorder, including infantile spasms, uncontrolled epilepsy, progressive encephalopathy; defer DTaP until neurologic status clarified and stabilized • Moderate or severe acute illness with or without fever
Haemophilus influenzae type b (Hib)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • Less than age 6 weeks	• Moderate or severe acute illness with or without fever
Hepatitis A (HepA)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] including neomycin	• Moderate or severe acute illness with or without fever
Hepatitis B (HepB)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] including yeast • *Pregnancy: Heplisav-B and PreHevbrio are not recommended due to lack of safety data in pregnant persons. Use other hepatitis B vaccines if HepB is indicated[4].*	• Moderate or severe acute illness with or without fever
Hepatitis A-Hepatitis B vaccine (HepA-HepB) [Twinrix]	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] including neomycin and yeast	• Moderate or severe acute illness with or without fever
Human papillomavirus (HPV)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • *Pregnancy: HPV vaccination not recommended.*	• Moderate or severe acute illness with or without fever
Measles, mumps, rubella (MMR) Measles, mumps, rubella, and varicella (MMRV)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • Severe immunodeficiency (e.g., hematologic and solid tumors, receipt of chemotherapy, congenital immunodeficiency, long-term immunosuppressive therapy or patients with HIV infection who are severely immunocompromised) • Pregnancy • Family history of altered immunocompetence, unless verified clinically or by laboratory testing as immunocompetent	• Recent (≤11 months) receipt of antibody-containing blood product (specific interval depends on product) • History of thrombocytopenia or thrombocytopenic purpura • Need for tuberculin skin testing or interferon-gamma release assay (IGRA) testing • Moderate or severe acute illness with or without fever • For MMRV only: Personal or family (i.e., sibling or parent) history of seizures of any etiology
Meningococcal ACWY (MenACWY) MenACWY-CRM [Menveo] MenACWY-TT [MenQuadfi]	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • For Men ACWY-CRM only: severe allergic reaction to any diphtheria toxoid—or CRM197—containing vaccine • For MenACWY-TT only: severe allergic reaction to a tetanus toxoid-containing vaccine	• For MenACWY-CRM only: Preterm birth if less than age 9 months • Moderate or severe acute illness with or without fever
Meningococcal B (MenB) MenB-4C [Bexsero] MenB-FHbp [Trumenba]	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3]	• Pregnancy • For MenB-4C only: Latex sensitivity • Moderate or severe acute illness with or without fever
Meningococcal ABCWY (MenACWY-TT/MenB-FHbp) [Penbraya]	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • Severe allergic reaction to a tetanus toxoid-containing vaccine	• Moderate or severe acute illness, with or without fever
Mpox [Jynneos]	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3]	• Moderate or severe acute illness, with or without fever
Pneumococcal conjugate (PCV)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • Severe allergic reaction (e.g., anaphylaxis) to any diphtheria-toxoid-containing vaccine or its component[3]	• Moderate or severe acute illness with or without fever
Pneumococcal polysaccharide (PPSV23)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3]	• Moderate or severe acute illness with or without fever
Poliovirus vaccine, inactivated (IPV)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3]	• Pregnancy • Moderate or severe acute illness with or without fever
RSV monoclonal antibody (RSV-mAb)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[5]	• Moderate or severe acute illness with or without fever
Respiratory syncytial virus vaccine (RSV)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3]	• Moderate or severe acute illness with or without fever
Rotavirus (RV) RV1 [Rotarix] RV5 [RotaTeq]	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • Severe combined immunodeficiency (SCID) • History of intussusception	• Altered immunocompetence other than SCID • Chronic gastrointestinal disease • RV1 only: Spina bifida or bladder exstrophy • Moderate or severe acute illness with or without fever
Tetanus, diphtheria, and acellular pertussis (Tdap) Tetanus, diphtheria (Td)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • For Tdap only: Encephalopathy (e.g., coma, decreased level of consciousness, prolonged seizures) not attributable to another identifiable cause within 7 days of administration of previous dose of DTP, DTaP, or Tdap	• Guillain-Barré syndrome (GBS) within 6 weeks after a previous dose of tetanus-toxoid–containing vaccine • History of Arthus-type hypersensitivity reactions after a previous dose of diphtheria-toxoid–containing or tetanus-toxoid–containing vaccine; defer vaccination until at least 10 years have elapsed since the last tetanus-toxoid–containing vaccine • For Tdap only: Progressive or unstable neurological disorder, uncontrolled seizures, or progressive encephalopathy until a treatment regimen has been established and the condition has stabilized • Moderate or severe acute illness with or without fever
Varicella (VAR)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • Severe immunodeficiency (e.g., hematologic and solid tumors, receipt of chemotherapy, congenital immunodeficiency, long-term immunosuppressive therapy or patients with HIV infection who are severely immunocompromised) • Pregnancy • Family history of altered immunocompetence, unless verified clinically or by laboratory testing as immunocompetent	• Recent (≤11 months) receipt of antibody-containing blood product (specific interval depends on product) • Receipt of specific antiviral drugs (acyclovir, famciclovir, or valacyclovir) 24 hours before vaccination (avoid use of these antiviral drugs for 14 days after vaccination) • Use of aspirin or aspirin-containing products • Moderate or severe acute illness with or without fever • If using MMRV, see MMR/MMRV for additional precautions

1. When a contraindication is present, a vaccine should NOT be administered. Kroger A, Bahta L, Hunter P. ACIP General Best Practice Guidelines for Immunization. www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html
2. When a precaution is present, vaccination should generally be deferred but might be indicated if the benefit of protection from the vaccine outweighs the risk for an adverse reaction. Kroger A, Bahta L, Hunter P. ACIP General Best Practice Guidelines for Immunization. www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html
3. Vaccination providers should check FDA-approved prescribing information for the most complete and updated information, including contraindications, warnings, and precautions. Package inserts for U.S.-licensed vaccines are available at www.fda.gov/vaccines-blood-biologics/approved-products/vaccines-licensed-use-united-states.
4. For information on the pregnancy exposure registries for persons who were inadvertently vaccinated with Heplisav-B or PreHevbrio while pregnant, please visit heplisavbpregnancyregistry.com or www.prehevbrio.com/#safety.
5. Full prescribing information for BEYFORTUS (nirsevimab-alip) www.accessdata.fda.gov/drugsatfda_docs/label/2023/761328s000lbl.pdf

Addendum Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger, United States, 2024

In addition to the recommendations presented in the previous sections of this immunization schedule, ACIP has approved the following recommendations by majority vote since October 26, 2023. The following recommendations have been adopted by the CDC Director and are now official. Links are provided if these recommendations have been published in *Morbidity and Mortality Weekly Report (MMWR)*.

Vaccines	Recommendations	Effective Date of Recommendation*
No new vaccines or vaccine recommendations to report		

*The effective date is the date when the CDC director adopted the recommendation and when the ACIP recommendation became official.

Skills Checklist – Unlicensed School Health Personnel

_____School District

Name:_____ School:_____ School Nurse:_____ Year:_

Routine Skills	Date	S	N	N/A
Completion of Certified First Aid or First Responder Course (repeat every two years)				
Current CPR Certification (every two years)				
Adheres to universal precautions and infection control techniques				
Verbalizes understanding of job description and chain of command within the school setting				
Knows when to call for assistance/consult with school nurse				
Maintains student confidentiality				
Communicates effectively with students, staff, parents and school nurse				
Knows school emergency plans and procedures				
Demonstrates ability to triage students				
Assesses temperature, using proper technique				
Uses first aid measures appropriately				
Demonstrates proper medication administration (the Five Rights)				
Demonstrates proper medication storage and record-keeping				
Maintains up-to-date clinic/emergency cards				
Documents appropriately (daily log, incident reports, medication forms, etc.)				
Maintains organized and clean health room				
Submits requested paperwork and monthly reports, complete and in a timely manner				
Completes the special needs list for student population				
Recognizes signs of child abuse and knows appropriate reporting procedures				
Uses appropriate resources for referrals				
Attends inservices provided by school district				

Code: S= Satisfactory N=Needs further education/practice N/A=Not applicable

Special Skills	Date	S	N	N/A
Demonstrates ability to recognize signs and symptoms of respiratory distress/asthma exacerbation and begins appropriate intervention				
Knows how to properly deliver nebulizer treatments and assist with inhaled medications				
Demonstrates ability to recognize the signs and symptoms of hypo- and hyperglycemia and begins appropriate intervention				
Demonstrates ability to recognize signs and symptoms of a seizure and begins appropriate intervention				
Is able to verbalize and demonstrate appropriate use of an Epi-pen				
Knows role in screening of students, as appropriate				
Vision				
Hearing				
Scoliosis				
Height and Weight				

Code: S= Satisfactory N=Needs further education/practice N/A=Not applicable

Comments:

Issues/ skills to work on:

Signatures:

School employee___ School Nurse_____

Principal____ Date_