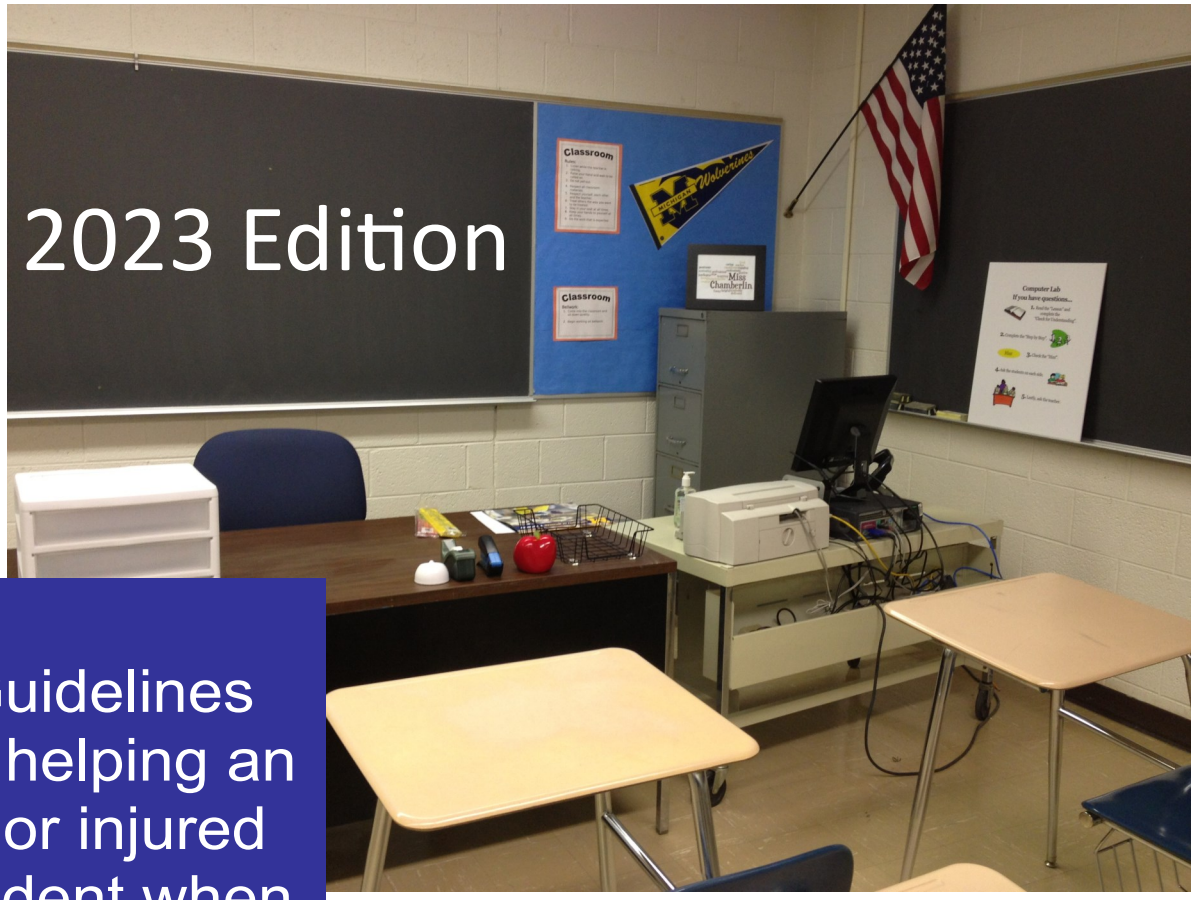
Emergency Guidelines For Nebraska Schools



Guidelines for helping an ill or injured student when the school nurse is not available.

Nebraska EMSC
Emergency Medical Services for Children

EMERGENCY PHONE NUMBERS

EMERGENCY MEDICAL SERVICES (EMS) INFORMATION

Know how to contact your EMS. Most areas use 9-1-1; others use a 7-digit phone number.

+ **EMERGENCY PHONE NUMBER: 9-1-1 OR** _____

+ Name of EMS agency _____

+ Their average emergency response time to your school _____

+ Directions to your school _____

_____

+ Location of the school's AED(s) _____

BE PREPARED TO GIVE THE FOLLOWING INFORMATION & DO NOT HANG UP BEFORE THE EMERGENCY DISPATCHER HANGS UP:

- Name and school name _____
- School telephone number _____
- Address and easy directions _____
- Nature of emergency _____
- Exact location of injured person (e.g., behind building in parking lot) _____
- Help already given _____
- Ways to make it easier to find you (e.g., standing in front of building, red flag, etc.).

OTHER IMPORTANT PHONE NUMBERS

+ School Nurse	_____
+ Responsible School Authority	_____
+ Poison Control Center	**1-800-222-1222**
+ Fire Department	**9-1-1 or** _____
+ Police	**9-1-1 or** _____
+ Hospital or Nearest Emergency Facility	_____
+ County Children Services Agency	_____
+ Rape Crisis Center	_____
+ Suicide Hotline	_____
+ Local Health Department	_____
+ Taxi	_____
+ Other medical services information (e.g., dentists or physicians):	_____

EMERGENCY GUIDELINES FOR NEBRASKA SCHOOLS

Nebraska Department of Health and Human Services
Division of Public Health
Office of Emergency Health Systems
Emergency Medical Services for Children

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Acknowledgements

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Ohio Department of Public Safety, Division of Emergency Medical Services, and Ohio Department of Health, which published Emergency Guidelines for Schools, 3rd Edition, 2007, upon which this document is modeled.

Permissions have been obtained from the Ohio Department of Health and the Georgia Division of Public Health for reproducing portions of this document, with modifications specific to Nebraska law and regulations.

We would also like to acknowledge the following for their contributions to the Emergency Guidelines for Schools (EGS) development:

School nurses and other school personnel who took time to provide feedback on their use of the EGS so the guidelines could be improved for future users.

A special thank you to Wendy Snodgrass, Education and Compliance Program Manager, Nebraska Office of Emergency Health System for updating the CPR section and all her support with this project.

ABOUT THE GUIDELINES

The Emergency Guidelines for Schools Manual is meant to provide recommended procedures for school staff that have little or no medical/nursing training to use when the school nurse is not available. It is recommended that staff who are in a position to provide first-aid to students complete an approved first-aid and CPR course. Although designed for a school environment, this resource is equally appropriate for a child care or home setting.

The emergency guidelines in this booklet were originally produced by the Ohio Department of Public Safety's Emergency Medical Services for Children Program in 1997. Nebraska Health and Human Services, Division of Public Health, Emergency Medical Services (EMS) Program has revised to make it specific for Nebraska.

The EGS has been created as **recommended** procedures. It is not the intent of the EGS to supersede or make invalid any laws or rules established by a school system, a school board or the State of Nebraska. Please consult your school nurse or regional school nurse consultant if you have questions about any of the recommendations. You may add specific instructions for your school as needed. In a true emergency situation, use your best judgment.

Please take some time to familiarize yourself with the format and review the "How to Use the Guidelines" section prior to an emergency situation.

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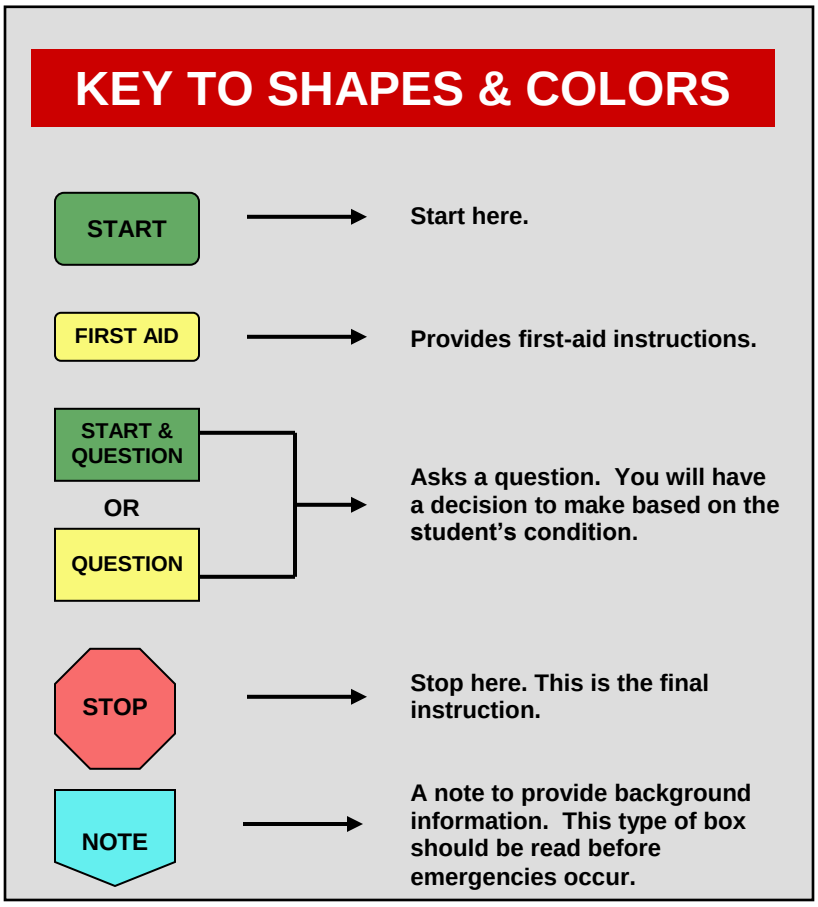
HOW TO USE THE EMERGENCY GUIDELINES

- In an emergency, refer first to the guideline for treating the most severe symptoms (e.g., unconsciousness, bleeding, etc.)
- Learn when EMS (Emergency Medical Services) should be contacted. Copy the "When to Call EMS" page and post in key locations.
- The Resource Section contains important information about key emergency numbers in your area. It is important to complete this information as soon as you receive the guidelines, as you will need to have this information ready in an emergency situation.
- The guidelines are arranged in **alphabetical order** for quick access.
- A colored flow chart format is used to guide you easily through all steps and symptoms from beginning to ending. See the **Key to Shapes and Colors.**
- Take some time to familiarize yourself with the **Emergency Procedures for Injury or Illness.** These procedures give a general overview of the recommended steps in an emergency situation and the safeguards that should be taken.
- In addition, information has been provided about **Infection Control, Planning for Students with Special Needs, Injury Reporting, School Safety Planning** and **Emergency Preparedness.**



WHEN TO CALL EMERGENCY MEDICAL SERVICES (EMS) 9-1-1

Call EMS if:

- ☐ The child is unconscious, semi-conscious or unusually confused.
- ☐ The child's airway is blocked.
- ☐ The child is not breathing.
- ☐ The child is having difficulty breathing, shortness of breath or is choking.
- ☐ The child has no pulse.
- ☐ The child has bleeding that won't stop.
- ☐ The child is coughing up or vomiting blood.
- ☐ The child has been poisoned.
- ☐ The child has a seizure for the first time or a seizure that lasts more than five minutes.

- ☐ The child has injuries to the neck or back.
- ☐ The child has sudden, severe pain anywhere in the body.
- ☐ The child's condition is limb-threatening (for example, severe eye injuries, amputations or other injuries that may leave the child permanently disabled unless he/she receives immediate care).
- ☐ The child's condition could worsen or become life-threatening on the way to the hospital.
- ☐ Moving the child could cause further injury.
- ☐ The child needs the skills or equipment of paramedics or emergency medical technicians.
- ☐ Distance or traffic conditions would cause a delay in getting the child to the hospital.

EMERGENCY PROCEDURES FOR INJURY OR ILLNESS

1. Remain calm and assess the situation. Be sure the situation is safe for you to approach. The following dangers will require caution: live electrical wires, gas leaks, building damage, fire or smoke, traffic or violence.
2. A responsible adult should stay at the scene and give help until the person designated to handle emergencies arrives.
3. Send word to the person designated to handle emergencies. This person will take charge of the emergency and render any further first aid needed.
4. Do **NOT** give medications unless there has been prior approval by the student's parent or legal guardian and doctor according to local school board policy, or if the school physician has provided standing orders or prescriptions.
5. Do **NOT** move a severely injured or ill student unless absolutely necessary for immediate safety. If moving is necessary, follow guidelines in **NECK AND BACK PAIN** section.
6. The responsible school authority or a designated employee should notify the parent/legal guardian of the emergency as soon as possible to determine the appropriate course of action.
7. If the parent/legal guardian cannot be reached, notify an emergency contact or the parent/legal guardian substitute and call either the physician or the designated hospital on the Emergency Medical Authorization form, so they will know to expect the ill or injured student. Arrange for transportation of the student by Emergency Medical Services (EMS), if necessary.
8. A responsible individual should stay with the injured student.
9. Fill out a report for all injuries requiring above procedures as required by local school policy.

POST-CRISIS INTERVENTION FOLLOWING SERIOUS INJURY OR DEATH

- Discuss with counseling staff.
- Determine level of intervention for staff and students.
- Designate private rooms for private counseling/defusing.
- Escort affected students, siblings, close friends, and other highly stressed individuals to counselors.
- Assess stress level of staff. Recommend counseling to all staff.
- Follow-up with students and staff who receive counseling.
- Designate staff person(s) to attend funeral.
- Allow for changes in normal routines or schedules to address injury or death.

PLANNING FOR STUDENTS WITH SPECIAL NEEDS

Some students in your school may have special emergency care needs due to health conditions, physical abilities or communication challenges. Include caring for these students' special needs in emergency and disaster planning.

HEALTH CONDITIONS:

Some students may have special conditions that put them at risk for life-threatening emergencies:

- Seizures
- Diabetes
- Asthma or other breathing difficulties
- Life-threatening or severe allergic reactions
- Technology-dependent or medically fragile conditions

Your school nurse or other school health professional, along with the student's parent or legal guardian and physician should develop individual action plans for these students when they are enrolled. These action plans should be made available to appropriate staff at all times.

In the event of an emergency situation, refer to the student's emergency care plan.

PHYSICAL ABILITIES:

Other students in your school may have special emergency needs due to their physical abilities. For example, students who are:

- In wheelchairs
- Temporarily on crutches/walking casts
- Unable or have difficulty walking up or down stairs

These students will need special arrangements in the event of a school-wide emergency (e.g., fire, tornado, evacuation, etc.). A plan should be developed and a responsible person should be designated to assist these students to safety. All staff should be aware of this plan.

COMMUNICATION CHALLENGES:

Other students in your school may have sensory impairments or have difficulty understanding special instructions during an emergency. For example, students who have:

- Vision impairments
- Hearing impairments
- Processing disorders
- Limited English proficiency
- Behavior or developmental disorders
- Emotional or mental health issues

These students may need special communication considerations in the event of a school-wide emergency. All staff should be aware of plans to communicate information to these students.

INFECTION CONTROL

To reduce the spread of infectious diseases *(diseases that can be spread from one person to another)*, it is important to follow **universal precautions**. Universal precautions are a set of guidelines that assume all blood and certain other body fluids are potentially infectious. It is important to follow universal precautions when providing care to *any* student, whether or not the student is known to be infectious. The following list describes universal precautions:

- **Wash hands thoroughly** with running water and soap for at least 15 seconds:
  1. Before and after physical contact with any student *(even if gloves have been worn)*.
  2. Before and after eating or handling food.
  3. After cleaning.
  4. After using the restroom.
  5. After providing any first aid.

Be sure to scrub between fingers, under fingernails and around the tops and palms of hands. If soap and water are not available, an alcohol-based waterless hand sanitizer may be used according to manufacturer's instructions.

- Wear disposable gloves when in contact with blood and other body fluids.
- Wear protective eyewear when body fluids may come in contact with eyes (e.g., squirting blood).
- Wipe up any blood or body fluid spills as soon as possible *(wear disposable gloves)*. Double-bag the trash in plastic bags and dispose of immediately. Clean the area with an appropriate cleaning solution.
- Send soiled clothing (i.e., clothing with blood, stool or vomit) home with the student in a double-bagged plastic bag.
- Do not touch your mouth or eyes while giving any first aid.

GUIDELINES FOR STUDENTS:

- Remind students to wash hands thoroughly after coming in contact with their own blood or body fluids.
- Remind students to avoid contact with another person's blood or body fluids.

AUTOMATIC EXTERNAL DEFIBRILLATORS (AEDS)

AEDs are devices that help to restore a normal heart rhythm by delivering an electric shock to the heart after detecting a life-threatening irregular rhythm. AEDs are not substitutes for CPR, but are designed to increase the effectiveness of basic life support when integrated into the CPR cycle.

AEDs are safe to use for ***all ages, according to the American Heart Association (AHA).**** Some AEDs are capable of delivering a "child" energy dose through smaller child pads. Use child pads/child system for children 0-8 years if available. If child system is not available, use adult AED and pads. Do not use the child pads or energy dose for adults in cardiac arrest. If your school has an AED, obtain training in its use before an emergency occurs, and follow any local school policies and manufacturer's instructions. The location of AEDs should be known to all school personnel.

American Heart Association Guidelines for AED/CPR Integration*

- For a sudden, witnessed collapse in an infant/child, use the AED first if it is immediately available. If there is any delay in the AED's arrival, begin CPR first. Prepare AED to check heart rhythm and deliver 1 shock as necessary. Then, immediately begin 30 CPR chest compressions within 15-18 seconds followed by 2 slow breaths of 1 second each. Complete 5 cycles of CPR (30 compressions to 2 breaths x 5) for about 2 minutes. The AED will perform another heart rhythm assessment and deliver a shock as needed. Continue with cycles of 2 minutes CPR to 1 AED rhythm check.

- For a sudden, unwitnessed collapse in an infant/child, perform 5 cycles of CPR first (30 compressions to 2 breaths x 5) of about 2 minutes, and then apply the AED to check the heart rhythm and deliver a shock as needed. Continue with cycles for about 2 minutes CPR to 1 AED rhythm check.

**Currents in Emergency Cardiovascular Care, American Heart Association, 2020.*

AUTOMATIC EXTERNAL DEFIBRILLATORS (AEDS)

CPR and AEDs are to be used when a person is unresponsive or when breathing or heart beat stops.

If your school has an AED, this guideline will refresh information provided in training courses as to incorporating AED use into CPR cycles.

1. Gently tap the shoulder and shout, “Are you OK?” If person is unresponsive, shout for help and **send someone to CALL EMS and get your school’s AED if available.**
2. Follow primary steps for CPR (see “*CPR*” for appropriate age group – infant, 1-8 years, over 8 years and adults).
3. If available, set up the AED according to the manufacturer’s instructions. Turn on the AED and follow the verbal instructions provided. Incorporate AED into CPR cycles according to instructions

IF CARDIAC ARREST OR COLLAPSE WAS WITNESSED:

4. Use the AED first if immediately available. If not, begin CPR.
5. Prepare AED to check heart rhythm and deliver 1 shock as necessary.
6. Begin 30 CPR chest compressions between 15-18 seconds followed by 2 normal rescue breaths. See age-appropriate CPR guideline.
7. Complete 5 cycles of CPR (30 chest compressions in between 15-18 seconds to 2 breaths for a rate of at least 100 to 120 compressions per minute).
8. Prompt another AED rhythm check.
9. Rhythm checks should be performed after every 2 minutes (about 5 cycles) of CPR.
10. REPEAT CYCLES OF 2 MINUTES OF CPR TO 1 AED RHYTHM CHECK UNTIL VICTIM RESPONDS OR HELP ARRIVES.

IF CARDIAC ARREST OR COLLAPSE WAS *NOT* WITNESSED:

4. Start CPR first. See age appropriate CPR guideline. Continue for 5 cycles or about 2 minutes of 30 chest compressions in about 15-18 seconds to 2 breaths at a rate of at least 100 to 120 compressions per minute.
5. Prepare the AED to check the heart rhythm and deliver a shock as needed.
6. REPEAT CYCLES OF 2 MINUTES OF CPR TO 1 AED RHYTHM CHECK UNTIL VICTIM RESPONDS OR HELP ARRIVES.

ALLERGIC REACTION

Students with a history of life-threatening allergies should be known to appropriate school staff. An Allergy Action Plan should be developed. NE law allows students to possess and use an epinephrine auto-injectable in schools. Staff in a position to administer the Epi-Pen® and/or Albuterol should receive training.

Children may experience symptoms within minutes up to 2 hours post exposure.

Does the student have any symptoms of a severe allergic reaction which may include:

- Flushed or Swollen face?
- Dizziness?
- Confusion?
- Loss of consciousness?
- Paleness?
- Hives all over body?
- Blueness around mouth?
- Difficulty breathing?
- Drooling or difficulty swallowing?

NO

Symptoms of a mild allergic reaction include:

- Red, watery eyes.
- Itchy, sneezing, runny nose.
- Hives or rash in one area.

Adult(s) supervising student during normal activities should be aware of the student's exposure and should watch for any delayed symptoms of a severe allergic reaction (see above) for up to 2 hours.

If student is so uncomfortable that he/she is unable to participate in school activities, contact responsible school authority & parent or legal guardian.

YES

Does student have an Allergy Action plan?

NO

Follow Rule 59 protocol.

CALL EMS 9-1-1. Contact responsible school authority & parent or legal guardian.

YES

Refer to student's Allergy Action plan.

Administer medication as directed in action plan.

Are symptoms not improving or getting worse? Are the lips or nail beds turning blue?

Follow Rule 59 protocol.

ASTHMA – WHEEZING – DIFFICULTY BREATHING

Students with a history of breathing difficulties including asthma/wheezing should be known to appropriate school staff. An Asthma Action plan should be developed. NE law allows students to possess and use a quick-relief inhaler in school. Staff in a position to administer the Epi-Pen® and/or Albuterol should receive training.

A student with asthma/wheezing may have breathing difficulties which may include:

- Uncontrollable coughing.
- Wheezing – a high-pitched sound during breathing out.
- Rapid breathing
- Flaring (widening) of nostrils
- Feeling of tightness in the chest.
- Not able to speak in full sentences.
- Increased use of stomach and chest muscles during breathing.

- Does the student have an Asthma Action plan?

YES → **Refer to student's Asthma Action plan.**

NO → Follow Rule 59 protocol for students with severe asthma symptoms.

YES → **CALL EMS 9-1-1** → Contact responsible school authority & parent/legal guardian.

NO → Has a quick-relief inhaler already been used? If yes, when and how often?

YES → Remain calm. Encourage the student to breathe slowly and deeply in through the nose and out through the mouth.

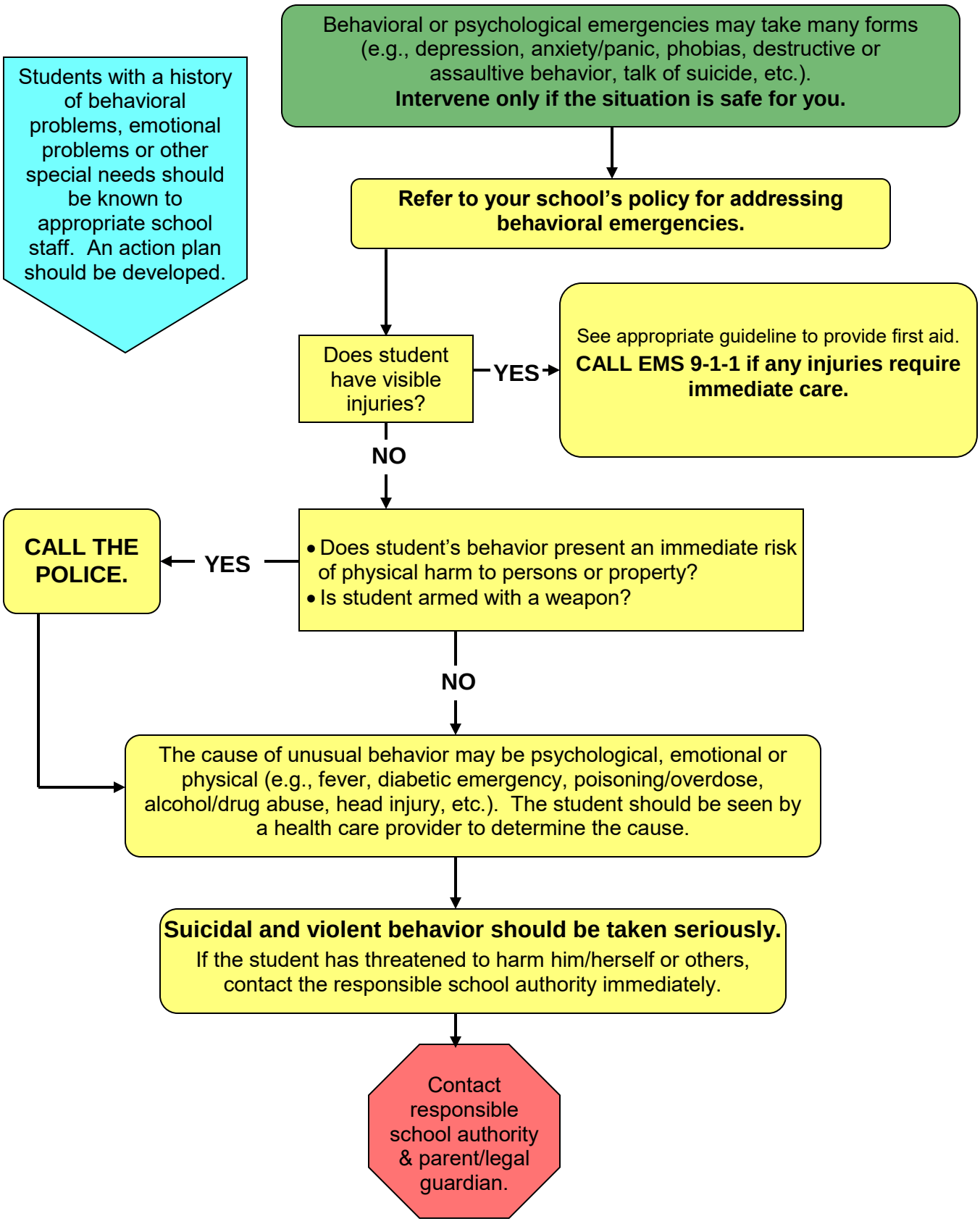
NO → Administer medication as directed in Action Plan

Are symptoms not improving or getting worse? Are the lips or nail beds turning blue?

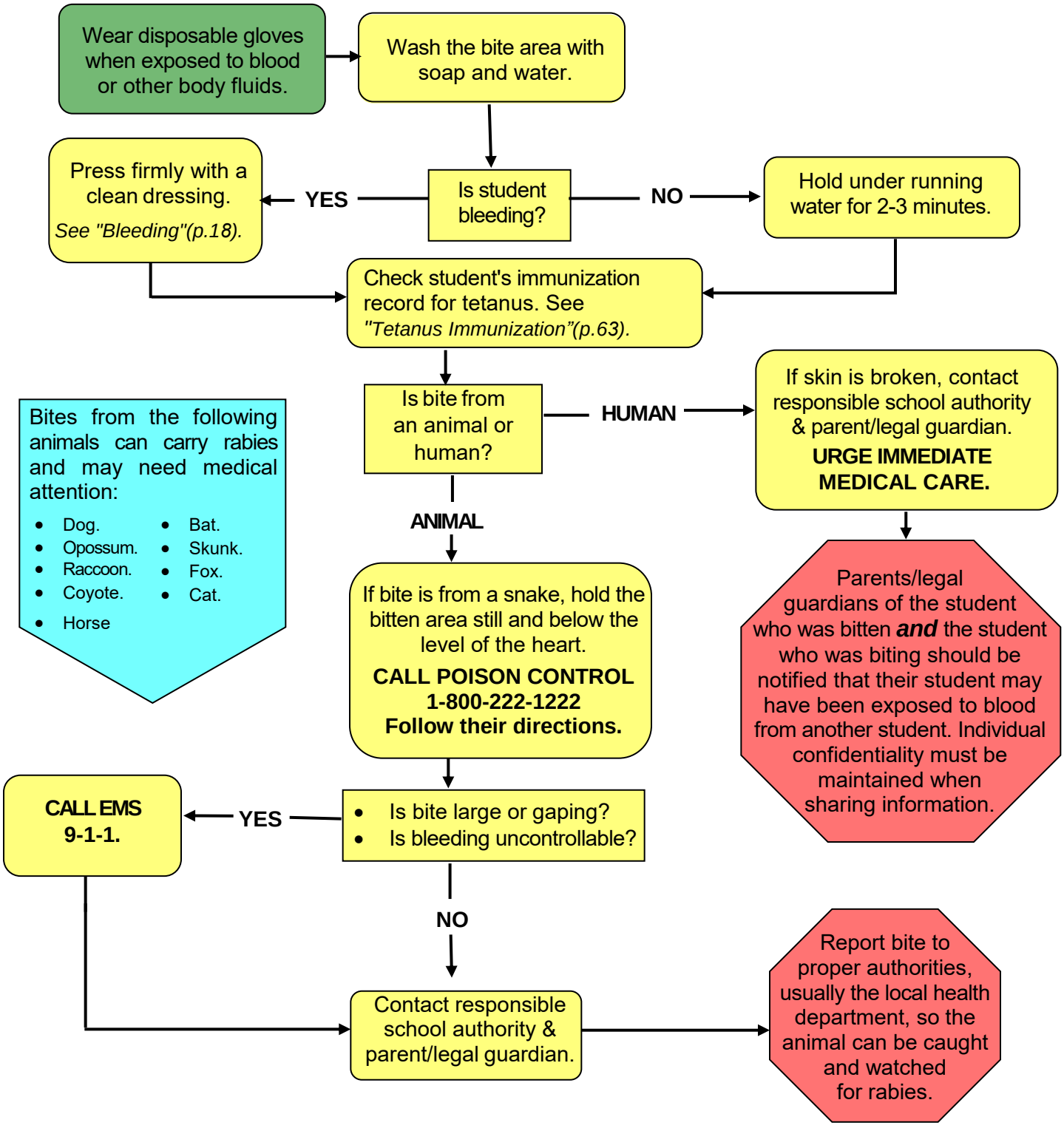
YES → Follow Rule 59 protocol. → **CALL EMS 9-1-1** → Contact responsible school authority & parent/legal guardian.

NO

BEHAVIORAL EMERGENCIES



BITES (HUMAN & ANIMAL)



BLEEDING

Check student's immunization record for tetanus. See *"Tetanus Immunization"(p. 63).*

Wear disposable gloves when exposed to blood or other body fluids.

Is injured part amputated (severed)?

NO

YES

CALL EMS 9-1-1.

- Place detached part in a plastic bag.
- Tie bag.
- Put bag in a container of ice water.
- **Do *NOT* put amputated part directly on ice.**
- Send bag to the hospital with student.

- Press firmly with a clean bandage to stop bleeding.
- If fracture is suspected, gently support part and elevate.
- Bandage wound firmly without interfering with circulation to the body part.
- **Do *NOT* use a tourniquet.**

Is there continued uncontrollable bleeding?

YES

CALL EMS 9-1-1.

- Have student lie down.
- Keep student's body temperature normal.
- Cover student with a blanket or sheet.

Contact responsible school authority & parent or legal guardian.

NO

If wound is gaping, student may need stitches. Contact responsible school authority & parent or legal guardian.

URGE MEDICAL CARE.

STOP THE BLEED®

SAVE A LIFE

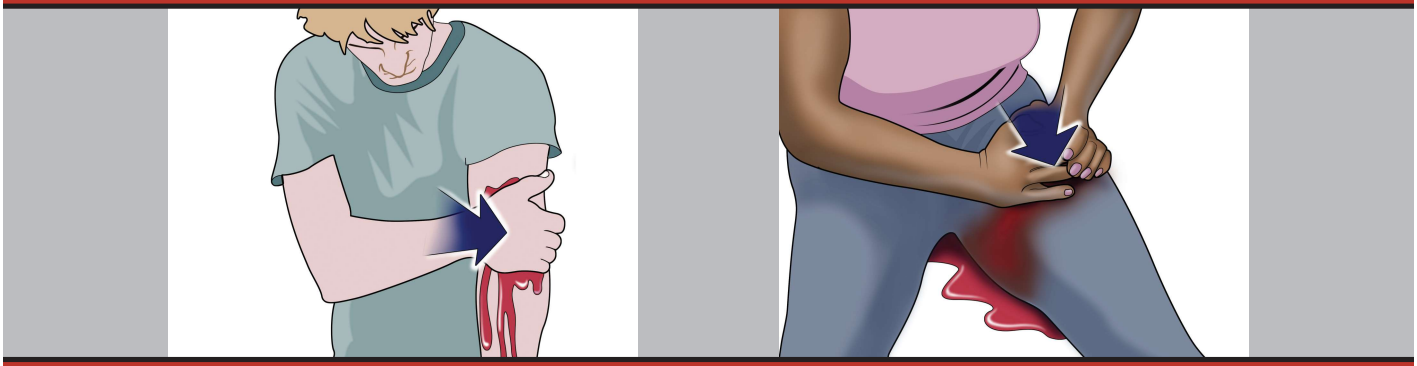
American College of Surgeons
Inspiring Quality:
Highest Standards, Better Outcomes
100+years

THE COMMITTEE ON TRAUMA

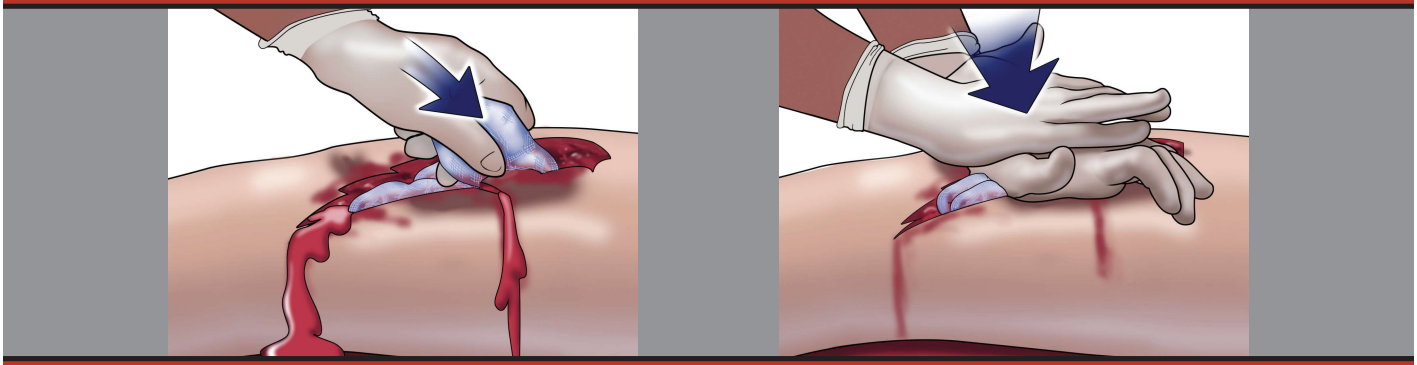
HARTFORD CONSENSUS
SAVE A LIFE
STOP THE BLEEDING

BLEEDINGCONTROL.ORG

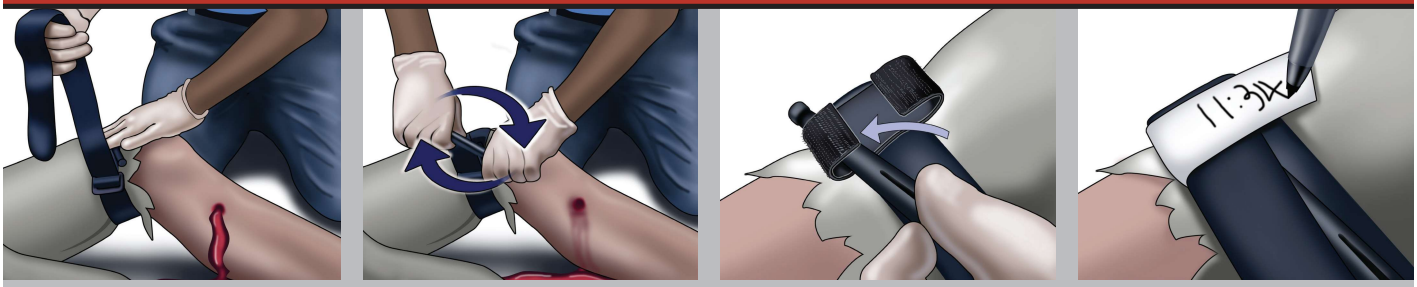
1 APPLY PRESSURE WITH HANDS



2 APPLY DRESSING AND PRESS



3 APPLY TOURNIQUET



WRAP **WIND** **SECURE** **TIME**

CALL 911

The 'Stop the Bleed' campaign was initiated by a federal interagency workgroup convened by the National Security Council Staff, The White House. The purpose of the campaign is to build national resilience by better preparing the public to save lives by raising awareness of basic actions to stop life threatening bleeding following everyday emergencies and man-made and natural disasters. Advances made by military medicine and research in hemorrhage control during the wars in Afghanistan and Iraq have informed the work of this initiative which exemplifies translation of knowledge back to the homeland to the benefit of the general public. 'Stop the Bleed' is a registered service mark of the Department of the Defense. Use of the equipment and the training does not guarantee that all bleeding will be stopped or that all lives will be saved.

Save a life

What everyone should know to stop bleeding after an injury

Ensure your safety.

Look for **life-threatening bleeding.**

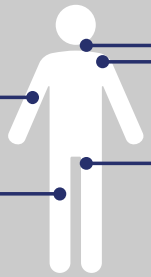
Is a **trauma first-aid kit** available?

No

- Use any **clean cloth.**
- Apply steady **direct pressure** directly on the wound.

Yes

Where is the wound?



Arm
Leg

Neck
Shoulder
Groin

Is a tourniquet available?

Yes

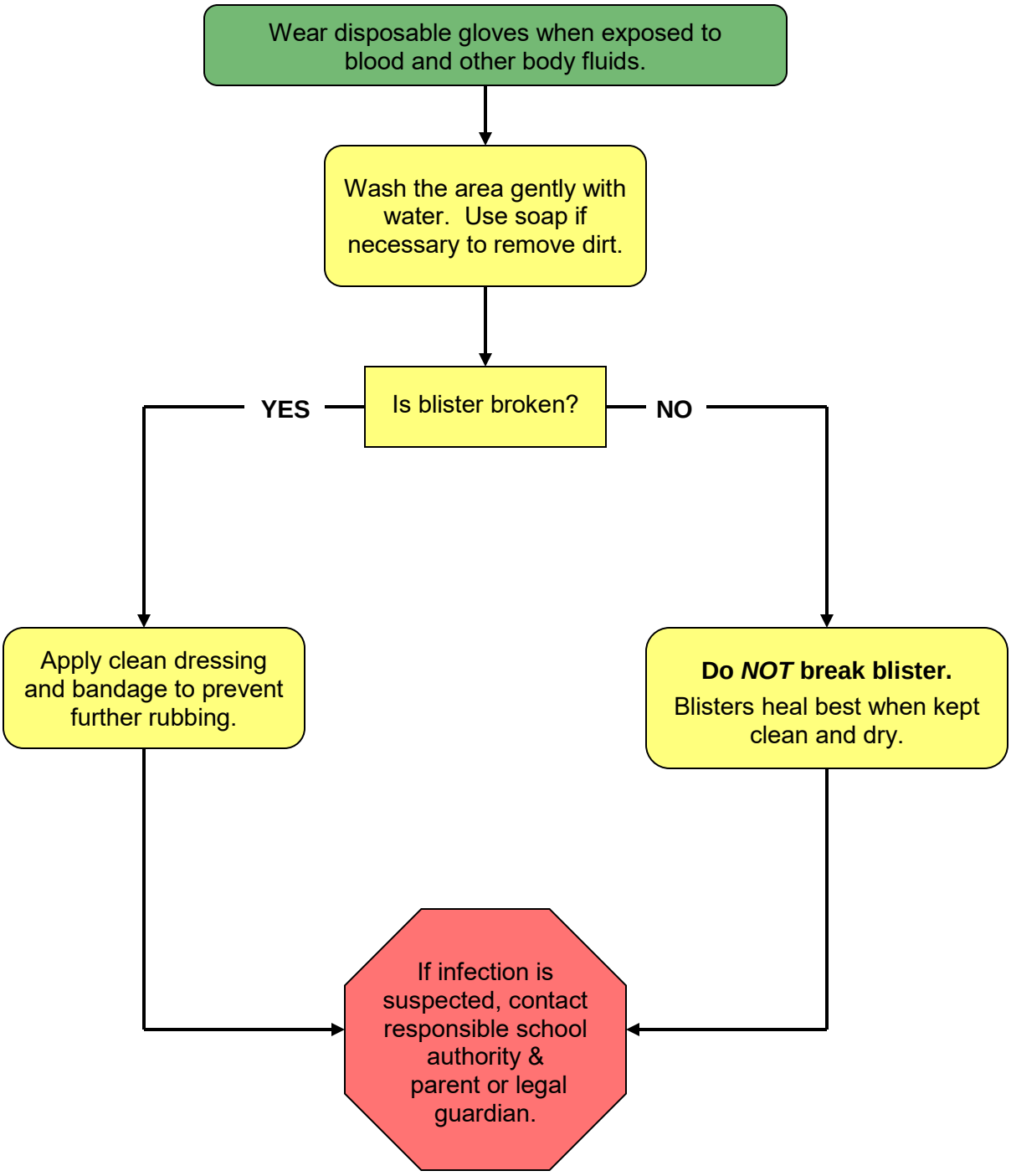
- Apply **above the bleeding site.**
- **Tighten** until the bleeding stops.

No

- **Pack the wound** with bleeding control (hemostatic) gauze (preferred), any gauze, or clean cloth.
- Apply steady **direct pressure.**

BLEEDINGCONTROL.ORG

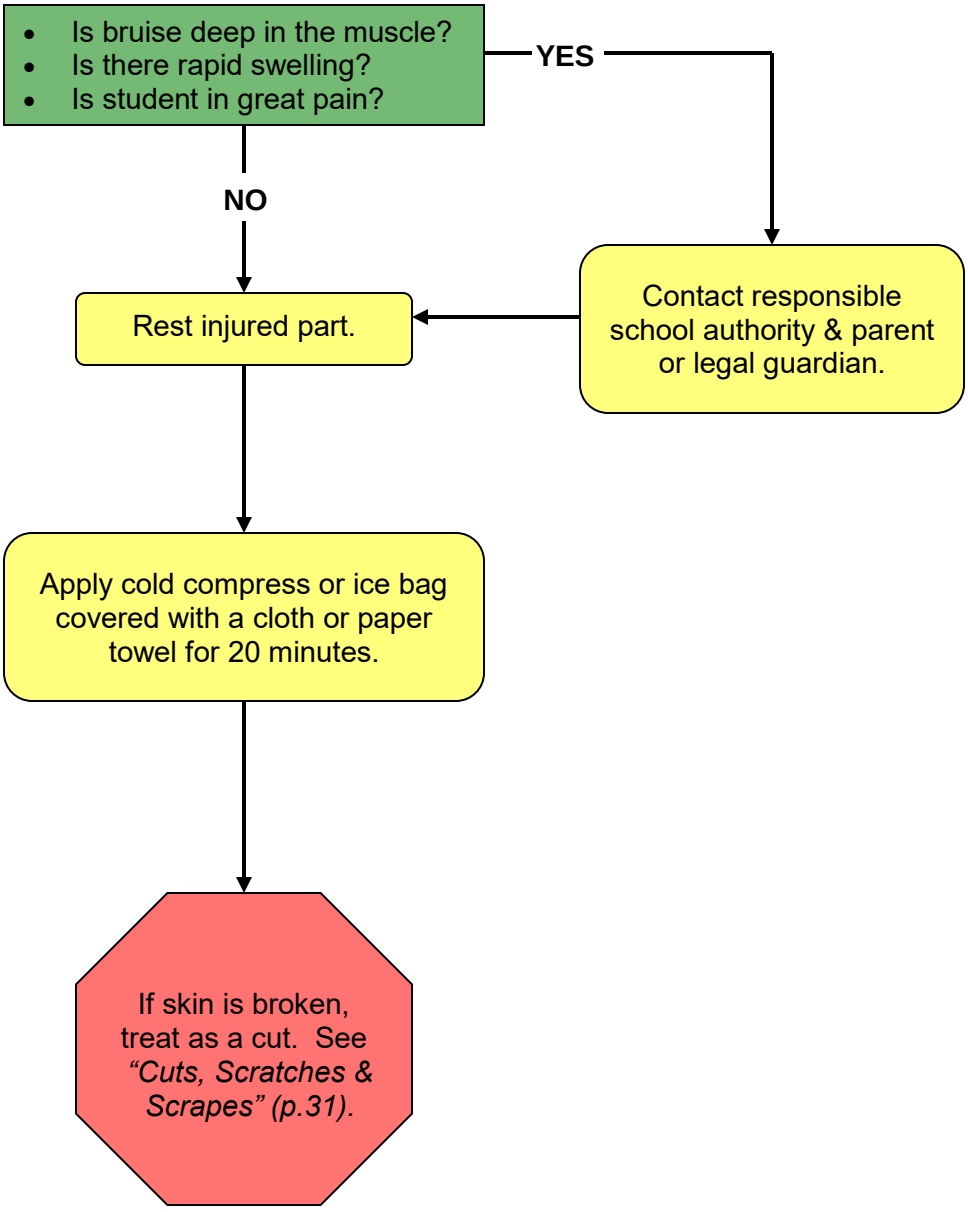
BLISTERS
(FROM FRICTION)

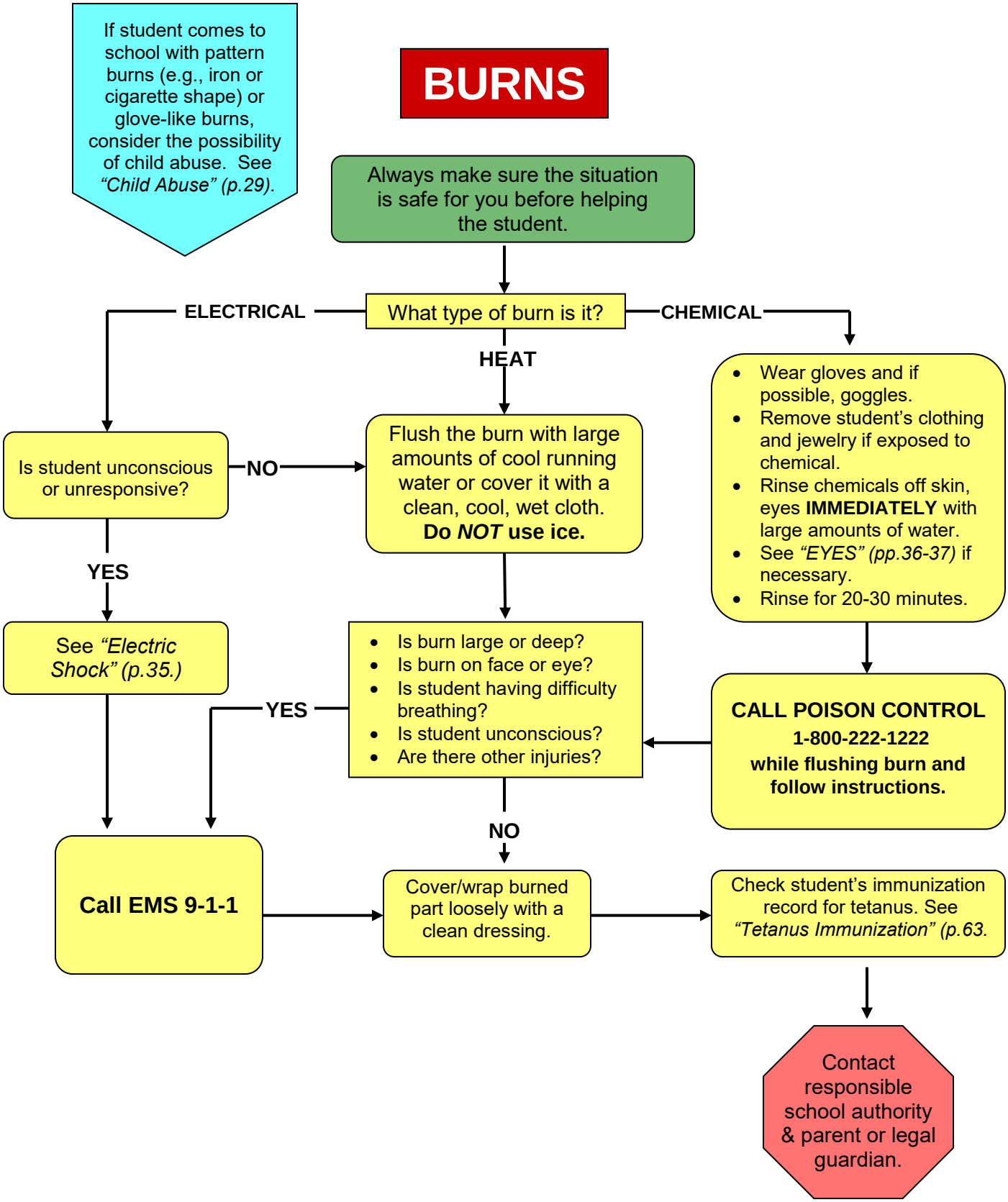


BRUISES

If student comes to school with unexplained unusual or frequent bruising consider the possibility of child abuse.

See *"Child Abuse" (p.29).*




If student comes to school with pattern burns (e.g., iron or cigarette shape) or glove-like burns, consider the possibility of child abuse. See "Child Abuse" (p.29).
BURNS
Always make sure the situation is safe for you before helping the student.
What type of burn is it?
ELECTRICAL
HEAT
CHEMICAL
Is student unconscious or unresponsive?
NO
YES
Flush the burn with large amounts of cool running water or cover it with a clean, cool, wet cloth. Do NOT use ice.
Wear gloves and if possible, goggles.
Remove student's clothing and jewelry if exposed to chemical.
Rinse chemicals off skin, eyes IMMEDIATELY with large amounts of water.
See "EYES" (pp.36-37) if necessary.
Rinse for 20-30 minutes.
See "Electric Shock" (p.35.)
Is burn large or deep?
Is burn on face or eye?
Is student having difficulty breathing?
Is student unconscious?
Are there other injuries?
YES
CALL POISON CONTROL 1-800-222-1222 while flushing burn and follow instructions.
NO
Call EMS 9-1-1
Cover/wrap burned part loosely with a clean dressing.
Check student's immunization record for tetanus. See "Tetanus Immunization" (p.63.
Contact responsible school authority & parent or legal guardian.

NOTES ON PERFORMING CPR

The American Heart Association (AHA) issued new CPR guidelines for laypersons in 2020.* Other organizations such as the American Red Cross also offer CPR training classes. If the guidance in this book differs from the instructions you were taught, follow the methods you learned in your training class. In order to perform CPR safely and effectively, skills should be practiced in the presence of a trained instructor. It is a recommendation of these guidelines that anyone in a position to care for students should be properly trained in CPR.

Current first aid, choking and CPR manuals, and wall chart(s) should also be available. The American Academyof Pediatrics offers many visual aids for school personnel and can be purchased at http://www.aap.org.

CHEST COMPRESSIONS

The AHA is placing more emphasis on the use of effective chest compressions in CPR. CPR chest compressions produce blood flow from the heart to the vital organs. To give effective compressions, rescuers should:

- Follow revised guidelines for hand use and placement based on age.
- Use a compression to breathing ratio of 30 compressions to 2 breaths.
- "Push hard and push fast." Compress chest at a rate of at least 100 to 120 compressions per minute for all victims.
- Compress about 1/3 the depth of the chest for infants (approximately 1 ½ inches), and 2 inches for children up to puberty, and at least 2 inches for children after puberty and adults.
- Avoid leaning on the chest wall between compressions to allow the full chest recoil.
- Minimize pauses in compressions.
- If rescuers are unwilling or unable to deliver breaths, we recommend rescuers perform compression-only CPR.

BARRIER DEVICES

Barrier devices, to prevent the spread of infections from one person to another, can be used when performing rescue breathing. Several different types (e.g., face shields, pocket masks) exist. It is important to learn and practice using these devices in the presence of a trained CPR instructor before attempting to use them in an emergency situation. Rescue breathing technique may be affected by these devices.

CHOKING RESCUE

It is recommended that schools that offer food service have at least one employee who has received instruction in methods to intervene and assist someone who is choking to be present in the lunch room at all times.

**Currents in Emergency Cardiovascular Care*, American Heart Association, 2020*

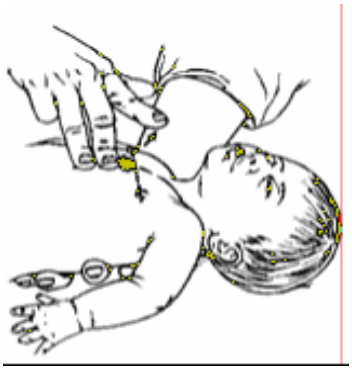
CARDIOPULMONARY RESUSCITATION (CPR)
FOR INFANTS UNDER 1 YEAR

CPR is to be used when an infant is unresponsive or when breathing or heart beat stops.

1. Gently tap the infant's shoulder or flick the bottom of the infant's feet. If no response, yell for help and send someone to call EMS.
2. Turn the infant onto his/her back as a unit by supporting the head and neck.
3. Lift chin up and out with one hand while pushing down on the forehead with the other to open the **AIRWAY** and check for no **BREATHING** for 5 – 10 seconds.

IF NOT BREATHING AND NOT RESPONSIVE:

4. Find finger position near center of breastbone just below the nipple line. (Make sure fingers are ***NOT*** over the very bottom of the breastbone.)



5. Compress chest hard and fast at a rate of 30 compressions in 15-18 seconds with 2 fingers approximately 1½" or about 1/3 of the infant's chest.
6. Limit interruptions in chest compressions.
7. Give 2 normal breaths, each lasting 1 second. Each breath should result in visible chest rise.
8. REPEAT CYCLES OF 30 COMPRESSIONS TO 2 BREATHS AT A RATE OF 100 to 120 COMPRESSIONS PER MINUTE UNTIL INFANT STARTS BREATHING EFFECTIVELY ON OWN OR HELP ARRIVES.

9. Call EMS after 2 minutes (5 cycles of 30 compressions to 2 rescue breaths) if not already called.

CARDIOPULMONARY RESUSCITATION (CPR)
FOR CHILDREN 1 TO 8 YEARS OF AGE

CPR is to be used when a student is unresponsive or when breathing or heart beat stops.

1. Gently tap the shoulder and shout, “Are you OK?” If child is unresponsive, shout for help and send someone to **call EMS and get your school’s AED if available.**
2. Turn the child onto his/her back as a unit by supporting the head and neck. If head or neck injury is suspected, DO NOT BEND OR TURN NECK.
3. Lift chin up and out with one hand while pushing down on the forehead with the other to open the **AIRWAY** and check for no **BREATHING.**
4. If you witnessed the child’s collapse, chest compressions should be started immediately. Use a defibrillator as soon as possible. CPR should be provided while the AED pads are applied and until the AED is ready to analyze the rhythm.

C

IF NOT BREATHING AND NOT RESPONSIVE

6. Find hand position near center of breastbone at the nipple line.
(Do ***NOT*** place your hand over the very bottom of the breastbone.)

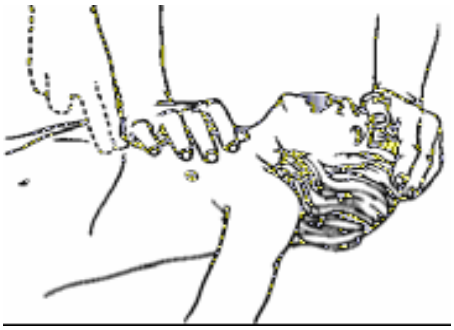
7. Compress chest hard and fast 30 times in 15-18 seconds with the heel of **1 or 2 hands.*** Compress at least 2” or 1/3 of the child’s chest. Allow the chest to return to normal position between each compression.

8. Limit interruptions in chest compressions.

9. Give 2 normal breaths, each lasting 1 second. Each breath should result in visible chest rise.

10. REPEAT CYCLES OF 30 COMPRESSIONS TO 2 BREATHS AT A RATE OF AT LEAST 100 to 120 COMPRESSIONS PER MINUTE OR 30 COMPRESSIONS IN ABOUT 15-18 SECONDS UNTIL THE CHILD STARTS BREATHING ON OWN OR HELP ARRIVES.

11. Call EMS after 2 minutes (5 cycles of 30 compressions to 2 rescue breaths) if not already called.



***Hand positions for child CPR:**

- **1 hand:** Use heel of 1 hand only.
- **2 hands:** Use heel of 1 hand with second on top of first.

CARDIOPULMONARY RESUSCITATION (CPR)
FOR CHILDREN OVER 8 YEARS OF AGE & ADULTS

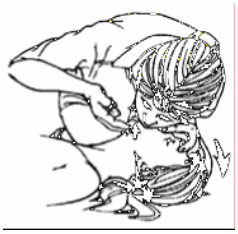
CPR is to be used when a person is unresponsive or when breathing or heart beat stops.

1. Gently tap the shoulder and shout, "Are you OK?" If person is unresponsive, shout for help and send someone to **call EMS AND get your school's AED if available.**
2. Turn the person onto his/her back as a unit by supporting head and neck. If head or neck injury is suspected, DO NOT BEND OR TURN NECK.
3. Lift chin up and out with one hand while pushing down on the forehead with the other to open the **AIRWAY.**
4. Check for no **BREATHING**. **Gasping in adults should be treated as *no breathing*.**
5. If you witnessed the child's or adult's collapse, chest compressions should be started immediately. Use a defibrillator as soon as possible. CPR should be provided while the AED pads are applied and until the AED is ready to analyze the rhythm.

IF NOT BREATHING AND NOT RESPONSIVE:

6. Place heel of one hand on top of the center of breastbone. Place heel of other hand on top of the first. Interlock fingers. (Do ***NOT*** place your hands over the very bottom of the breastbone.)

7. Position self vertically above victim's chest and with straight arms, **compress chest hard and fast at least 2 inches at a rate of 30 compressions in about 15-18 seconds with both hands.** Allow the chest to return to normal position between each compression. *Lift fingers when compressing to avoid pressure on ribs.* Limit interruptions in chest compressions.



8. Give 2 normal breaths, each lasting 1 second. Each breath should result in visible chest rise.

9. REPEAT CYCLES OF 30 COMPRESSIONS TO 2 BREATHS AT A RATE OF 100 to 120 COMPRESSIONS PER MINUTE UNTIL VICTIM RESPONDS OR HELP ARRIVES.

10. Call EMS after 2 minutes (5 cycles of 30 compressions to 2 rescue breaths) if not already called.

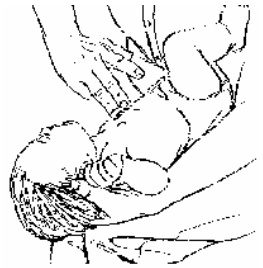
CHOKING (Conscious Victims)

Call EMS 9-1-1 after starting rescue efforts.

INFANTS UNDER 1 YEAR

Begin the following if the infant is choking and is unable to breathe. However, if the infant is coughing or crying, do ***NOT*** do any of the following, but call EMS, try to calm the child and watch for worsening of symptoms. If cough becomes ineffective (loss of sound), begin step 1 below.

1. Position the infant, with head slightly lower than chest, face down on your arm and support the head (support jaw; do ***NOT*** compress throat).
2. Give up to 5 back slaps with the heel of hand between infant's shoulder blades.



3. If object is not coughed up, position infant face up on your forearm with head slightly lower then rest of body.
4. With 2 or 3 fingers, give 5 chest thrusts near center of breastbone, just below the nipple line.
5. Open mouth and look. If foreign object is seen, sweep it out with the finger.
6. REPEAT STEPS 1-5 UNTIL OBJECT IS COUGHED UP OR INFANT STARTS TO BREATHE OR BECOMES UNCONSCIOUS.
7. Call EMS after 2 minutes (5 cycles of 30 compressions to 2 rescue breaths) if not already called.

IF INFANT BECOMES UNCONSCIOUS, GO TO STEP 5 OF INFANT CPR (p.25).

CHILDREN OVER 1 YEAR OF AGE & ADULTS

Begin the following if the victim is choking and unable to breathe. Ask the victim: "Are you choking?" If the victim nods yes or can't respond, help is needed. However, if the victim is coughing, crying or speaking, do ***NOT*** do any of the following, but call EMS, try to calm him/her and watch for worsening of symptoms. If cough becomes ineffective (loss of sound) and victim cannot speak, begin step 1 below.

1. Stand or kneel behind child with arms encircling child.
2. Place thumbside of fist against middle of abdomen just above the navel. (Do ***NOT*** place your hand over the very bottom of the breastbone. Grasp fist with other hand).
3. Give up to 5 quick inward and upward abdominal thrusts.
4. REPEAT STEPS 1-2 UNTIL OBJECT IS COUGHED UP, CHILD STARTS TO BREATHE OR CHILD BECOMES UNCONSCIOUS.

IF THE CHILD BECOMES UNCONSCIOUS, PLACE ON BACK AND GO TO STEP 7 OF CHILD, OR STEP 6 OF ADULT CPR (p.26).

FOR OBESE OR PREGNANT PERSONS:

Stand behind person and place your arms under the armpits to encircle the chest. Press with quick backward thrusts.

CHILD ABUSE & NEGLECT

Child abuse is a complicated issue with many potential signs. According to Nebraska law, all school personnel who suspect that a child is being abused or neglected are mandated (required) to make a report to their Department of Health and Human Services or local law enforcement agency. The law provides immunity from liability for those who make reports of possible abuse or neglect. Failure to report suspected abuse or neglect may result in civil or criminal liability.

If student has visible injuries, refer to the appropriate guideline to provide first aid. **CALL EMS 9-1-1** if any injuries require immediate medical care.

All school staff are required to report suspected child abuse and neglect to the Nebraska Department of Health & Human Services. Refer to your own school's policy for additional guidance on reporting.

NE DHHS Phone # 800-652-1999

Abuse may be physical, sexual or emotional in nature. Some signs of abuse follow. This *NOT* a complete list:

- Depression, hostility, low self-esteem, poor self-image.
- Evidence of repeated injuries or unusual injuries.
- Lack of explanation or unlikely explanation for an injury.
- Pattern bruises or marks (e.g., burns in the shape of a cigarette or iron, bruises or welts in the shape of a hand).
- Unusual knowledge of sex, inappropriate touching or engaging in sexual play with other children.
- Severe injury or illness without medical care.
- Poor hygiene, underfed appearance.

If a student reveals abuse to you:

- Remain calm.
- Take the student seriously.
- Reassure the student that he/she did the right thing by telling.
- Let the student know that you are required to report the abuse to the Department of Social Services.
- Do not make promises that you cannot keep.
- Respect the sensitive nature of the student's situation.
- If you know, tell the student what steps to expect next.
- Follow required school reporting procedures.

Contact responsible school authority. Contact DHHS. Follow up with school report.

COMMUNICABLE DISEASES

For more information on protecting yourself from communicable diseases, see "*Communicable Disease Resources" (Resource Section).*

A communicable disease is a disease that can be spread from one person to another. Germs (bacteria, virus, fungus, parasite) cause communicable diseases.

Chickenpox, pink eye, strep throat and influenza (flu) are just a few of the common communicable diseases that affect children. There are many more. In general, there will be little you can do for a student in school who has a communicable disease.

Refer to your local school's policy for ill students.

Signs of PROBABLE illness:

- Sore throat.
- Redness, swelling, drainage of eye.
- Unusual spots/rash with fever or itching.
- Crusty, bright yellow, gummy skin sores.
- Diarrhea (more than 2 loose stools a day).
- Vomiting.
- Yellow skin or yellow "white of eye".
- Oral temperature greater than 100.0 F.
- Extreme tiredness or lethargy.
- Unusual behavior.

Contact responsible school authority & parent or legal guardian.

ENCOURAGE MEDICAL CARE.

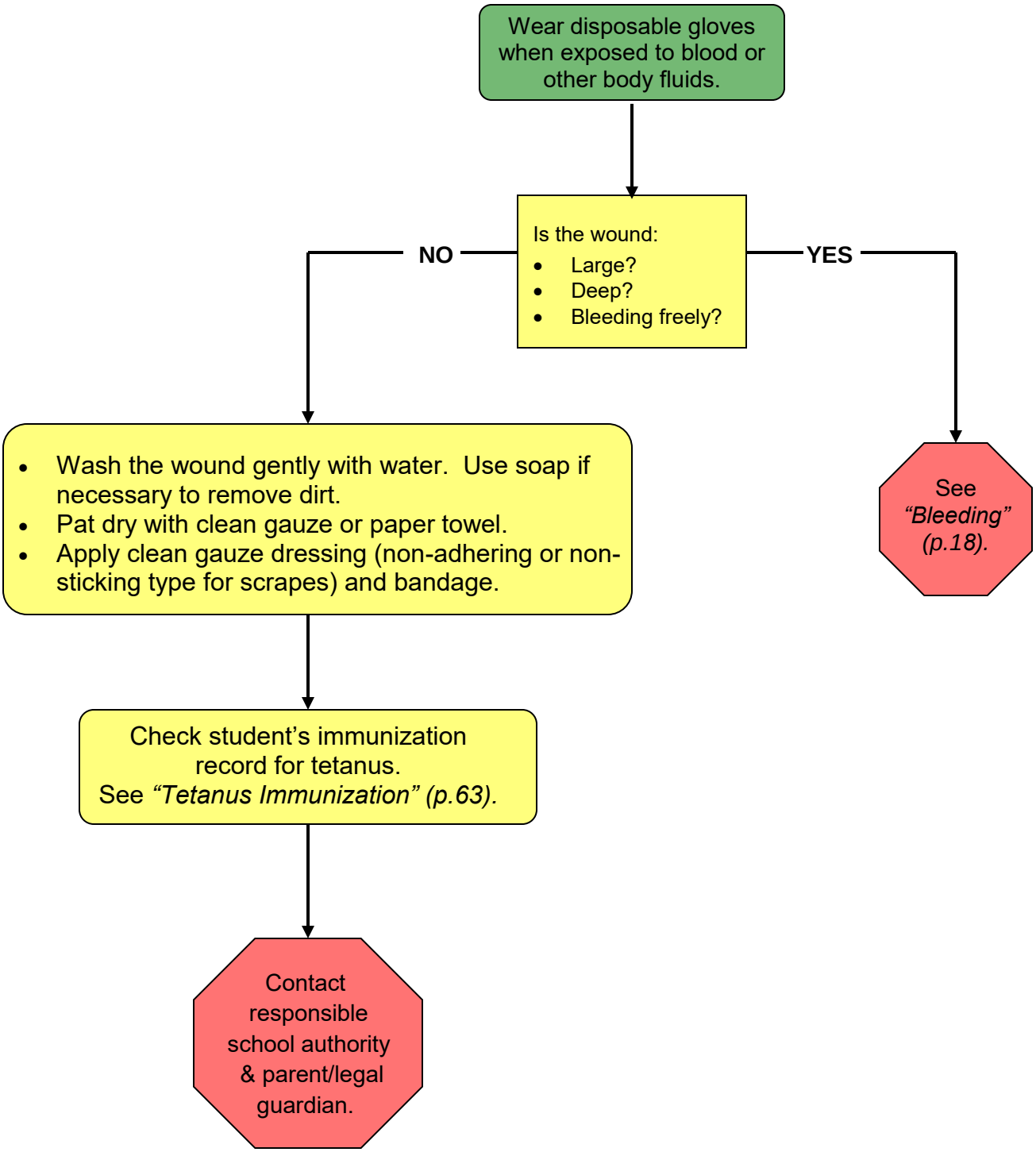
Signs of POSSIBLE illness:

- Earache.
- Fussiness.
- Runny nose.
- Mild cough.

Monitor student for worsening of symptoms. Contact parent/legal guardian and discuss.

Refer to Communicable Diseases in Resources Section.

CUTS (SMALL), **SCRATCHES & SCRAPES** (INCLUDING ROPE & FLOOR BURNS)



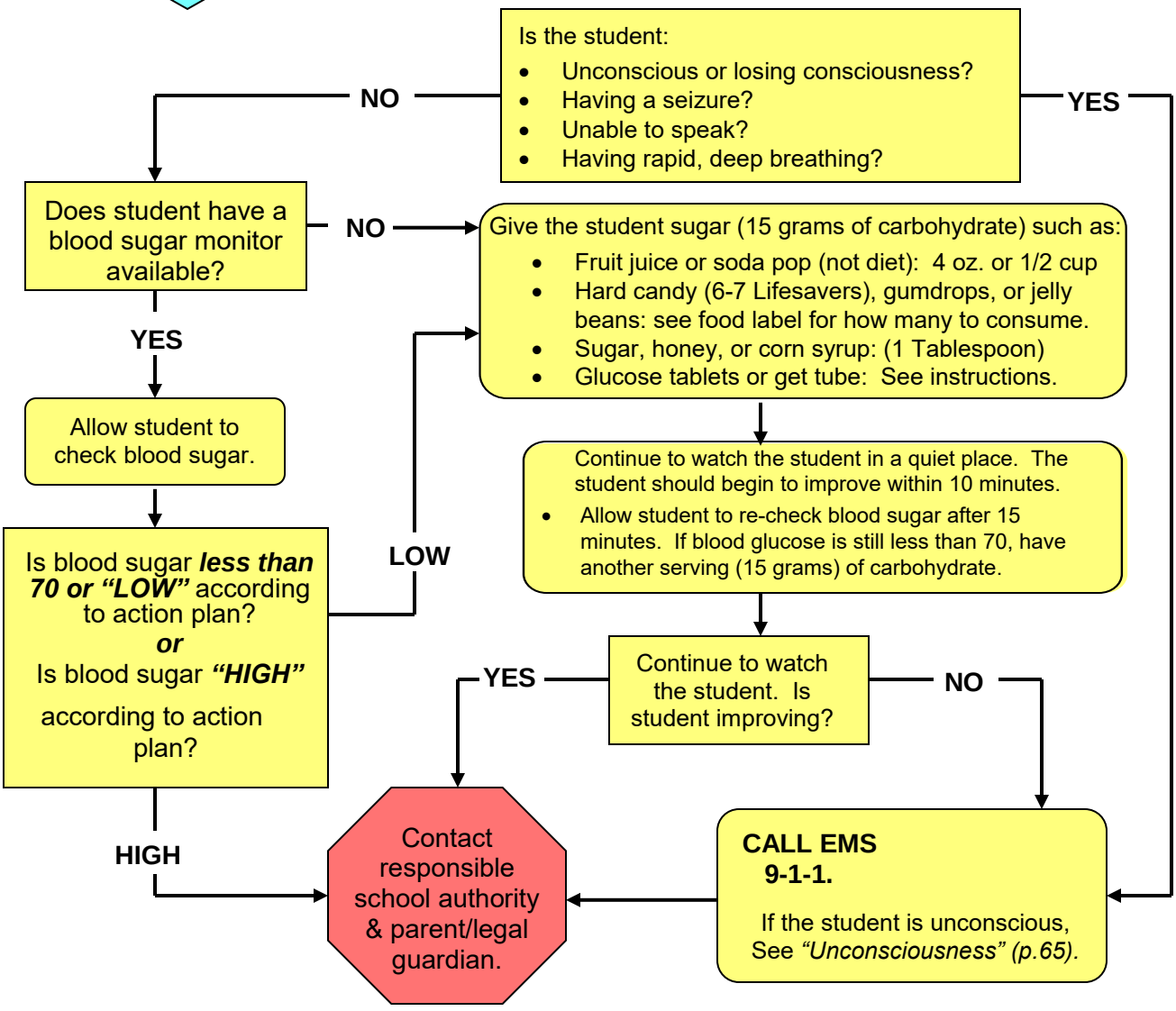
DIABETES

A student with diabetes may have the following symptoms:

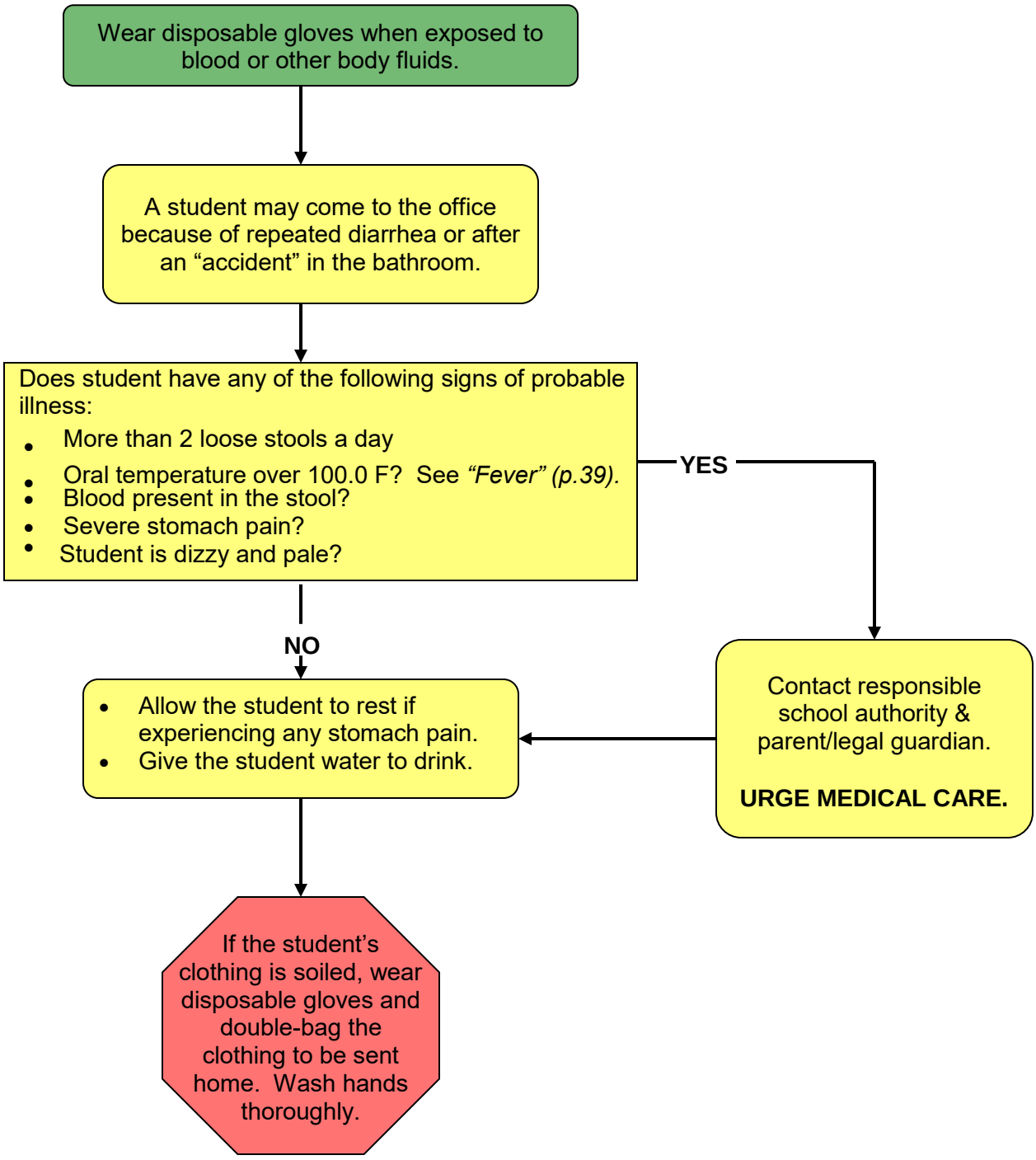
- Irritability and feeling upset.
- Change in personality.
- Sweating and feeling "shaky."
- Loss of consciousness.
- Confusion or strange behavior.
- Rapid, deep breathing.

A student with diabetes should be known to appropriate school staff. A Diabetic Action plan must be developed. Staff in a position to administer a Glucagon injection should receive instruction.

Refer to student's Diabetes Action plan.

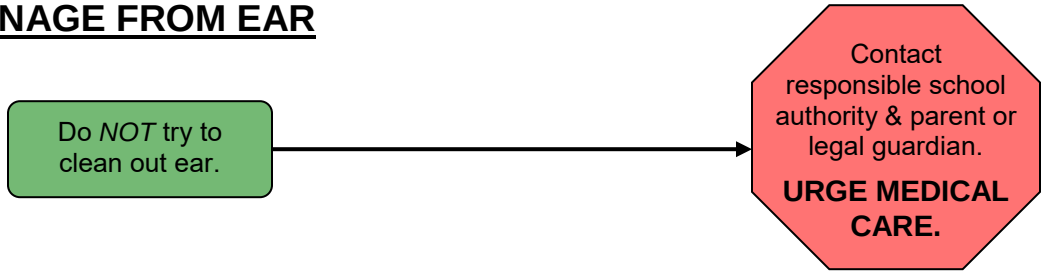


DIARRHEA

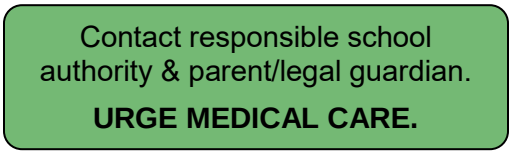

Wear disposable gloves when exposed to blood or other body fluids.
A student may come to the office because of repeated diarrhea or after an "accident" in the bathroom.
Does student have any of the following signs of probable illness:
More than 2 loose stools a day
Oral temperature over 100.0 F? See "Fever" (p.39).
Blood present in the stool?
Severe stomach pain?
Student is dizzy and pale?
YES
NO
Contact responsible school authority & parent/legal guardian.
URGE MEDICAL CARE.
Allow the student to rest if experiencing any stomach pain.
Give the student water to drink.
If the student's clothing is soiled, wear disposable gloves and double-bag the clothing to be sent home. Wash hands thoroughly.

EAR PROBLEMS

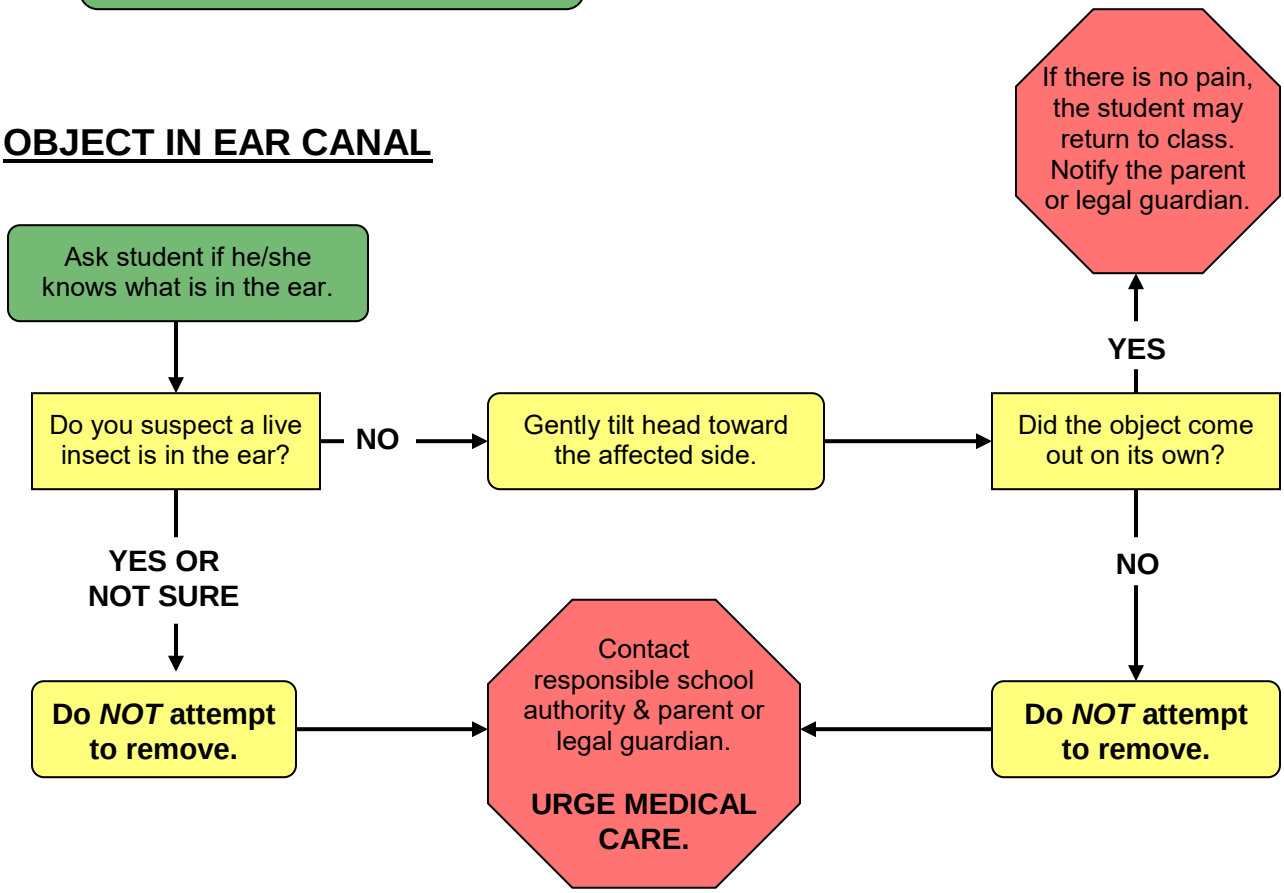
DRAINAGE FROM EAR



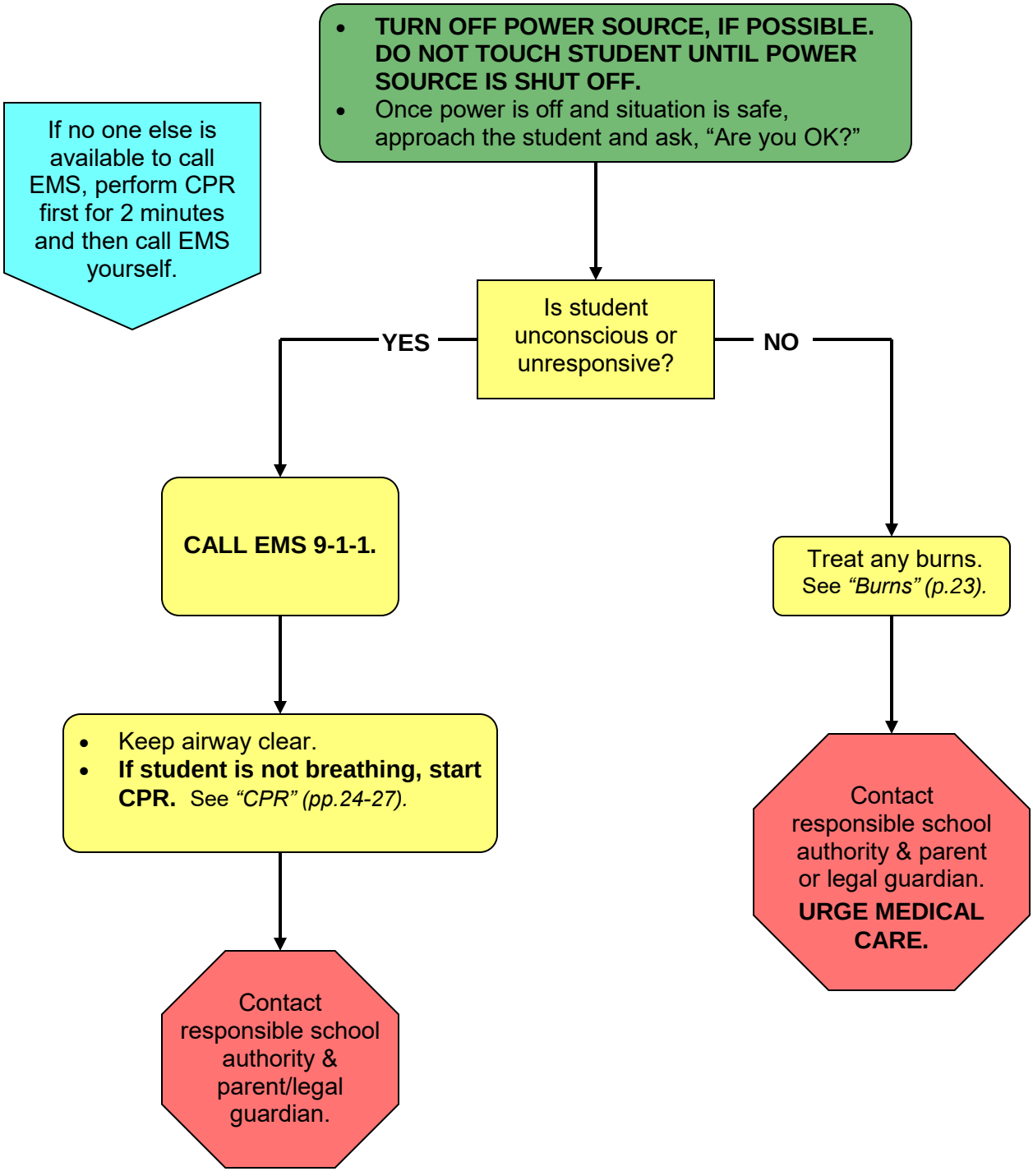
EARACHE



OBJECT IN EAR CANAL



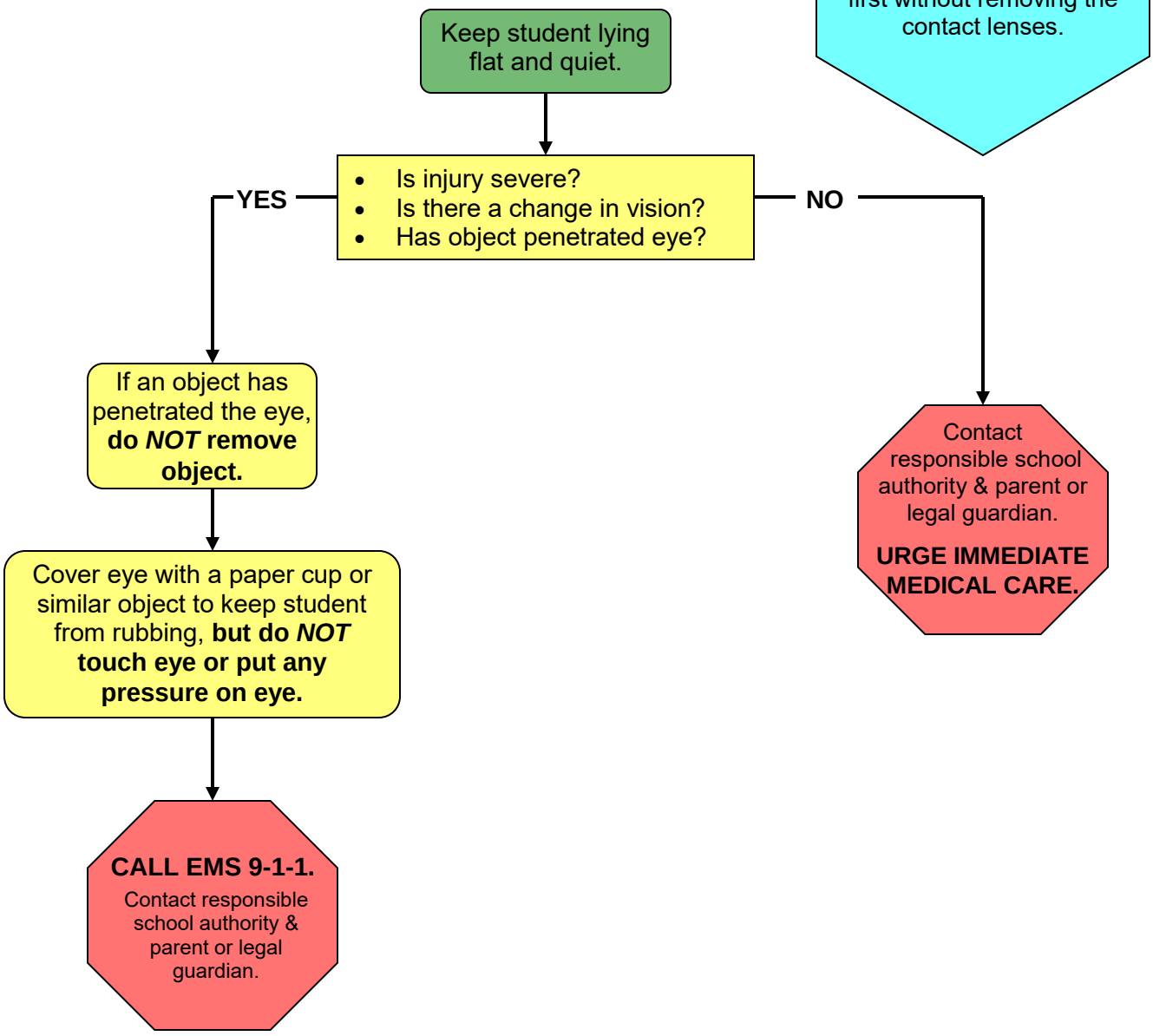
ELECTRIC SHOCK



EYE PROBLEMS

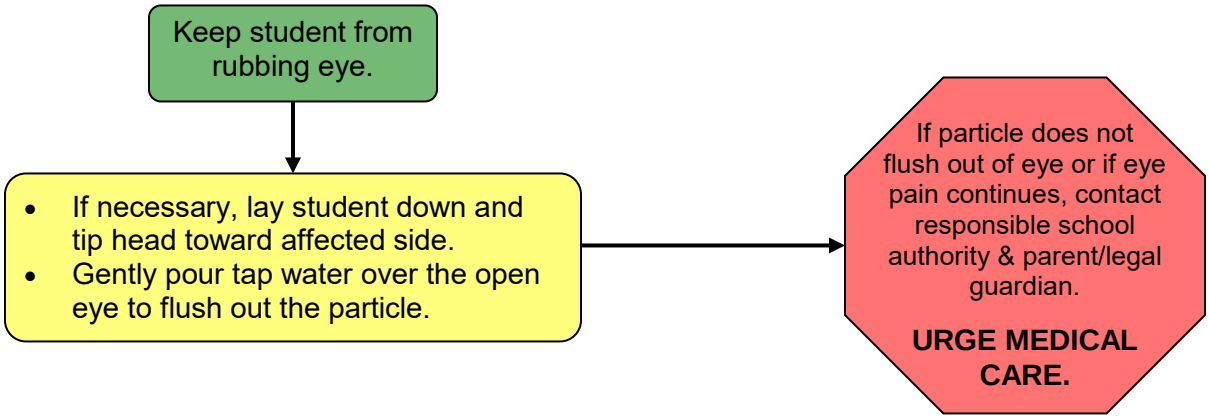
With any eye problem, ask the student if he/she wears contact lenses. Have student remove contacts before giving any first aid to eye unless chemicals have splashed in the eye. Flush first without removing the contact lenses.

EYE INJURY:

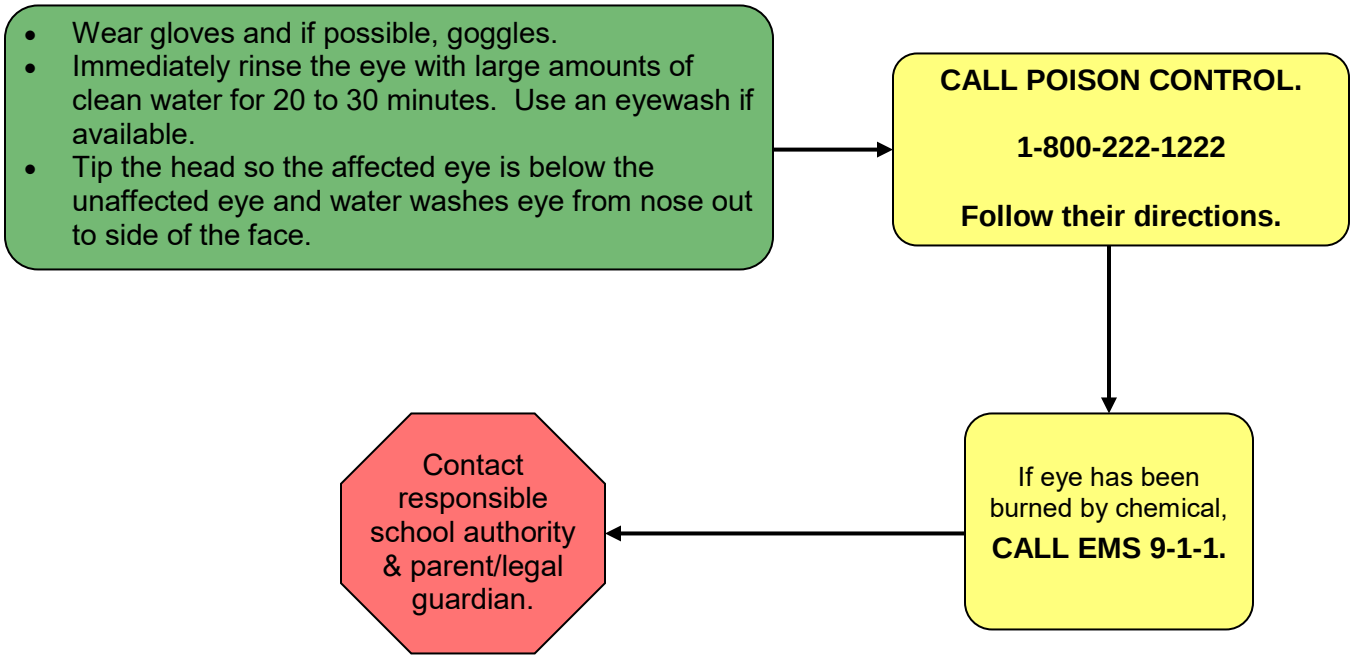


EYE PROBLEMS

PARTICLE IN EYE



CHEMICALS IN EYE



FAINTING

If you observe any of the following signs of fainting, have the student lie down to prevent injury from falling:

- Extreme weakness or fatigue.
- Dizziness or light-headedness.
- Extreme sleepiness.
- Pale, sweaty skin.
- Nausea.

Fainting may have many causes including:

- Injuries.
- Illness.
- Blood loss/shock.
- Heat exhaustion.
- Diabetic reaction.
- Severe allergic reaction.
- Standing still for too long.

If you know the cause of the fainting, see the appropriate guideline.

Most students who faint will recover quickly when lying down. If student does not regain consciousness immediately, See *"Unconsciousness" (p.65).*

- Is fainting due to injury?
- Was student injured when he/she fainted?

YES OR NOT SURE

Treat as possible neck injury. See *"Neck & Back Pain" (p.48).*

Do *NOT* move student.

NO

- Keep student in flat position.
- Elevate feet.
- Loosen clothing around neck and waist.

- Keep airway clear and monitor breathing.
- Keep student warm, but not hot.
- Control bleeding if needed (wear disposable gloves).
- Give nothing by mouth.

Are symptoms (*dizziness, light-headedness, weakness, fatigue, etc.)* still present?

YES

Keep student lying down. Contact responsible school authority & parent or legal guardian. **URGE MEDICAL CARE.**

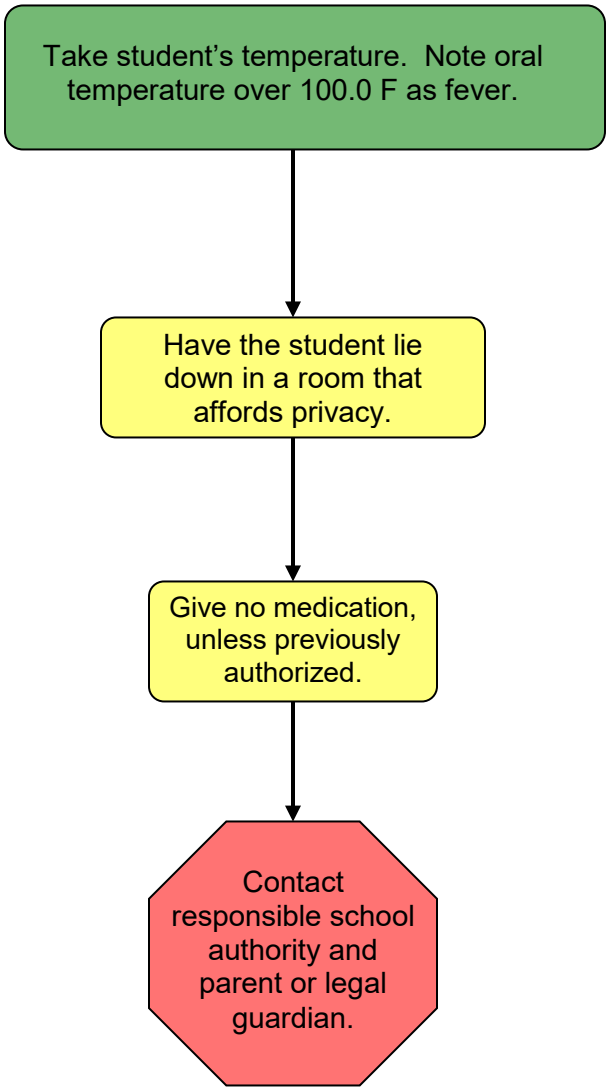
NO

If student feels better, and there is no danger of neck injury, he/she may be moved to a quiet, private area.

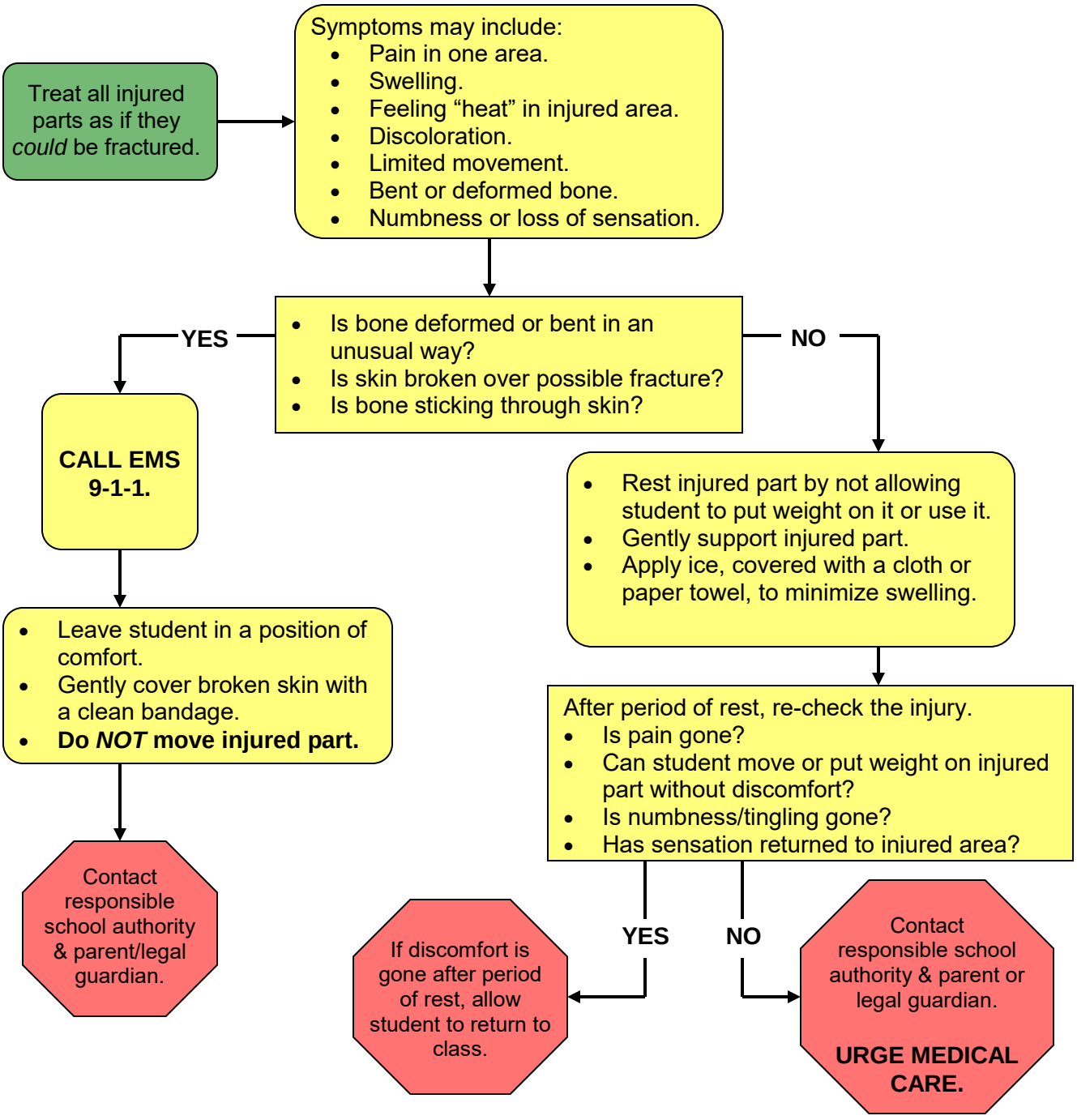
Contact responsible school authority & parent/legal guardian.

NOTE
If student has no history of fainting, seek medical consultation.

FEVER & NOT FEELING WELL



FRACTURES, DISLOCATIONS, SPRAINS OR STRAINS



FROSTBITE

Frostbite can result in the same type of tissue damage as a burn. It is a serious condition and requires medical attention.

Exposure to cold even for short periods of time may cause "HYPOTHERMIA" in children (See *"Hypothermia" p.45*). The nose, ears, chin, cheeks, fingers and toes are the parts most often affected by frostbite.

Frostbitten skin may:

- Look discolored (flushed, grayish-yellow, pale).
- Feel cold to the touch.
- Feel numb to the student.

Deeply frostbitten skin may:

- Look white or waxy.
- Feel firm or hard (frozen).

- Take the student to a warm place.
- Remove cold or wet clothing and give student warm, dry clothes.
- Protect cold part from further injury.
- **Do *NOT* rub or massage the cold part *or* apply heat such as a water bottle or hot running water.**
- Cover part loosely with nonstick, sterile dressings or dry blanket.

Does extremity/part:

- Look discolored – grayish, white or waxy?
- Feel firm/hard (frozen)?
- Have a loss of sensation?

YES

CALL EMS 9-1-1.
Keep student warm and part covered.

Contact responsible authority & parent or legal guardian.

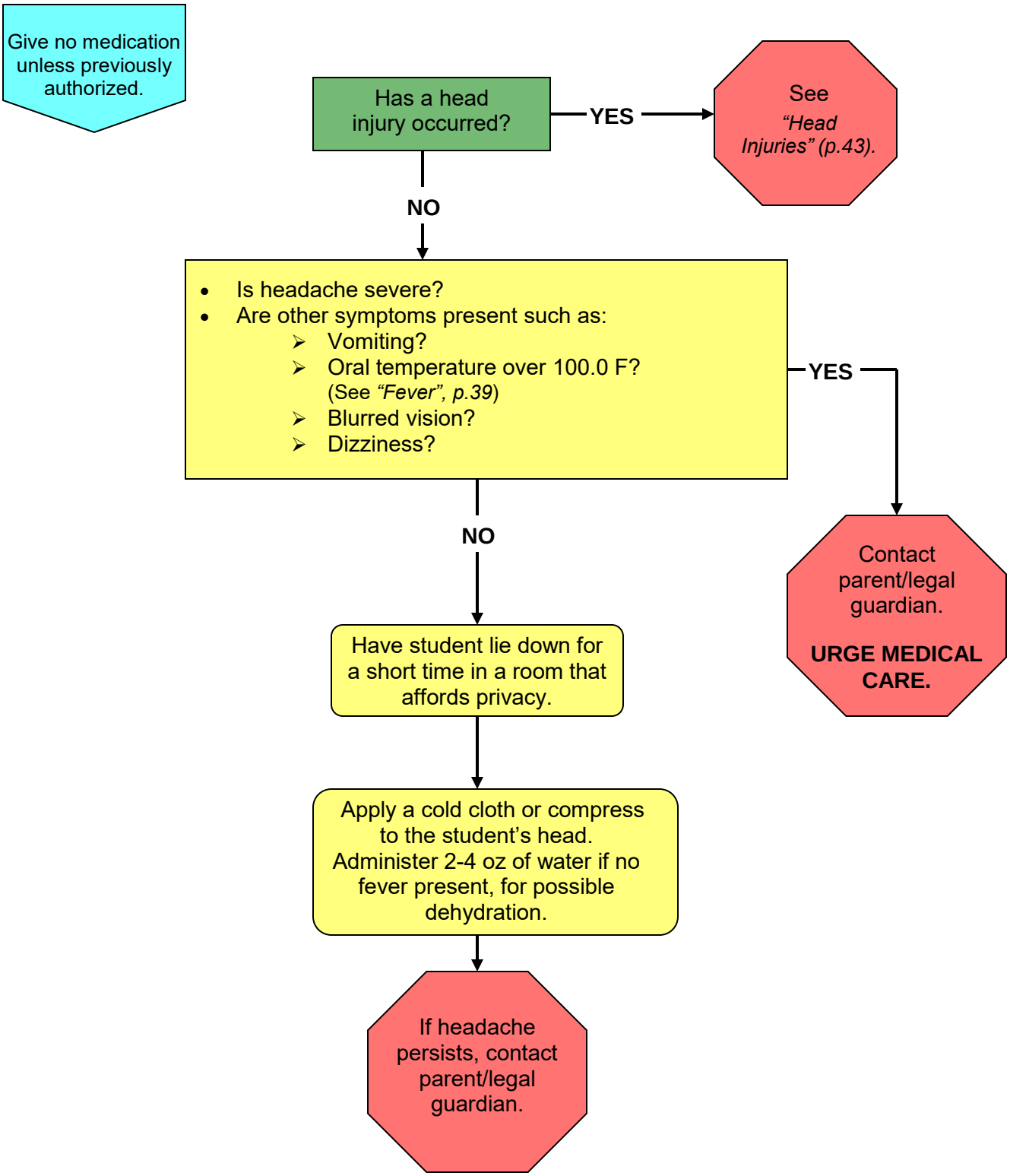
NO

Keep student and part warm.

Contact responsible authority & parent or legal guardian.

Encourage medical care.

HEADACHE


Give no medication unless previously authorized.
Has a head injury occurred?
YES
See "Head Injuries" (p.43).
NO
Is headache severe?
Are other symptoms present such as:
Vomiting?
Oral temperature over 100.0 F? (See "Fever", p.39)
Blurred vision?
Dizziness?
YES
Contact parent/legal guardian.
URGE MEDICAL CARE.
NO
Have student lie down for a short time in a room that affords privacy.
Apply a cold cloth or compress to the student's head. Administer 2-4 oz of water if no fever present, for possible dehydration.
If headache persists, contact parent/legal guardian.

HEAD INJURIES

Many head injuries that happen at school are minor. Head wounds may bleed easily and form large bumps. Bumps to the head may not be serious. Head injuries from falls, sports and violence may be serious. If head is bleeding, See *"Bleeding" (p.18).*

If student *only* bumped head and does not have any other complaints or symptoms, See *"Bruises" (p.22).*

- With a head injury (*other than head bump*), always suspect neck injury as well.
- **Do *NOT* move or twist the back or neck.**
- See *"Neck & Back Pain"* (p.48) for more information.

- Have student rest, lying flat.
- Keep student quiet and warm.

Is student vomiting?

YES

Turn the head and body together to the side, keeping the head and neck in a straight line with the trunk.

NO

Watch student closely.
Do *NOT* leave student alone.

Are any of the following symptoms present:

- Unconsciousness?
- Seizure?
- Neck pain?
- Student is unable to respond to simple commands?
- Blood or watery fluid in the ears?
- Student is unable to move or feel arms or legs?
- Blood is flowing freely from the head?
- Student is sleepy or confused?

YES

CALL EMS 9-1-1.

- Check student's airway.
- **If student stops breathing, start CPR.** See *"CPR" (pp.24-27).*

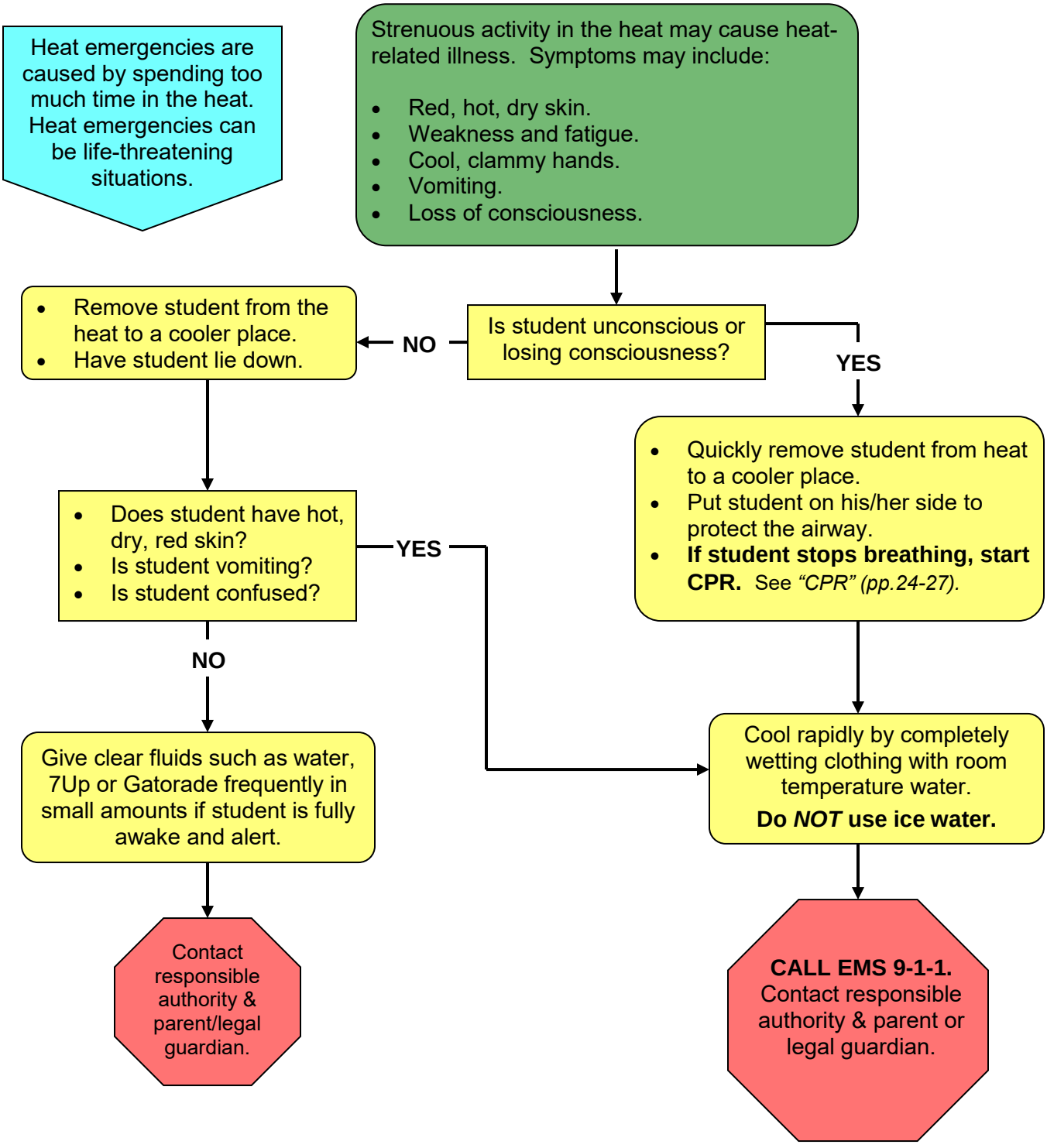
Give nothing by mouth. Contact responsible school authority & parent or legal guardian.

NO

Even if student was only briefly confused and seems fully recovered, contact responsible school authority & parent or legal guardian. **URGE MEDICAL CARE.** Watch for delayed symptoms.

Refer to Concussions Signs & Symptoms and Heads Up Fact Sheet for School Nurses in the Resource Section

HEAT STROKE – HEAT EXHAUSTION



HYPOTHERMIA
(EXPOSURE TO COLD)

Hypothermia happens after exposure to cold when the body is no longer capable of warming itself. Young children are particularly susceptible to hypothermia. It can be a life-threatening condition if left untreated for too long.

Hypothermia can occur after a student has been outside in the cold or in cold water. Symptoms may include:

- Confusion.
- Weakness.
- Blurry vision.
- Slurred speech.
- Shivering.
- Sleepiness.
- White or grayish skin color.
- Impaired judgment.

- Take the student to a warm place.
- Remove cold or wet clothing and wrap student in a warm, dry blanket.

Does the student have:

- Loss of consciousness?
- Slowed breathing?
- Confused or slurred speech?
- White, grayish or blue skin?

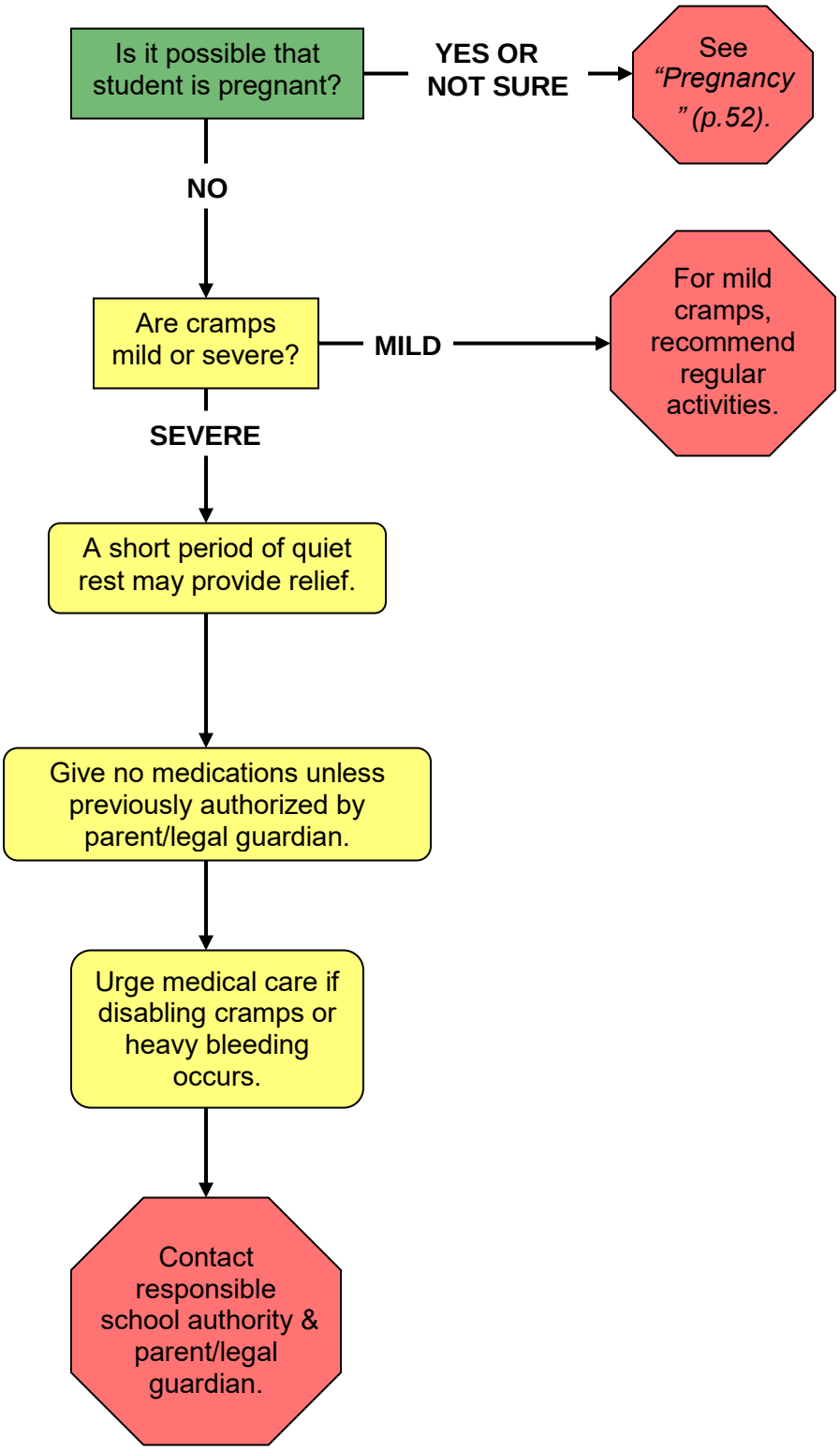
NO → Continue to warm student with blankets. If student is fully awake and alert, offer warm (***NOT HOT***) fluids, but no food.

YES

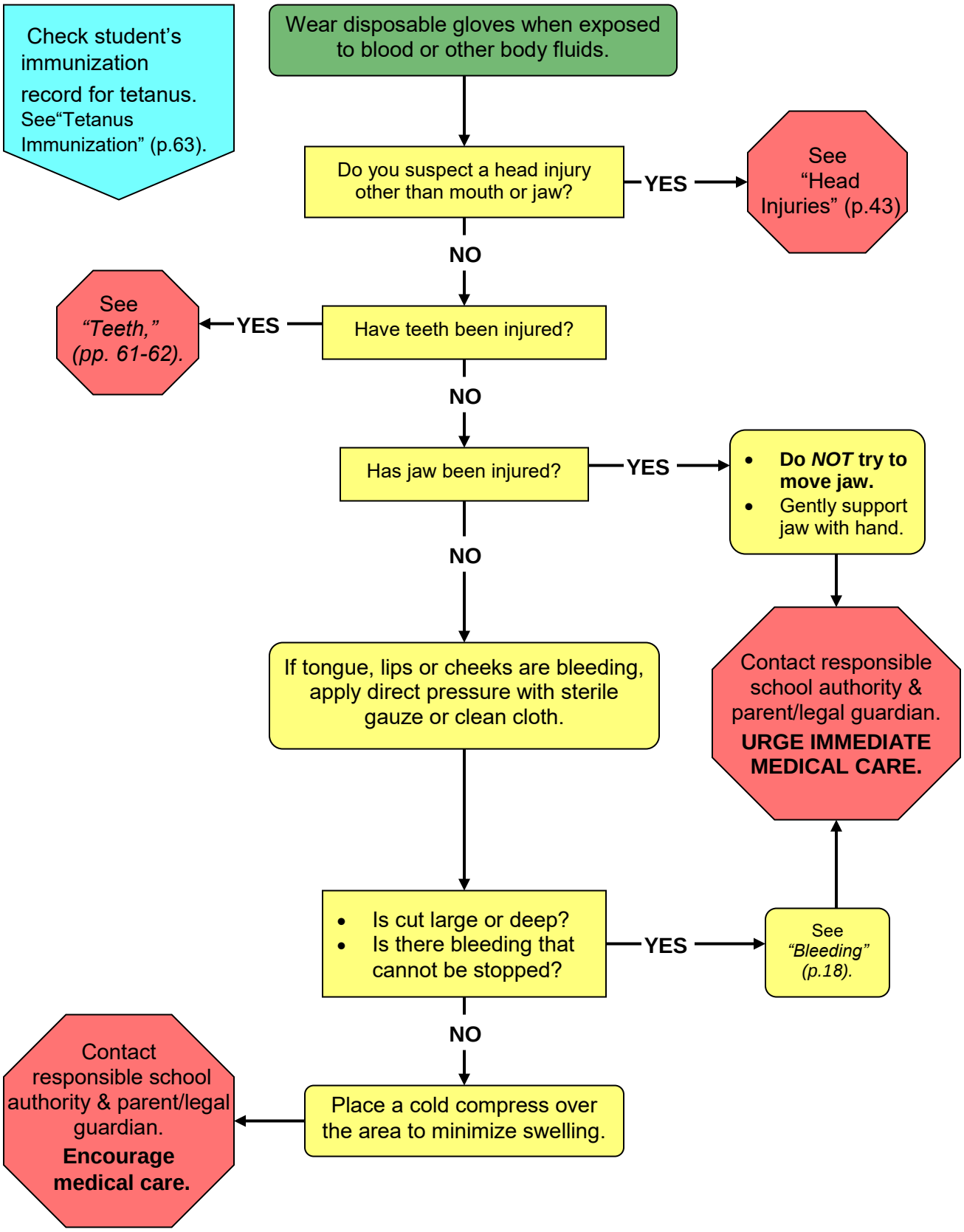
- **CALL EMS 9-1-1.**
- Give nothing by mouth.
- Continue to warm student with blankets.
- If student is asleep or losing consciousness, place student on his/her side to protect airway.
- **If student stops breathing, start CPR.** See *"CPR" (pp.24-27).*

Contact responsible authority & parent or legal guardian. **Encourage medical care.**

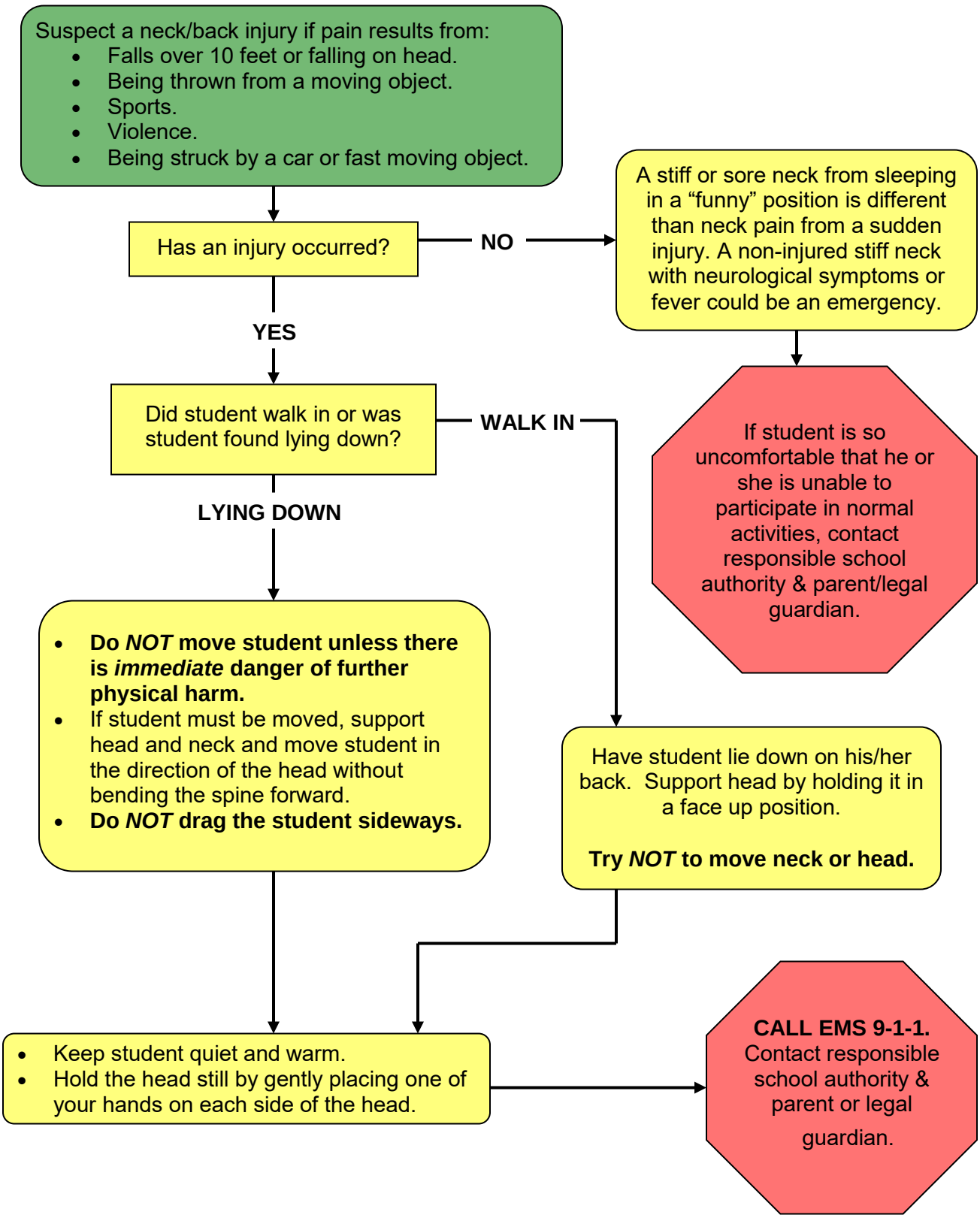
MENSTRUAL DIFFICULTIES



MOUTH & JAW INJURIES



NECK & BACK PAIN



NOSE PROBLEMS

See *"Head Injuries"* (p.43) if you suspect a head injury other than a nosebleed or broken nose.

NOSEBLEED

Wear disposable gloves when exposed to blood or other body fluids.

Place student sitting comfortably with head slightly forward or lying on side with head raised on pillow.

Encourage mouth breathing and discourage nose blowing, repeated wiping or rubbing.

If blood is flowing freely from the nose, provide constant uninterrupted pressure by pressing the nostrils firmly together for about 15 minutes. Apply ice to nose.

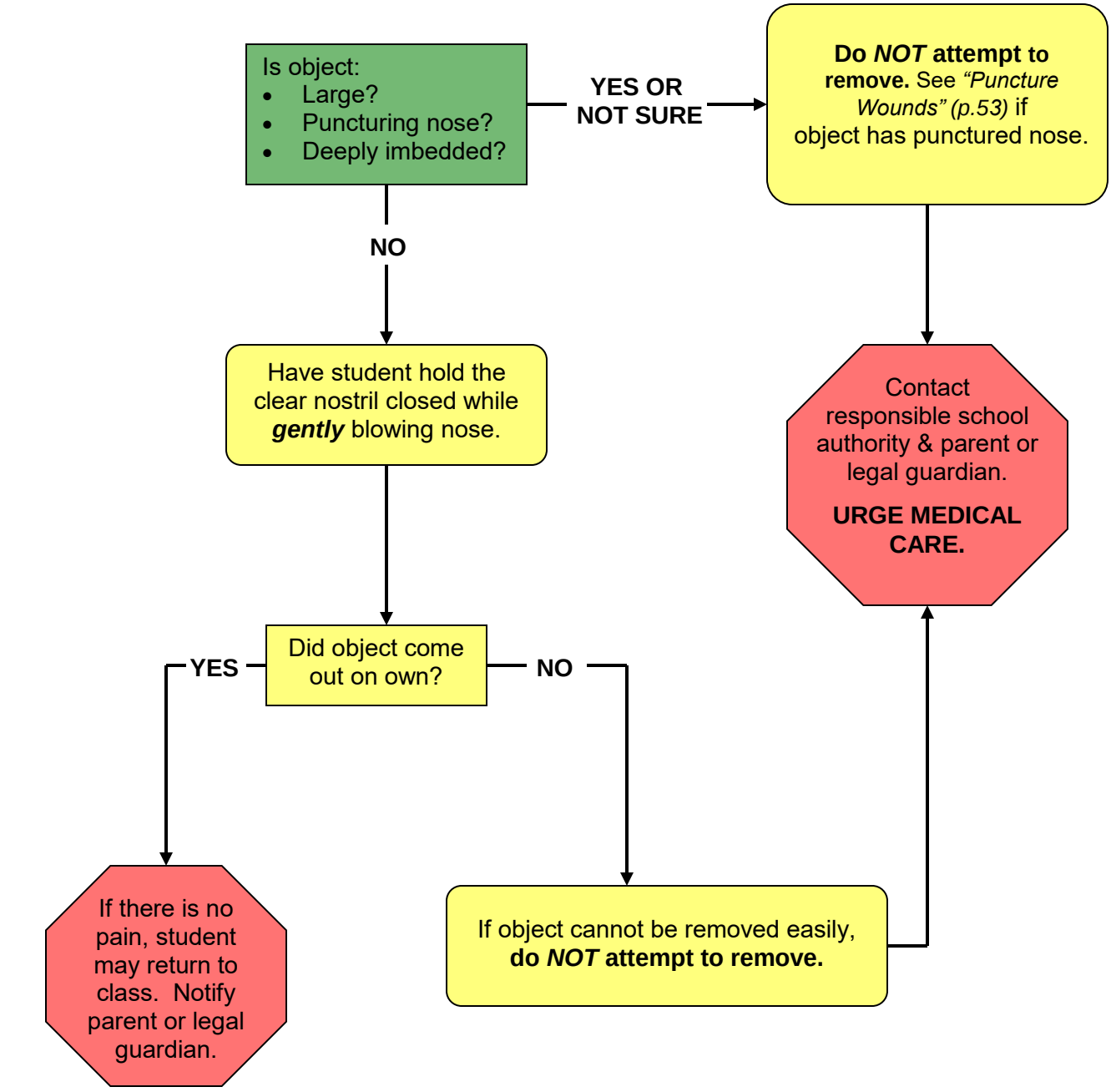
If blood is still flowing freely after applying pressure and ice, contact responsible school authority & parent/legal guardian.

BROKEN NOSE

- Care for nose as in *"Nosebleed"* above.
- Contact responsible school authority & parent/legal guardian.
- **URGE MEDICAL CARE.**

NOSE PROBLEMS

OBJECT IN NOSE



POISONING & OVERDOSE

Poisons can be swallowed, inhaled, absorbed through the skin or eyes, or injected. Call Poison Control when you suspect poisoning from:

- Medicines.
- Insect bites and stings.
- Snake bites.
- Plants.
- Chemicals/cleaners.
- Drugs/alcohol.
- Food poisoning.
- Inhalants.

Or if you are not sure.

Possible warning signs of poisoning include:

- Pills, berries or unknown substances in student's mouth.
- Burns around mouth or on skin.
- Strange odor on breath.
- Sweating.
- Upset stomach or vomiting.
- Dizziness or fainting.
- Seizures or convulsions.

- Wear disposable gloves.
- Check student's mouth.
- Remove any remaining substance(s) from mouth.

If possible, find out:

- Age and weight of student.
- What the student swallowed.
- What type of "poison" it was.
- How much and when it was taken.

CALL POISON CONTROL
1-800-222-1222
Follow their directions.

- **Do *NOT* induce vomiting or give anything *UNLESS* instructed to by Poison Control.** With some poisons, vomiting can cause greater damage.
- Do ***NOT*** follow the antidote label on the container; it may be incorrect.

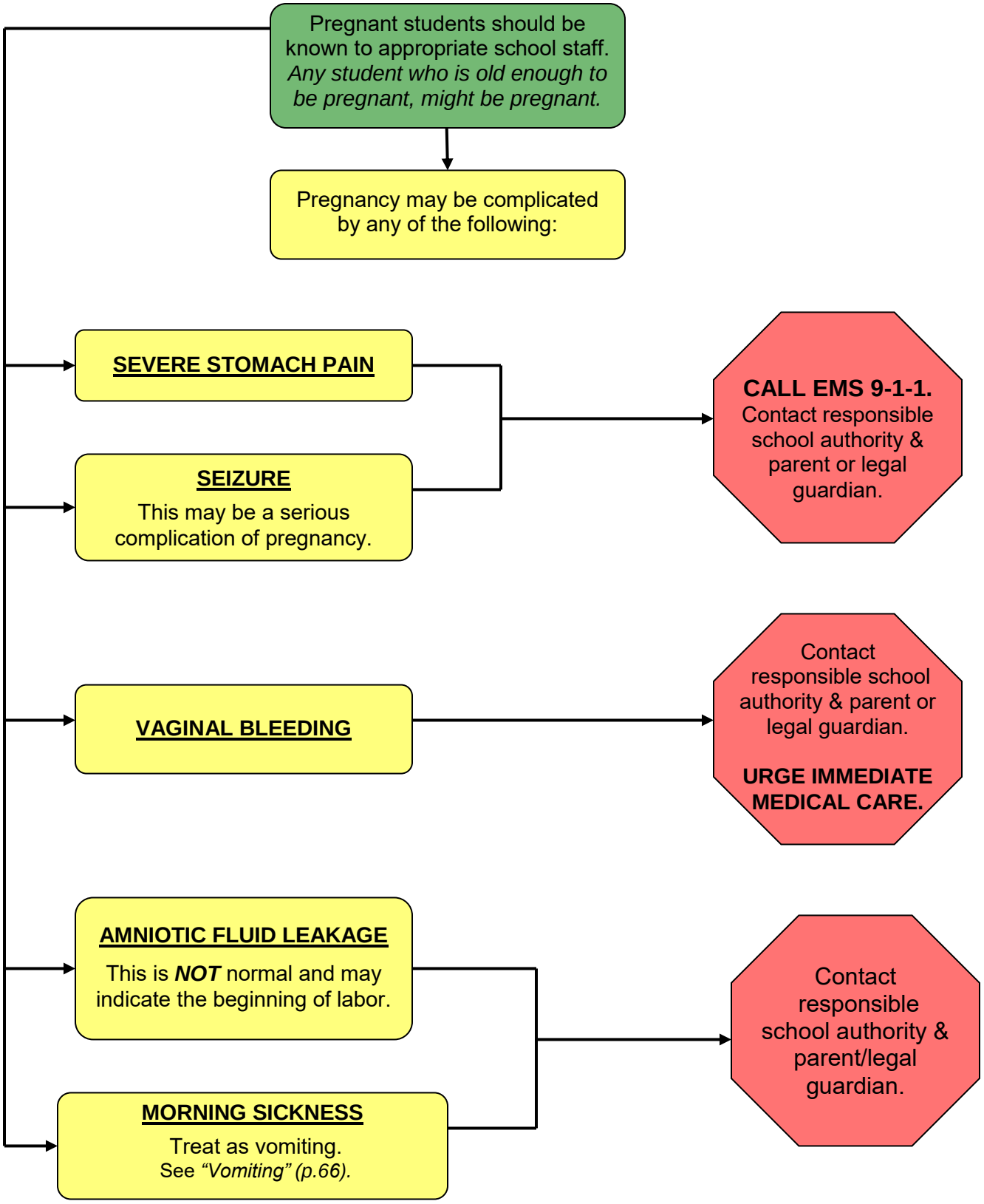
- If student becomes unconscious, place on his/her side. Check airway.
- **If student stops breathing, start CPR.**
  See *"CPR" (pp.24-27).*

CALL EMS 9-1-1.

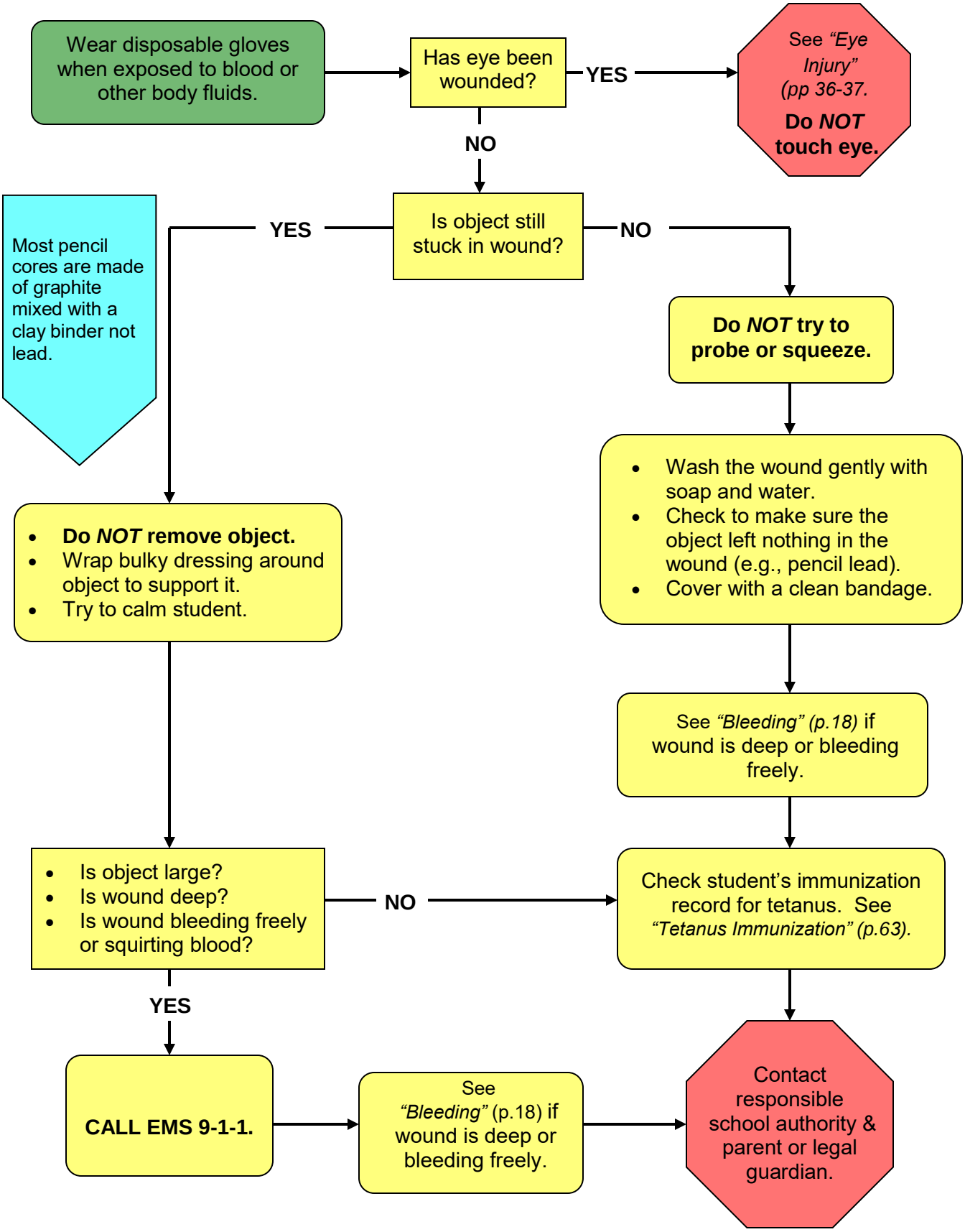
Contact responsible school authority & parent or legal guardian.

Send sample of the vomited material and ingested material with its container (if available) to the hospital with the student.

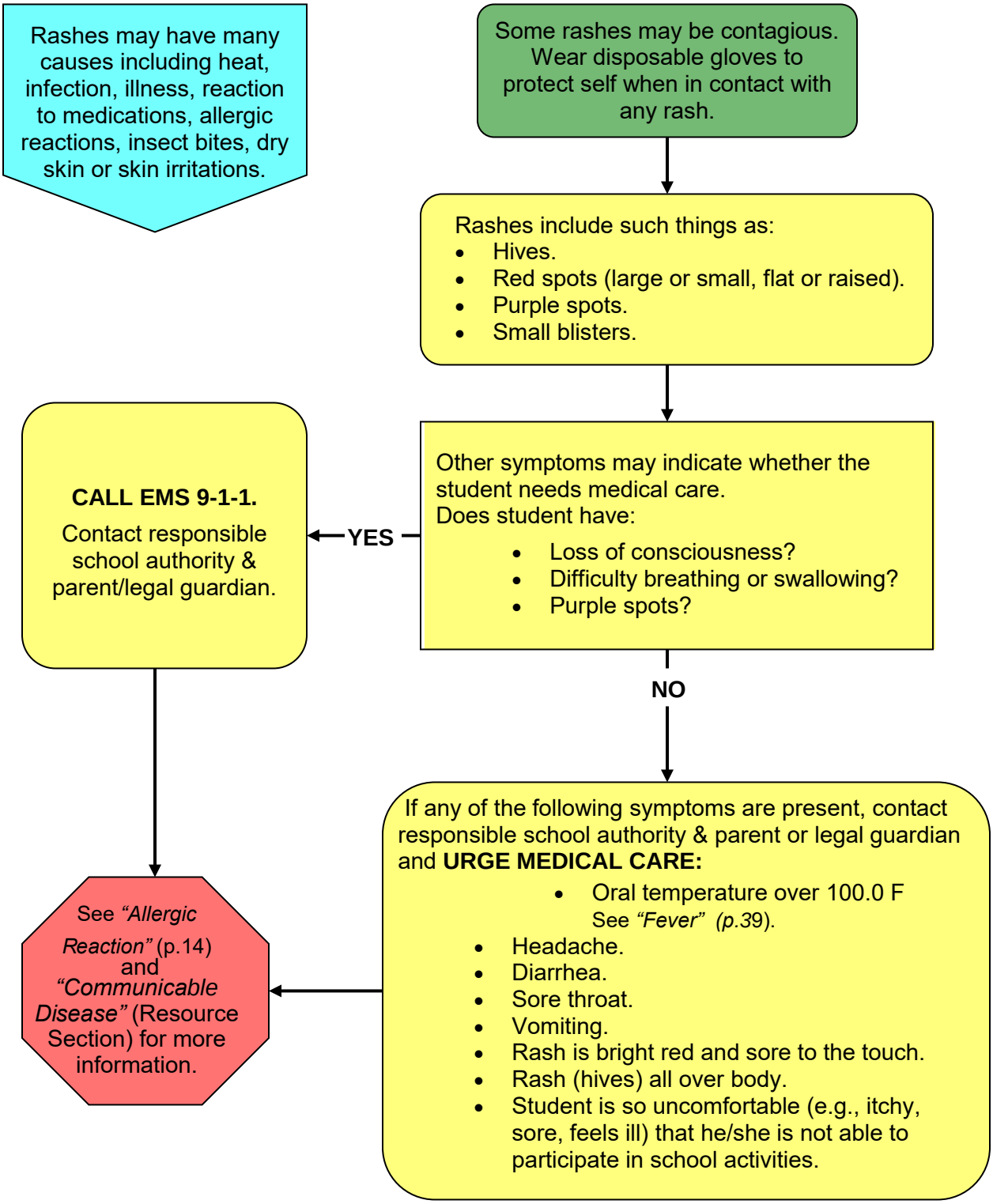
PREGNANCY


Pregnant students should be known to appropriate school staff. *Any student who is old enough to be pregnant, might be pregnant.*
Pregnancy may be complicated by any of the following:
SEVERE STOMACH PAIN
SEIZURE
This may be a serious complication of pregnancy.
CALL EMS 9-1-1. Contact responsible school authority & parent or legal guardian.
VAGINAL BLEEDING
Contact responsible school authority & parent or legal guardian.
URGE IMMEDIATE MEDICAL CARE.
AMNIOTIC FLUID LEAKAGE
This is ***NOT*** normal and may indicate the beginning of labor.
MORNING SICKNESS
Treat as vomiting.
See *"Vomiting" (p.66).*
Contact responsible school authority & parent/legal guardian.

PUNCTURE WOUNDS



RASHES


Rashes may have many causes including heat, infection, illness, reaction to medications, allergic reactions, insect bites, dry skin or skin irritations.
Some rashes may be contagious. Wear disposable gloves to protect self when in contact with any rash.
Rashes include such things as:
• Hives.
• Red spots (large or small, flat or raised).
• Purple spots.
• Small blisters.
Other symptoms may indicate whether the student needs medical care.
Does student have:
• Loss of consciousness?
• Difficulty breathing or swallowing?
• Purple spots?
YES
CALL EMS 9-1-1.
Contact responsible school authority & parent/legal guardian.
NO
If any of the following symptoms are present, contact responsible school authority & parent or legal guardian and URGE MEDICAL CARE:
• Oral temperature over 100.0 F
See "Fever" (p.39).
• Headache.
• Diarrhea.
• Sore throat.
• Vomiting.
• Rash is bright red and sore to the touch.
• Rash (hives) all over body.
• Student is so uncomfortable (e.g., itchy, sore, feels ill) that he/she is not able to participate in school activities.
See "Allergic Reaction" (p.14) and "Communicable Disease" (Resource Section) for more information.

SEIZURES

Seizures may be any of the following:

- Episodes of staring with loss of eye contact.
- Staring involving twitching of the arm and leg muscles.
- Generalized jerking movements of the arms and legs.
- Unusual behavior for that person (e.g., running, belligerence, making strange sounds, etc.).

A student with a history of seizures should be known to appropriate school staff. A Seizure Action plan should be developed, containing a description of the onset, type, duration and after effects of the seizures.

Refer to student's Seizure Action plan.

- If student seems off balance, place him/her on the floor (on a mat) for observation and safety.
- **Do *NOT* restrain movements.**
- Move surrounding objects to avoid injury.
- **Do *NOT* place anything in between the teeth or give anything by mouth.**
- Keep airway clear by placing student on his/her side. A pillow should *NOT* be used.

Observe details of the seizure for parent/legal guardian, emergency personnel or physician. Note:

- Duration.
- Kind of movement or behavior.
- Body parts involved.
- Loss of consciousness, etc.

NO

- Is student having a seizure lasting longer than *5 minutes*?
- Is student having seizures following one another at short intervals?
- Is student *without a known history* of seizures having a seizure?
- Is student having any breathing difficulties after the seizure?

YES

Seizures are often followed by sleep. The student may also be confused. This may last from 15 minutes to an hour or more. After the sleeping period, the student should be encouraged to participate in all normal class activities.

CALL EMS 9-1-1.

Contact responsible school authority & parent or legal guardian.

SHOCK

If injury is suspected, see *"Neck & Back Pain"* (p.48) and treat as a possible neck injury. **Do *NOT* move student unless he/she is endangered.**

- Any serious injury or illness may lead to shock, which is a lack of blood and oxygen getting to the body tissues.
- Shock is a life-threatening condition.
- Stay calm and get immediate assistance.
- Check for medical bracelet or student's emergency care plan if available.

See the appropriate guideline to treat the most severe (life or limb threatening) symptoms first. Is Student:

- Not breathing? See *"CPR" (pp.24-27)* and/or *"Choking" (p. 28).*
- Unconscious? See *"Unconsciousness" (p.65).*
- Bleeding profusely? See *"Bleeding" (p.18).*

YES

CALL EMS 9-1-1.

NO

- Keep student in flat position of comfort.
- Elevate feet 8-10 inches, unless this causes pain or a neck/back or hip injury is suspected.
- Loosen clothing around neck and waist.
- Keep body normal temperature. Cover student with a blanket or sheet.
- Give nothing to eat or drink.
- If student vomits, roll onto left side keeping back and neck in straight alignment if injury is suspected.

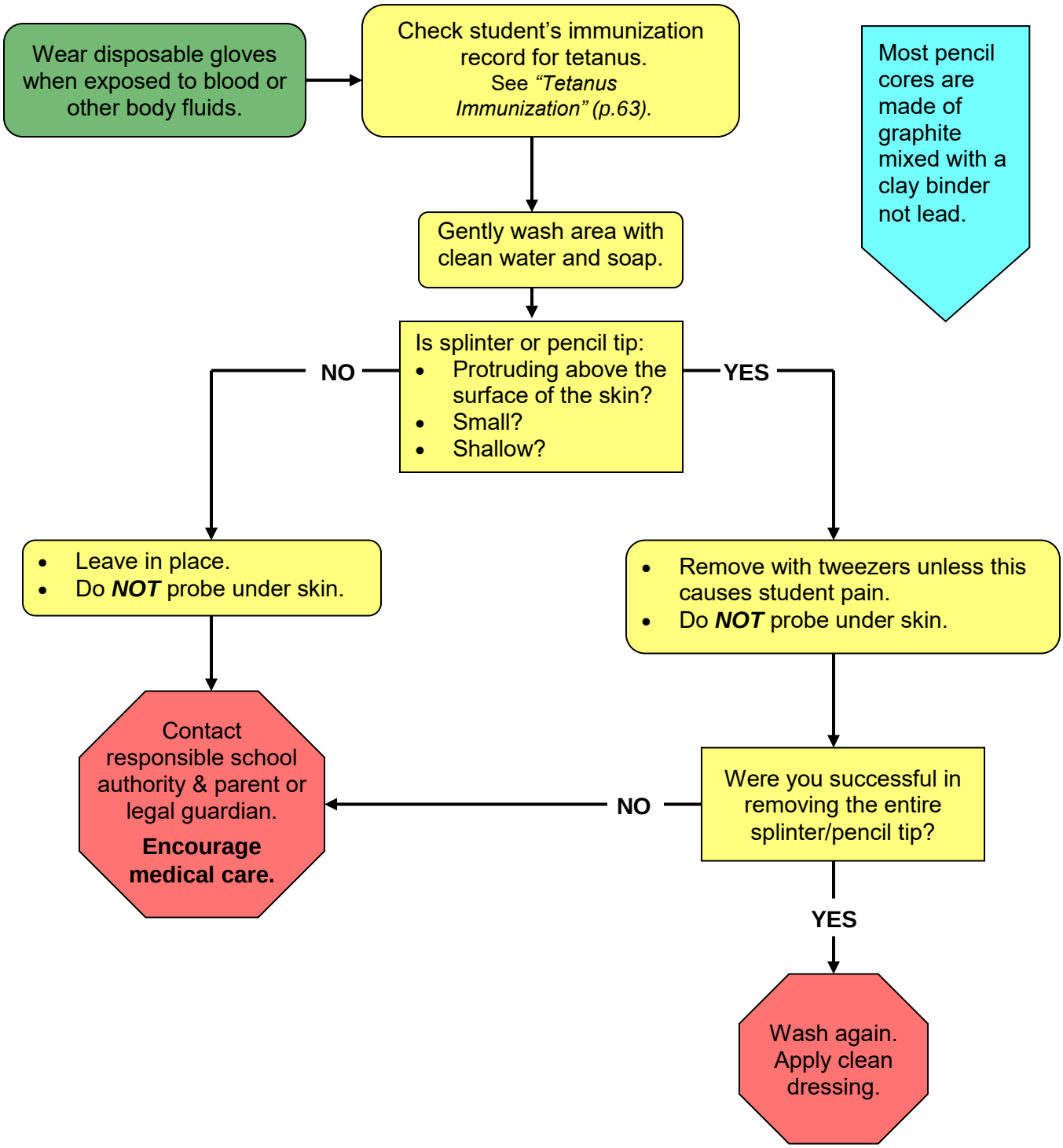
Contact responsible school authority & parent or legal guardian.

URGE MEDICAL CARE if EMS not called.

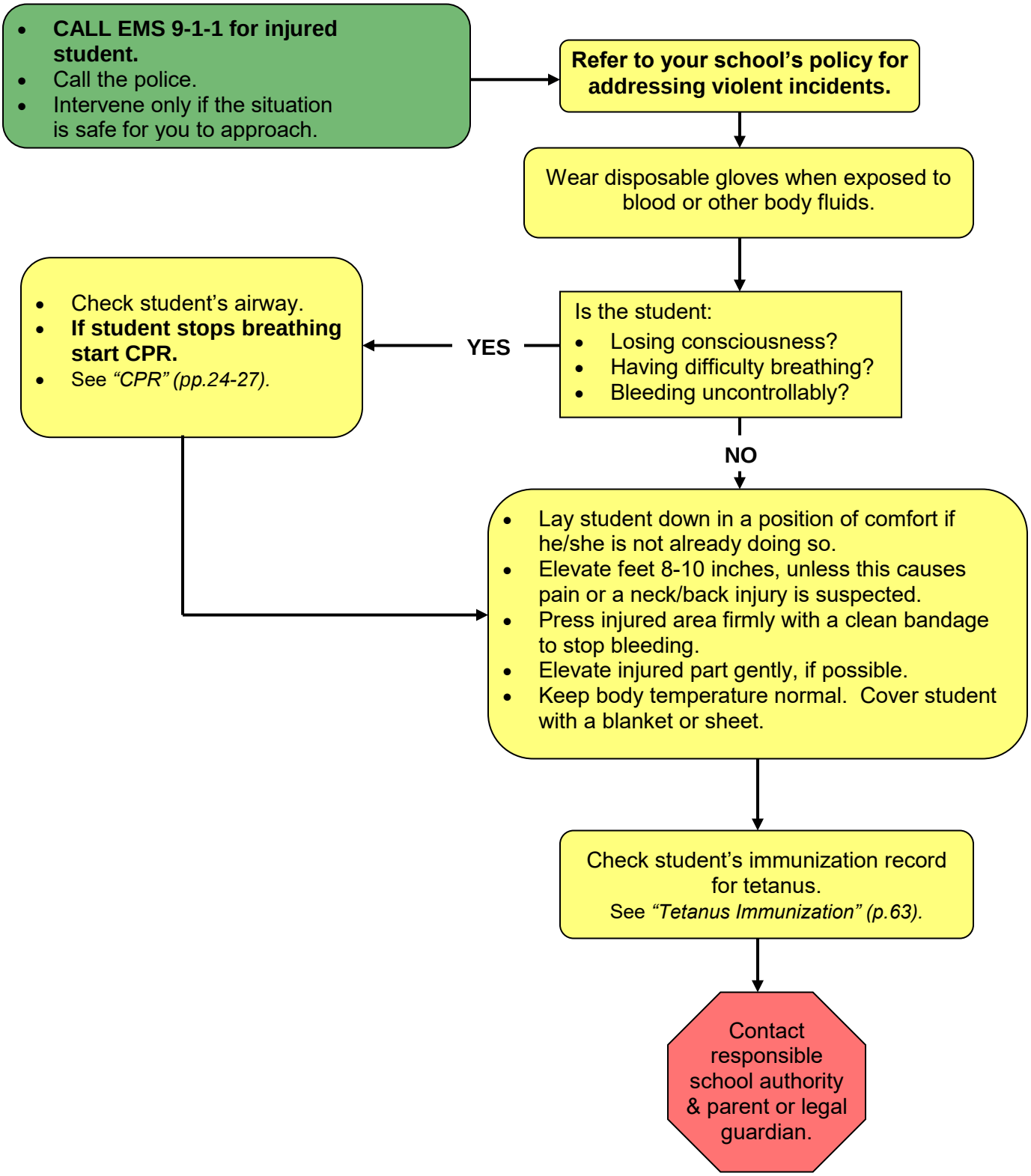
Signs of Shock:

- Pale, cool, moist skin.
- Mottled, ashen, blue skin.
- Altered consciousness or confused.
- Nausea, dizziness or thirst.
- Severe coughing, high pitched whistling sound.
- Blueness in the face.
- Fever greater than 100.0 F in combination with lethargy, loss of consciousness, extreme sleepiness, abnormal activity.
- Unresponsive.
- Difficulty breathing or swallowing.
- Rapid breathing.
- Rapid, weak pulse.
- Restlessness/irritability.

SPLINTERS OR IMBEDDED PENCIL TIP



STABBING & GUNSHOT INJURIES



STINGS

Students with a history of allergy to stings should be known to all school staff. An Allergy Action plan should be developed.

Does student have:

- Difficulty breathing?
- A rapidly expanding area of swelling, especially of the lips, mouth or tongue?
- A history of allergy to stings?

NO

A student may have a delayed allergic reaction up to ***2 hours*** after the sting. Adult(s) supervising student during normal activities should be aware of the sting and should watch for any delayed reaction.

- Remove stinger if present.
- Wash area with soap and water.
- Apply cold compress.

Follow Rule 59 Protocol.

YES

Refer to student's Allergy Action plan.

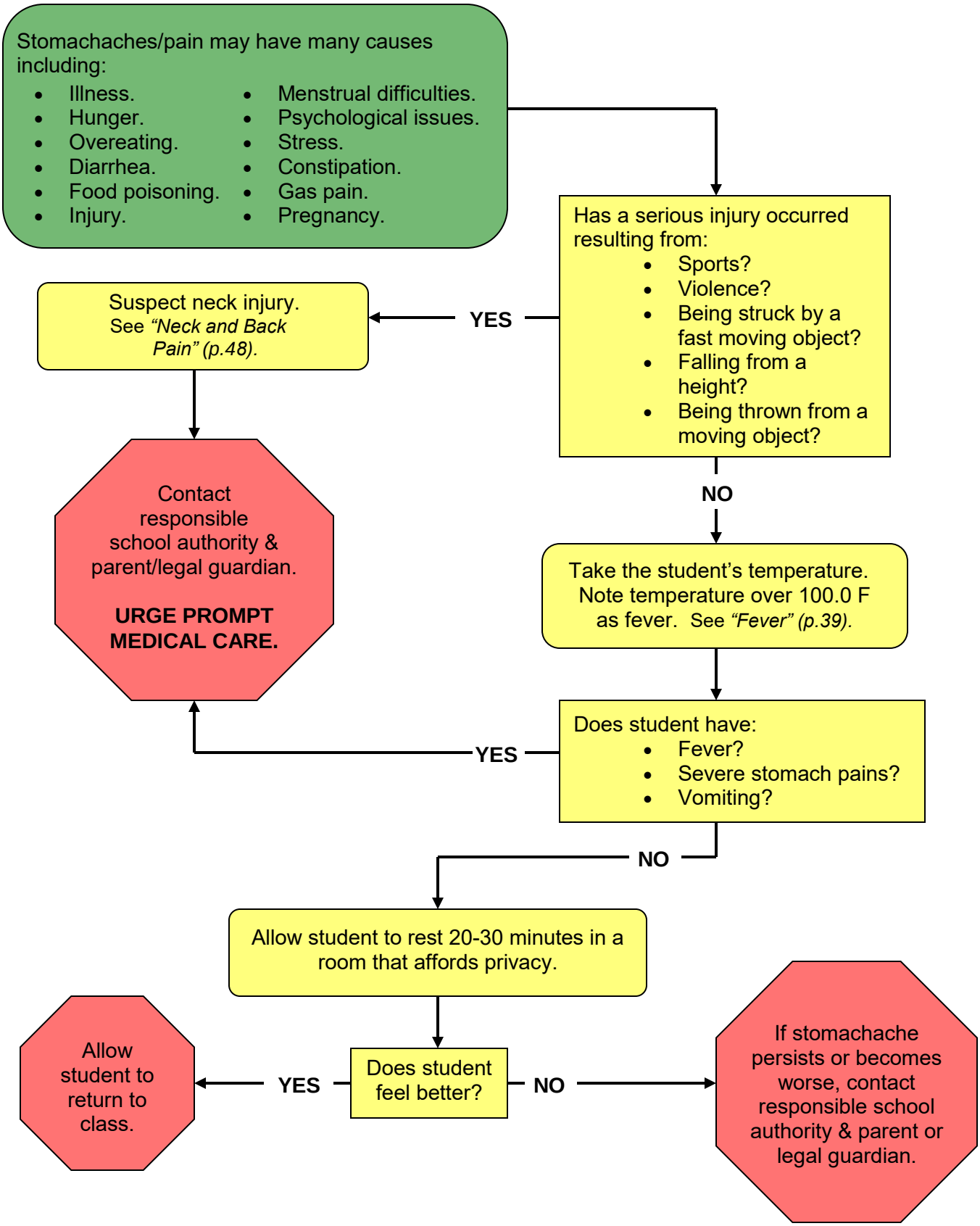
Administer medications as directed in action plan.

CALL EMS 9-1-1.

Are symptoms not improving or getting worse? Are the lips or nail beds turning blue?

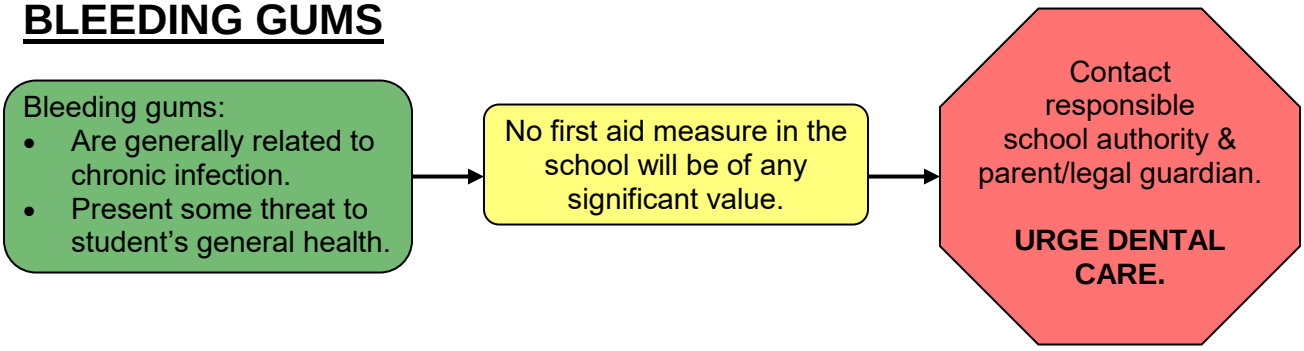
Contact responsible school authority & parent or legal guardian.

STOMACH ACHES/PAIN

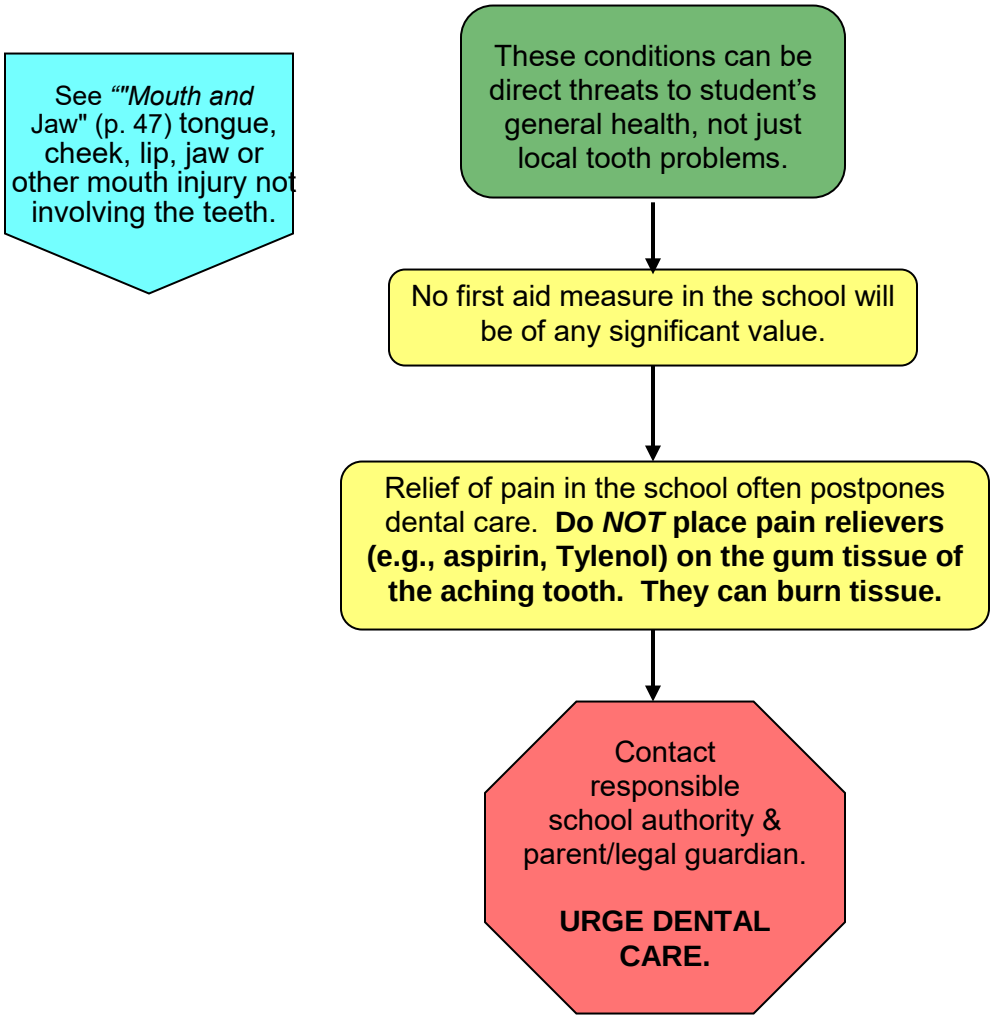


TEETH PROBLEMS

BLEEDING GUMS



TOOTHACHE OR GUM INFECTION



TEETH PROBLEMS

DISPLACED TOOTH

Do *NOT* try to move tooth into correct position.

Contact responsible school authority & parent/legal guardian.

OBTAIN EMERGENCY DENTAL CARE.

KNOCKED-OUT OR BROKEN PERMANENT TOOTH

- Find tooth.
- Do ***NOT*** handle tooth by the root.

If tooth is dirty, clean gently by rinsing with water.

Do *NOT* scrub the knocked-out tooth.

Do not replant primary (baby) teeth back in socket. (No. 1 in list.)

The following steps are listed in order of preference.

Within 15-20 minutes:

1. Place gently back in socket and have student hold in place with tissue or gauze, ***or***
2. Place in glass of milk, ***or***
3. Place in normal saline, ***or***
4. Have student spit in cup and place tooth in it, ***or***
5. Place in a glass of water.

TOOTH MUST *NOT* DRY OUT.

Consider possible head injury

Apply a cold compress to face to minimize swelling.

Contact responsible school authority & parent or legal guardian.

OBTAIN EMERGENCY DENTAL CARE. THE STUDENT SHOULD BE SEEN BY A DENTIST AS SOON AS POSSIBLE.

TETANUS IMMUNIZATION

Protection against tetanus should be considered with any wound, even a minor one. After any wound, check the student's immunization record for tetanus and notify parent or legal guardian.

A **minor wound** would need a tetanus booster **only** if it has been at least **10 years** since the last tetanus shot or if the student is **5 years old or younger.**

Other wounds such as those contaminated by dirt, feces and saliva (or other body fluids); puncture wounds; amputations; and wounds resulting from crushing, burns, and frostbite need a tetanus booster if it has been more than **5 years** since last tetanus shot.

TICKS

Students should be inspected for ticks after time in woods or brush. Ticks may carry serious infections and must be completely removed.

Do *NOT* handle ticks with bare hands.

Refer to your school's policy regarding the removal of ticks.

Wear disposable gloves when exposed to blood and other body fluids.

Wash the tick area gently with soap and water before attempting removal.

- Using tweezers, grasp the tick as close to the skin surface as possible and pull upward with steady, even pressure.
- **Do *NOT* twist or jerk the tick as the mouth parts may break off.** It is important to remove the *ENTIRE* tick.
- Take care not to squeeze, crush or puncture the body of the tick as its fluids may carry infection.

- After removal, wash the tick area thoroughly with soap and water.
- Wash your hands.
- Apply a bandage.

Ticks can be safely thrown away by placing them in container of alcohol or flushing them down the toilet.

Contact responsible school authority & parent/legal guardian.

UNCONSCIOUSNESS

If student stops breathing, and no one else is available to call EMS, administer CPR for 2 minutes and then call EMS yourself.

Unconsciousness may have many causes including:

- Injuries.
- Blood loss/shock.
- Poisoning.
- Severe allergic reaction.
- Diabetic reaction.
- Heat exhaustion.
- Illness.
- Fatigue.
- Stress.
- Not eating.

If you know the cause of the unconsciousness, see the appropriate guideline.

Did student regain consciousness immediately?

YES → See *"Fainting" (p.38.*

NO

Is unconsciousness due to injury?

YES

- See *"Neck & Back Pain" (p.4*8) and treat as a possible neck injury.
- **Do *NOT* move student.**

NO

- Open airway with head tilt/chin lift.

Is student breathing?

YES → **CALL EMS 9-1-1.**

NO → **Begin CPR.** *See "CPR" (pp.24-27).*

CALL EMS 9-1-1.

- Keep student in flat position of comfort.
- Elevate feet 8-10 inches unless this causes pain or a neck/back or hip injury is suspected.
- Loosen clothing around neck and waist.
- Keep body normal temperature. Cover student with a blanket or sheet.
- Give nothing to eat or drink.
- If student vomits, roll onto left side keeping back and neck in straight alignment if injury is suspected.
- Examine student from head-to-toe and give first aid for conditions as needed.

Contact responsible school authority & parent/legal guardian.

VOMITING

If a number of students or staff become ill with the same symptoms, suspect food poisoning.

CALL POISON CONTROL 1-800-222-1222.

and ask for instructions. See *"Poisoning" (p.50)* and notify local health department.

Vomiting may have many causes including:

- Illness.
- Bulimia.
- Anxiety.
- Pregnancy.
- Injury/head injury.
- Heat exhaustion.
- Overexertion.
- Food Poisoning.

Wear disposable gloves when exposed to blood and other body fluids.

Take student's temperature. Note oral temperature over 100.0 F as fever.
See Fever (p. 39)

- Have student lie down on his/her side in a room that affords privacy and allow him/her to rest.
- Apply a cool, damp cloth to student's face or forehead.
- Have a bucket available.
- Give no food or medications, although you may offer student ice chips or small sips of clear fluids containing sugar (such as 7Up or Gatorade), if the student is thirsty.

Does the student have:

- Repeated vomiting?
- Fever?
- Severe stomach pains?

Is the student dizzy and pale?

YES

Contact responsible school authority & parent/legal guardian.

URGE MEDICAL CARE.

NO

Contact responsible school authority & parent/legal guardian.

RESOURCE SECTION

NEBRASKA DEPARTMENT
OF EDUCATION

RULE 59

REGULATIONS FOR SCHOOL HEALTH AND SAFETY

TITLE 92, NEBRASKA ADMINISTRATIVE CODE,
CHAPTER 59

EFFECTIVE DATE
MAY 13, 2006
(REVISED)

State of Nebraska
Department of Education
301 Centennial Mall South
Lincoln, Nebraska 68509

TITLE 92 - NEBRASKA DEPARTMENT OF EDUCATION
CHAPTER 59 - REGULATIONS FOR SCHOOL HEALTH AND SAFETY

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CHAPTER 59 - REGULATIONS FOR SCHOOL HEALTH AND SAFETY

001 General Provisions.

001.01 Statutory Authority. This Chapter is adopted pursuant to Sections 79-305, 79-318; Sections 79-1102 to 79-1104 and the Medication Aide Act in Sections 71-6718 through 71-6742 of the Revised Statutes of Nebraska (R.R.S.).

001.02 Medication Aide Act Requirements. Sections 003, 004 and 005 of this Chapter set forth the methods for competency assessment for school staff who provide medications and/or participate in observing and reporting for monitoring medications. In order for a school to assess the competency of staff members to provide medication as mentioned above, the staff members must be able to successfully pass a competency assessment no less than every three (3) years. Such competency assessments shall consist of a demonstration by the school staff member of each of the competencies listed in Sections 004.01A through 004.01N to the satisfaction of the health care professional designated by the school to conduct the assessment.

001.02A Nothing in this Chapter shall be construed to require any school to employ or use a school nurse or medication aide in order to be in compliance with the Medication Aide Act.

001.03 Related Regulations. In addition to this Chapter, accredited schools must comply with 92 NAC 10; approved schools must comply with 92 NAC 14; and, early childhood education programs must comply with 92 NAC 11. The requirements of Sections 003, 004 and 005 of this Chapter are directly related to the provisions set forth in Title 172, Nebraska Administrative Code, Chapter 95 which is promulgated by the Department of Health and Human Services Regulation and Licensure and is entitled, *Regulations Governing the Provision of Medications by Medication Aides and Other Unlicensed Persons*.

002 Definitions.

002.01 Accredited Schools shall mean a public school district or a nonpublic school or group of nonpublic schools under a governing body organized to provide education in elementary, middle, secondary, and/or high school grades accredited pursuant to Title 92, NAC, Chapter 10.

002.02 Administration of medication shall include, but is not limited to:

002.02A Providing medication for another person according to the five rights as defined in Section 002.07;

002.02B Recording medication provision; and,

002.02C Observing, monitoring, reporting, and otherwise taking appropriate actions regarding desired effects, side effects, interactions, and contraindications associated with the medication.

002.03 Approved schools shall mean a nonpublic school or group of schools under a governing body organized to provide education in elementary and/or secondary grades approved pursuant to Title 92, NAC, Chapter 14.

002.04 Caretaker shall mean a parent, foster parent, family member, friend, or legal guardian who provides care for an individual.

002.05 Direction and monitoring shall mean the acceptance of responsibility for observing and taking appropriate action regarding any desired effects, side effects, interactions, and contraindications associated with the medication by:

002.05A A recipient with capability and capacity to make an informed decision about medications;

002.05B Caretaker; or,

002.05C Licensed health care professional.

002.06 Approved Early Childhood Education Program shall mean any prekindergarten part-day or full-day program with a stated purpose of promoting social, emotional, intellectual, language, physical, and aesthetic development and learning for children from birth to kindergarten entrance age and family development and support established by a school board or an educational service unit and approved pursuant to Title 92, NAC, Chapter 11.

002.07 Five rights shall mean getting the right drug to the right recipient in the right dosage by the right route at the right time.

002.08 Health care professional shall mean an individual for whom administration of medication is included in his/her scope of practice, and is licensed by the Department of Health and Human Services.

002.09 Informed decision shall mean a decision made knowingly, based upon capacity to process information about choices and consequences, and made voluntarily.

002.10 Medication shall mean any prescription or nonprescription drug intended

for treatment or prevention of disease or to affect body function in humans.

002.11 Medication Aide shall mean an individual who is listed on the medication aide registry operated by the Department of Health and Human Services Regulation and Licensure.

002.12 Minimum Competencies shall include:

002.12A Maintaining confidentiality;

002.12B Complying with a recipient's right to refuse to take medication;

002.12C Maintaining hygiene and current accepted standards for infection control;

002.12D Documenting accurately and completely;

002.12E Providing medications according to the five rights;

002.12F Having the ability to understand and follow instructions;

002.12G Practicing safety in application of medication procedures;

002.12H Complying with limitations and conditions under which a medication aide (and other unlicensed persons) may provide medications according to provisions contained in Title 172, Nebraska Administrative Code, Chapter 95; and,

002.12I Having an awareness of abuse and neglect reporting requirements and any other areas as shall be determined by Title 172, Nebraska Administrative Code, Chapter 95.

002.13 PRN shall mean an administration scheme in which a medication is not routine, is taken as needed and requires assessment for need and effectiveness.

002.14 Provision of medication shall mean the component of the administration of medication that includes giving or applying a dose of a medication to an individual and includes helping an individual in giving or applying such medication to himself or herself.

002.15 Recipient with capability and capacity to make an informed decision about medications shall mean an individual who is an adult (at least 19 years of age) and has knowledge related to the medication(s) such as purposes and desired effects, potential side effects, and the consequences if the medication is not provided and received as prescribed or recommended.

002.16 Routine, with reference to medication, shall mean the frequency of administration, amount, strength, and method are specifically fixed.

002.17 School shall mean an entity or person meeting the requirements for a school set by Chapter 79, including accredited schools pursuant to 92 NAC 10 and approved schools pursuant to 92 NAC 14.

002.18 School staff shall mean individuals who are employed by a school, some of whom may be required to undergo a competency assessment pursuant to this Chapter. School staff shall include substitute teachers and all other temporary employees. Licensed health care professionals who are employed by a school are exempt from the competency assessments contained in this Chapter.

003 Medication Aide Act - Provision of Medication.

003.01 A staff member of a school may participate in medication administration, when directed and monitored by a recipient with capability and capacity to make an informed decision about medications, caretaker, or health care professional, by providing medications in compliance with the Medication Aide Act and rules and regulations adopted and promulgated under the Act, including Title 172, Nebraska Administrative Code, Chapter 95. In each case, the individual responsible for providing direction and monitoring shall be identified in writing and indication that such individual has accepted such responsibility shall also be identified in writing.

003.02 A staff member of a school determined to be competent by a recipient with capability and capacity to make an informed decision about medications, or by a caretaker, or by the method set forth in Section 004.01 may provide routine medications by the following routes:

003.02A Oral which includes any medication given by mouth including sublingual (placing under the tongue) and buccal (placing between the cheek and gum) routes and oral sprays;

003.02B Inhalation which includes inhalers, and nebulizers. Oxygen may be given by inhalation;

003.02C Topical application of sprays, creams, ointments, and lotions and transdermal patches; and,

003.02D Instillation by drops, ointments, and sprays into the eyes, ears and nose.

003.03 A staff member of a school determined to be competent by a recipient with capability and capacity to make an informed decision about medications, or by a

caretaker, or by the method set forth in Section 004.01 may provide medications through additional activities listed in Sections 003.03A through 003.03C, if it has been determined by a licensed health care professional and placed in writing that these activities can be done safely for a specified recipient.

003.03A Provision of PRN medications;

003.03B Provision of medications by routes in addition to those identified in Sections 003.02A through 003.02D including, but not limited to gastrostomy tube, rectal, and vaginal; and/or

003.03C Participation in observing and reporting for monitoring medications.

003.04 Direction for staff members of a school to provide medication by routes not listed in Section 003.02 must be for recipient specific procedures and must be in writing. Direction for PRN medication must be in writing and include the parameters for provision of the PRN medication. Direction for observing and reporting for monitoring medication must be in writing and include the parameters for the observation and reporting. Staff members of a school shall comply with written directions.

004 Medication Aide Act - Competency Assessment.

004.01 Competencies. In order for a school to assess the competency of staff members to provide medication, the staff members of the school must be able to successfully pass a competency assessment no less than every three (3) years. Such competency assessments shall consist of a demonstration by the school staff member of each of the following competencies (as set forth in Title 172, Nebraska Administrative Code, Chapter 95, Section 004) to the satisfaction of the health care professional designated by the school to conduct the assessment:

004.01A Recognize the recipient's right to personal privacy regarding health status, any diagnosis of illness, medication therapy and items of similar nature. Information of this nature should only be shared with appropriate interdisciplinary team members.

004.01B Recognize and honor the right of those recipients with capability and capacity to make informed decision about medications, to refuse medications and at no time force a recipient to take medications. In the case of a recipient who does not have the capability and capacity to make informed decisions about medication, recognize the requirement to seek advice and consultation from the caretaker or the licensed health care professional providing direction and monitoring regarding the procedures and persuasive methods to be used to encourage compliance with medication provision. Recognize that persuasive methods should not include anything that causes injury to the recipient.

004.01C Follow currently acceptable standards in hygiene and infection control including hand washing.

004.01D Follow facility policies and procedures regarding storage and handling of medication, medication expiration date, disposal of medication and similar policies and procedures implemented in the facility to safeguard medication provision to recipients.

004.01E Recognize general unsafe conditions indicating that the medication should not be provided including change in consistency or color of the medication, unlabeled medication or illegible medication label, and those medications that have expired. Recognize that the unsafe condition(s) should be reported to the caretaker or licensed health care professional responsible for providing direction and monitoring.

004.01F Accurately document medication name, dose, route, and time administered, or refusal.

004.01G Provide the right medication, to the right person, at the right time, in the right dose, and by the right route.

004.01G1 As part of the assessment related to this "competency," staff members must demonstrate an understanding of what specific identification measures are appropriate, including visual identification for situations when the school staff member is not familiar with the child's identity. Schools are responsible for developing safeguards to ensure that students are not misidentified when receiving medication.

004.01H Provide medications according to the specialty needs of recipients based upon such things as age, swallowing ability, and ability to cooperate.

004.01I Recognize general conditions which may indicate an adverse reaction to medication such as rashes/hives, and recognize general changes in recipient condition which may indicate inability to receive medications. Examples include altered state of consciousness, inability to swallow medications, vomiting, inability to cooperate with receiving medications and other similar conditions. Recognize that all such conditions shall be reported to the caretaker or licensed health care professional responsible for providing direction and monitoring.

004.01J Safely provide medications for all ages of recipients according to the following routes: oral, topical, inhalation and instillation as referenced in Title 172, Nebraska Administrative Code, Chapter 95--Section 005.

004.01K Recognize the limits and conditions by which a medication aide or other unlicensed person may provide medications.

004.01L Recognize the responsibility to report and the mechanisms for communicating such to the appropriate authorities if reasonable cause exists to believe that a vulnerable adult has been subjected to abuse or conditions or circumstances which would result in abuse in accordance with Neb. Rev. Stat. §28-372.

004.01M Recognize the responsibility to report and the mechanisms for communicating such to the appropriate authorities if reasonable cause exists to believe that a child has been subjected to abuse or neglect or observes a child being subjected to conditions or circumstances which reasonably would result in abuse or neglect in accordance with Neb. Rev. Stat. §28-711.

004.01N Recognize the recipient's property rights and physical boundaries.

004.02 School staff members shall not be required to take a course, or be listed on the Medication Aide Registry in order to meet the requirements of this Chapter.

005 Medication Aide Act - Documentation.

005.01 Health care professionals designated by the school to conduct competency assessments, as described in Section 004, shall provide the school staff member and the school with written documentation of successful completion of competency assessment. Documentation may be by letter, certificate, or other official record designated by the school and shall include:

005.01A The name of the school staff member who successfully completed the competency assessment;

005.01B The date the competency assessment was conducted; and,

005.01C The name, profession, and license number of the health care professional who conducted the competency assessment.

005.02 Schools shall maintain written documentation of successful completion of competency assessments, identification of the individual providing direction and monitoring, and acceptance of the responsibility for direction and monitoring for a minimum of two (2) years.

005.03 Schools shall keep and maintain accurate records of administration of medication by school staff. The record of administration of medication shall include but not be limited to:

005.03A Identification of the recipient;

005.03B Name of the medication given;

005.03C The date, time, dosage and route for each medication provided;

005.03D Identification of the person who provided the medication; and,

005.03E Any refusal by the recipient to take and/or receive a medication.

005.04 Records maintained pursuant to Sections 005.01, 005.02, and 005.03 shall be available to the Department of Education and the Department of Health and Human Services Regulation and Licensure for inspection and copying according to the Family Education Rights and Privacy Act (FERPA) requirements.

006 Emergency Response to Life Threatening Asthma or Systemic Allergic Reactions (Anaphylaxis).

006.01 Emergency Protocol. All Accredited Schools, Approved Schools, and Approved Early Childhood Education Programs shall adopt and implement the Emergency Response to Life-Threatening Asthma or Systemic Allergic Reactions (Anaphylaxis) Protocol contained in Appendix A of this Chapter. In addition to adopting the protocol, Accredited Schools, Approved Schools and Early Childhood Education Programs shall procure and maintain the equipment and medication necessary to implement the protocol in each school building while school is in session in the case of any student and/or school staff emergency.

006.02 Physician Authorization. Accredited schools, Approved schools, and Approved Early Childhood Education Programs shall obtain a minimum of one signature of a physician licensed to practice medicine in Nebraska on the bottom of the protocol in Appendix A of this Chapter.

006.03 Effective Date. Accredited Schools, Approved Schools, and Approved Early Childhood Education Programs shall comply with the requirement to adopt the protocol and be prepared to begin implementing the protocol in emergency situations no later than the end of the 2003-2004 academic school year.

006.04 Parental and/or Guardian Objections to Protocol. The requirements of this Chapter do not preclude Accredited Schools, Approved Schools, and Approved Early Childhood Education Programs from complying with a request from a parent or guardian that a minor student not receive emergency treatment under the protocol. A school district's decision to withhold emergency treatment in such circumstances is not governed by this Chapter.

007 Enforcement.

007.01 A school shall be subject to discipline under Title 92, Nebraska Administrative Code, Chapter 10 or Chapter 14 for violation of the Medication Aide Act or Sections 002 through 005 in this Chapter, or provisions in Title 172, Nebraska Administrative Code, Chapter 95.

EMERGENCY RESPONSE TO LIFE-THREATENING ASTHMA OR SYSTEMIC ALLERGIC REACTIONS (ANAPHYLAXIS)

DEFINITION: Life-threatening asthma consists of an *acute episode of worsening airflow obstruction. Immediate action and monitoring are necessary.*

A systemic allergic reaction (anaphylaxis) is a severe response resulting in cardiovascular collapse (shock) after the injection of an antigen (e.g. bee or other insect sting), ingestion of a food or *medication*, or exposure to other allergens, such as animal fur, chemical irritants, pollens or molds, among others. The blood pressure falls, the pulse becomes weak, **AND DEATH CAN OCCUR**. Immediate allergic reactions may require emergency treatment and medications.

LIFE-THREATENING ASTHMA SYMPTOMS: Any of these symptoms may occur:

- Chest tightness
- Wheezing
- Severe shortness of breath
- Retractions (chest or neck "sucked in")
- Cyanosis (lips and nail beds exhibit a grayish or bluish color)
- Change in mental status, such as agitation, anxiety, or lethargy
- A hunched-over position
- Breathlessness causing speech in one-to-two word phrases or complete inability to speak

ANAPHYLACTIC SYMPTOMS OF BODY SYSTEM: Any of the symptoms may occur within seconds. The more immediate the reactions, the more severe the reaction may become. Any of the symptoms present requires several hours of monitoring.

- Skin: warmth, itching, and/or tingling of underarms/groin, flushing, hives
- Abdominal: pain, nausea and vomiting, diarrhea
- Oral/Respiratory: sneezing, swelling of face (lips, mouth, tongue, throat), lump or tightness in the throat, hoarseness, difficulty inhaling, shortness of breath, decrease in peak flow meter reading, wheezing reaction
- Cardiovascular: headache, low blood pressure (shock), lightheadedness, fainting, loss of consciousness, rapid heart rate, ventricular fibrillation (no pulse)
- Mental status: apprehension, anxiety, restlessness, irritability

EMERGENCY PROTOCOL:

1. **CALL 911**
2. Summon school nurse if available. If not, summon designated trained, non-medical staff to implement emergency protocol
3. Check airway patency, breathing, respiratory rate, and pulse
4. Administer medications (EpiPen and albuterol) per standing order
5. Determine cause as quickly as possible
6. Monitor vital signs (pulse, respiration, etc.)
7. Contact parents immediately and physician as soon as possible
8. Any individual treated for symptoms with epinephrine at school will be transferred to medical facility

STANDING ORDERS FOR RESPONSE TO LIFE-THREATENING ASTHMA OR ANAPHYLAXIS:

- Administer an IM EpiPen-Jr. for a child less than 50 pounds or an adult EpiPen for any individual over 50 pounds
- Follow with nebulized albuterol (premixed) while awaiting EMS. If not better, may repeat times two, back-to-back
- Administer CPR, if indicated

_____ _____
(PHYSICIAN) Date (PHYSICIAN) Date

_____ _____
(PHYSICIAN) Date (PHYSICIAN) Date

RECOMMEDED FIRST AID EQUIPMENT AND SUPPLIES FOR SCHOOLS

1. Current first aid, choking and CPR manual and wall chart(s) such as the American Academy of Pediatrics' Pediatric First Aid for Caregivers and Teachers (PedFACTS) Resource Manual and 3-in-1 First Aid, Choking, CPR Chart available at http://www.aap.org and similar organizations.
2. Cot: mattress with waterproof cover (disposable paper covers and pillowcases).
3. Small portable basin.
4. Covered waste receptacle with disposable liners.
5. Bandage scissors & tweezers.
6. Non-mercury thermometer.
7. Sink with running water.
8. Expendable supplies:
    - Sterile cotton-tipped applicators, individually packaged.
    - Sterile adhesive compresses (1"x3"), individually packaged.
    - Cotton balls.
    - Sterile gauze squares (2"x2"; 3"x3"), individually packaged.
    - Adhesive tape (1" width).
    - Gauze bandage (1" and 2" widths).
    - Cold packs (compresses).
    - Tongue blades.
    - Triangular bandages for sling.
    - Safety pins.
    - Soap.
    - Disposable facial tissues.
    - Paper towels.
    - Sanitary napkins.
    - Disposable gloves (vinyl preferred).
    - Pocket mask/face shield for CPR.
    - Disposable surgical masks.
    - One flashlight with spare bulb and batteries.
    - Appropriate cleaning solution such as a tuberculocidal agent that kills hepatitis B virus or household chlorine bleach. *A fresh solution of chlorine bleach must be mixed every 24 hours in a ratio of 1 unit bleach to 9 units water.*

PANDEMIC FLU PLANNING FOR SCHOOLS

FLU TERMS DEFINED

Seasonal (or common) flu is a respiratory illness that can be transmitted person-to-person. Most people have some immunity and a vaccine is available.

Avian (or bird) flu is caused by influenza viruses that occur naturally among wild birds. The H5N1 variant is deadly to domestic fowl and can be transmitted from birds to humans. There is no human immunity and no vaccine is available.

Pandemic flu is human flu that causes a global outbreak, or pandemic, of illness. Because there is little natural immunity, the disease can spread easily from person to person.

INFLUENZA SYMPTOMS

According to the Centers for Disease Control and Prevention (CDC) influenza symptoms usually start suddenly and may include the following:

- Fever
- Headache
- Extreme tiredness
- Dry cough
- Sore throat
- Body ache

Influenza is a respiratory disease.

Source: Centers for Disease Control and Prevention (CDC)

INFECTION CONTROL GUIDELINES FOR SCHOOLS

1) Recognize the symptoms of flu:
   Fever Headache
   Cough Body ache

2) Stay home if you are ill and remain home for at least 24 hours after you no longer have a fever, or signs of a fever, without the use of fever-reducing medicines. Students, staff, and faculty may return 24 hours after symptoms have resolved.

3) Cover your cough:

   - Use a tissue when you cough or sneeze and put used tissue in the nearest wastebasket.
   - If tissues are not available, cough into your elbow or upper sleeve area, not your hand.
   - Wash your hands after you cough or sneeze.

4) Wash your hands:
   - Using soap and water after coughing, sneezing or blowing your nose
   - Using alcohol-based hand sanitizers if soap and paper towel available

5) Have regular inspections of the school hand washing facilities to assure soap and paper available.

6) Follow a regular cleaning schedule of frequently touched surfaces including handrails, door handles and restrooms using usual cleaners.

7) Have appropriate supplies for students and staff including tissues, waste receptacles for disposing used tissues and hand washing supplies (soap and water or alcohol-based hand sanitizers.

SCHOOLS ACTION STEPS FOR PANDEMIC FLU

The following are steps schools can take before, during and after a pandemic flu outbreak. Remember that a pandemic may have several cycles, waves or outbreaks so these steps may need to be repeated. Guidelines issued by the Nebraska Department of Health and Human Services are in the process of being rewritten.

PREPAREDNESS/PLANNING PHASE – BEFORE AN OUTBREAK OCCURS

1. Develop a pandemic flu plan for your school using the CDC School Pandemic Flu Planning Checklist available at https://www.cdc.gov/h1n1flu/schools.
2. Build a strong relationship with your local health department and include them in the planning process.
3. Train school staff to recognize symptoms of influenza.
4. Follow your school policies to decide to what extent you will encourage or require students and staff to stay home when they are ill.
5. Have a method of disease recognition (disease surveillance) in place. Report increased absenteeism or new disease trends to the local health department.
6. Make sure the school is stocked with supplies for frequent hand hygiene including soap, water, alcohol-based hand sanitizers and paper towels.
7. Encourage good hand hygiene and respiratory etiquette in all staff and students.
8. Identify students who are immune compromised or chronically ill who may be most vulnerable to serious illness. Encourage their families to talk with their health care provider regarding special precautions during influenza outbreaks.
9. Develop alternative learning strategies to continue education in the event of an influenza pandemic.

RESPONSE – DURING AN OUTBREAK

1. Heighten disease surveillance and reporting to the local health department.
2. Communicate regularly with parents informing them of the community and school status and expectations during periods of increased disease.
3. Work with local education representatives and the local health department to determine if the school should cancel non-academic events or close the school.
4. Report any school dismissals due to influenza online at https://www.cdc.gov/FluSchoolDismissal.
5. Continue to educate students, staff and families on the importance of hand hygiene and respiratory etiquette.

RECOVERY – FOLLOWING AN OUTBREAK

1. Continue to communicate with the local health department regarding the status of disease in the community and the school.
2. Communicate with parents regarding the status of the education process.
3. Continue to monitor disease surveillance and report disease trends to the health department.
4. Provide resources/referrals to staff and students who need assistance in dealing with the emotional aspects of the pandemic experience. Trauma-related stress may occur after any catastrophic event and may last a few days, a few months or longer, depending on the severity of the event.

SHOOTING

IF A PERSON THREATENS WITH A FIREARM OR BEGINS SHOOTING

Staff and Children:

- *If you are outside with the shooter outside* – go inside the building as soon as possible. If you cannot get inside, make yourself as compact as possible; put something between yourself and the shooter; do not gather in groups.
- *If you are inside with the shooter inside* – turn off lights; lock all doors and windows; shut curtains, if it is safe to do so.
- Children, staff and visitors should crouch under furniture without talking and remain there until an all-clear is given by the administrator or designee.
- Check open areas for wandering children and bring them immediately into a safe area.
- Staff should take roll call and immediately notify the administrator of any missing children or staff when it is safe to do so.

Administrator/Police Liaison:

- Assess the situation as to:
  - The shooter's location
  - Any injuries
  - Potential for additional shooting
- Call 9-1-1 and give as much detail as possible about the situation.
- Secure the facility, if appropriate.
- Assist children and staff in evacuating from immediate danger to safe area.
- Care for the injured as carefully as possible until law enforcement and paramedics arrive.
- Be careful to preserve the scene while providing care to the injured patient.
- Refer media to designated public information person per media procedures.
- Administrator to prepare information to release to media and parent(s)/guardian(s).
- Notify parent(s)/guardian(s) according to policies.
- Hold information meeting with staff.
- Initiate a crisis/grief counseling plan.

CRISIS TEAM MEMBERS

Position	Name	Work #	Home #	Cell/Pager	Room#
Administrator					
Designee					
Psychologist					
Counselor					
Nurse					
Secretary					

CPR/FIRST AID CERTIFIED STAFF

Name	Room	CPR – Yes/No	First Aid – Yes/No

CRISIS CONTACTS

Name	Emergency Contact Information	Alternate Contact Information
Local Critical Incident Management Team		

TITLE 173 CONTROL OF COMMUNICABLE DISEASE

CHAPTER 3 SCHOOL HEALTH, COMMUNICABLE DISEASE CONTROL, AND IMMUNIZATION STANDARDS

3-001 SCOPE AND AUTHORITY: These regulations are intended to implement Neb. Rev. Stat. §§ 79-217 to 79-223.

3-002 DEFINITIONS: For purposes of these regulations:

Booster dose means a dose of vaccine given after the initial series to enhance waning immunity to specific disease(s).

Child or children means any student or students enrolled in a public or private elementary or secondary school system in Nebraska.

Department means the Department of Health and Human Services.

Local health department means a county, district, or city-county health department approved by the Department of Health and Human Services as a local full-time public health service.

Reportable communicable disease means those diseases which are required by law to be reported pursuant to 173 NAC 1.

3-003 SYMPTOMS OF COMMUNICABLE DISEASE; EXCLUSION FROM SCHOOL: Children showing any signs or symptoms of a contagious or infectious disease are required by law to be sent to their homes immediately, or as soon as safe and proper conveyance can be found.

Teachers are encouraged to observe each child carefully for signs of illness each time the child returns to school. This is particularly important when epidemic diseases are known to be present in the community.

The presence of one or more of the following signs or symptoms should make the teacher suspect a communicable disease:

Fever, flushed face, headache, aches in muscles or joints, unexplained tiredness or listlessness, loss of appetite, stomach ache, nausea or vomiting, diarrhea, convulsions, sore throat, nasal congestion or discharge, unexplained skin eruption, sore or inflamed eyes.

3-004 REPORTING

3-004.01 Suspected Contagious or Infectious Disease: When a child is sent home because of a suspected contagious or infectious disease, the law requires the proper school authority, school board, or board of education to be notified without delay.

3-004.02 Suspected Reportable Disease: When a school nurse or an individual acting in the capacity of a school nurse identifies a case or suspected case of a reportable disease, s/he must report that case to the local public health department or the DHHS Division of Public Health as provided in 173 NAC 1-007.04.

3-005 DURATION OF EXCLUSION PERIOD: Children excluded for a confirmed communicable disease should not be allowed to return to school until the minimum isolation period has elapsed, and all signs or symptoms of acute illness have disappeared. The period of exclusion should extend throughout the period when acute signs of illness are present, or until the student is fever-free for 24 hours without the use of fever-reducing medication.

Minimum isolation periods are shown in the table on Attachment 1, Contagious and Infectious Disease/Condition Chart, which is attached to 173 NAC 3 and incorporated by this reference. School boards and boards of education may observe these periods, or adopt and enforce their own exclusion regulations which may not be shorter or less restrictive than those contained in 173 NAC 3.

3-006 EXCLUSION OF HEALTH CONTACTS: With a few exceptions (which are shown in the table on Attachment 1) there are no restrictions placed upon the health contacts of communicable diseases by these regulations; consequently, they may attend school unless the local health department, board of health, school board or board of education has adopted rules and regulations to the contrary. If officials consider exclusion of health contacts necessary, it is suggested that whenever possible this be confined to the latter portion of the incubation period and enforced only for those children who are not known to be immune.

3-007 (RESERVED)

3-008 IMMUNIZATION STANDARDS: Each student must be protected by immunization against the following diseases, unless otherwise exempted from this requirement under the provisions of 173 NAC 3-010:

Measles	Diphtheria	Invasive pneumococcal disease
Mumps	Tetanus	
Rubella	Pertussis	
Polio	Haemophilus Influenzae type b (Hib)	
Hepatitis B	Varicella	

3-008.01 For the purposes of complying with the requirement of immunization against the diseases listed above:

3-008.01A Students 2-5 years of age enrolled in a school-based program not licensed as a child care provider are considered to be immunized if they have received:

3 doses of hepatitis B vaccine;
4 doses of DTaP, DTP, or DT vaccine;
3 doses of polio vaccine;
1 dose of MMR vaccine given no earlier than 4 days before the first birthday;
3 doses of hib vaccine or 1 dose of hib vaccine given at or after 15 months of age;
1 dose of varicella vaccine; and
4 doses of pneumococcal vaccine or 1 dose of pneumococcal vaccine given at or after 15 months.

3-008.01B Students enrolling for the first time (kindergarten or 1st grade, depending on the school district's entering grade), enrolling in 7th grade, and all transfer students from outside the state regardless of the grade they are entering are considered immunized if they have received:

3 doses DTaP, DTP, DT, or Td vaccine with at least 1 dose given no earlier than 4 days before 4 years of age;
3 doses of polio vaccine;
2 doses of MMR vaccine with the first dose given no earlier than 4 days before the first birthday and the 2 doses separated by at least 28 days;
3 doses of pediatric hepatitis B vaccine, or, if the alternate hepatitis B vaccination schedule is used, 2 doses of a licensed adult hepatitis B vaccine specified for adolescents 11-15 years of age; and
2 doses of varicella vaccine with the first dose given no earlier than 4 days before the first birthday and the 2 doses separated by at least 28 days.

Students enrolling in 7th grade must provide evidence of having 1 booster dose of a tetanus, diphtheria, and pertussis (Tdap) vaccine, given on or after 7 years of age.

3-008.01C All other students are considered immunized if they have received:

3 doses of DTaP, DTP, DT, or Td vaccine, with at least 1 dose given no earlier than 4 days before 4 years of age;
3 doses of polio vaccine;
2 doses of MMR vaccine with the first dose given no earlier than 4 days before the first birthday and the 2 doses separated by at least 28 days;
3 doses of hepatitis B vaccine; and
2 doses of varicella vaccine with the first dose given no earlier than 4 days before the first birthday and the 2 doses separated by at least 28 days.

3-009 REQUIRED EVIDENCE OF IMMUNIZATION

3-009.01 For purposes of compliance with the immunization requirement, the board of education or school board or other governing authority, must require the presentation of

an immunization history which includes the name of the vaccine and the month, day, and year of administration.

3-009.02 Laboratory evidence of circulating antibodies for measles, mumps, or rubella constitutes evidence of immunity against those diseases provided the following information is supplied: name of laboratory, date of test, name of test, test result, signature of laboratory technician performing the test or of the laboratory director, and date of signature. For purposes of compliance with this rule, clinical history of measles, mumps, or rubella without laboratory or epidemiologic confirmation does not constitute evidence of immunity.

3-009.03 Epidemiologic confirmation of a diagnosis means that the clinical history of measles, mumps, or rubella is corroborated by association with laboratory proven case(s) and that such epidemiologic case(s) have been reported to and counted by the Department.

3-009.04 A documented history of varicella disease from a parent or health care provider with the year of infection constitutes evidence of immunity to varicella. The documentation must include one of the following:

1. Signature of the parent or legal guardian and the date (year) of the child's varicella illness, or
2. Signature of a health care provider and the date (year) of the child's varicella illness, or
3. Laboratory evidence of a child's varicella immunity, or
4. A clinical diagnosis of shingles.

3-010 MEDICAL AND RELIGIOUS EXEMPTION; PROVISIONAL ENROLLMENT: Each student must be protected against the diseases listed using the standards described in 173 NAC 3-008 and submit evidence of immunization as described in 173 NAC 3-009. Any student who does not comply with these requirements must not be permitted to enroll in school, except as provided in 173 NAC 3-010.01 through 3-010.03.

3-010.01 Immunization is not required for a student's enrollment in any school in this state if he or she submits to the admitting official either of the following:

3-010.01A A statement signed by a physician, physician assistant, or nurse practitioner stating that, in the health care provider's opinion, the specified immunization(s) required would be injurious to the health and well-being of the student or any member of the student's family or household; or

3-010.01B A notarized affidavit signed by the student or, if he or she is a minor, by a legally authorized representative of the student, stating that the immunization conflicts with the tenets and practice of a recognized religious denomination of which the student is an adherent or member or that immunization conflicts with the personally and sincerely followed religious beliefs of the student.

3-010.02 A student may be provisionally enrolled in a school in Nebraska if he or she has begun the immunizations against the specified diseases prior to enrollment and continues the necessary immunizations as rapidly as is medically feasible. For purposes of complying with these requirements:

3-010.02A A student is considered to have begun immunizations against polio, diphtheria, tetanus, pertussis, hepatitis B, measles, mumps, and rubella and varicella if he or she has had at least one dose of DTaP/DTP/DT/Td, one dose of hepatitis B, one dose of either trivalent OPV or one dose of IPV, either one dose of the combined measles, mumps, and rubella vaccine or one dose of each vaccine for measles, mumps, and rubella, and one dose of varicella vaccine.

3-010.02B Continuation of necessary immunizations as rapidly as is medically feasible must be documented by a written statement from the student's immunization provider which shows the scheduled dates to complete the required immunization series. Failure to receive the necessary immunizations as rapidly as is medically feasible will result in exclusion of the student from attending school until either documentation of immunization or a medical statement or religious affidavit is provided to the school. The time interval for the completion of the required immunization series must not exceed nine months.

3-010.03 A student may also be provisionally enrolled in a school in Nebraska if he or she is the child or legal ward of an officer or enlisted person, or the child or legal ward of the spouse of such officer or enlisted person on active duty in any branch of the military services of the United States, and said student is enrolling in a Nebraska school following residence in another state or in a foreign country.

3-010.03A As a condition for the provisional enrollment of a student under this Section, a parent or adult legal guardian of the student must provide the school with a signed written statement certifying that the student has completed the course of immunizations required by 173 NAC 3-008.

3-010.03B The provisional enrollment of a student qualified for such enrollment under 173 NAC 3-010.03 must not continue beyond 60 days from the date of such enrollment. At such time, the school must be provided, with regard to said student, written evidence of compliance with 173 NAC 3-008. The student must not be permitted to continue in school after such date until evidence of compliance is provided.

3-011 TIME OF COMPLIANCE: Each student must present documentation as outlined in 173 NAC 3-009 and 3-010 prior to enrollment.

3-012 REPORTING REQUIREMENTS: A report to the Department summarizing immunization status is required by November 15 of each year from the board of education or school board of each school district, or other governing authority of the school. The report must include the following information regarding those entering school for the first time (kindergarten or 1st grade), those entering the 7th grade, and all transfer students from outside the state (excluding the entering and 7th grades):

3-012.01 For children in the entering grade (kindergarten or 1st grade depending on the school district's entering grade):

1. The total number of students enrolled.
2. The total number of students with an exemption on file or who are in the process of completing immunizations.
3. Diphtheria, tetanus, and pertussis (DTP/DTaP/DT/Td):
   a. The number of students with 3 or more doses of DTP/DTaP/DT/Td, with at least one dose given at or after 4 years of age.
   b. The number of students with medical exemptions on file for diphtheria, tetanus, and pertussis.
   c. The number of students with religious exemptions on file for diphtheria, tetanus, and pertussis.
   d. The number of students provisionally enrolled.
4. Polio (IPV/OPV):
   a. The number of students with 3 or more doses of polio vaccine.
   b. The number of students with medical exemptions on file for polio.
   c. The number of students with religious exemptions on file for polio.
   d. The number of students provisionally enrolled.
5. Measles, mumps, and rubella (MMR):
   a. The number of students with 2 doses of MMR with the first dose given no earlier than 4 days before the first birthday and the 2 doses separated by at least 28 days.
   b. The number of students presenting laboratory evidence of circulating antibodies or epidemiologic confirmation of measles, mumps, and rubella.
   c. The number of students with medical exemptions on file for MMR.
   d. The number of students with religious exemptions on file for MMR.
   e. The number of students provisionally enrolled.
6. Hepatitis B:
   a. The number of students with 3 doses of pediatric hepatitis B, or, if the alternate hepatitis B vaccination schedule is used, the number of students with 2 doses of a licensed adult hepatitis B vaccine specified for adolescents 11-15 years of age.
   b. The number of students with medical exemptions on file for hepatitis B.
   c. The number of students with religious exemptions on file for hepatitis B.
   d. The number of students provisionally enrolled.
7. Varicella:
   a. The number of students with 2 doses of varicella vaccine with the first dose given no earlier than 4 days before the first birthday and the 2 doses separated by at least 28 days.
   b. The number of students with documented history of varicella disease on file.
   c. The number of students with medical exemptions on file for varicella.
   d. The number of students with religious exemptions on file for varicella.
   e. The number of students provisionally enrolled.
   f. The number of students with a documented clinical diagnosis of shingles.

3-012.02 For children entering 7th grade:

1. The total number of students enrolled.
2. The total number of students with an exemption on file or who are in the process of completing immunizations.
3. Measles, mumps, and rubella (MMR):
   a. The number of students with 2 doses of MMR, with the first dose given no earlier than 4 days before the first birthday and the 2 doses separated by at least 28 days.
   b. The number of students presenting laboratory evidence of circulating antibodies or epidemiologic confirmation of measles, mumps, and rubella.
   c. The number of students with medical exemptions on file for MMR.
   d. The number of students with religious exemptions on file for MMR.
   e. The number of students provisionally enrolled.
4. Hepatitis B:
   a. The number of students with 3 doses of pediatric hepatitis B, or, if the alternate hepatitis B vaccination schedule is used, the number of students with 2 doses of a licensed adult hepatitis B vaccine specified for adolescents 11-15 years of age.
   b. The number of students with medical exemptions on file for hepatitis B.
   c. The number of students with religious exemptions on file for hepatitis B.
   d. The number of students provisionally enrolled.
5. Varicella:
   a. The number of students with 2 doses of varicella vaccine with the first dose given no earlier than 4 days before the first birthday and the two doses separated by at least 28 days.
   b. The number of students with documented history of varicella disease on file.
   c. The number of students with medical exemptions on file for varicella.
   d. The number of students with religious exemptions on file for varicella.
   e. The number of students provisionally enrolled.
   f. The number of students with a documented clinical diagnosis of shingles.
6. Beginning July 2010, and thereafter, one booster dose containing tetanus, diphtheria and pertussis (Tdap):
   a. The number of students with 1 dose of Tdap (tetanus, diphtheria and pertussis).
   b. The number with a medical exemptions on file for Tdap.
   c. The number of students with religious exemptions on file for Tdap.
   d. The number of students provisionally enrolled.

3-012.03 For transfer students from outside the state:

1. The total number of students enrolled.
2. The total number of students with an exemption on file or who are in the process of completing immunizations.
3. Measles, mumps, and rubella (MMR):
   a. The number of students with 2 doses of MMR, with the first dose given no earlier than 4 days before the first birthday and the 2 doses separated by at least 28 days.
   b. The number of students presenting laboratory evidence of circulating antibodies or epidemiologic confirmation of measles, mumps, and rubella.
   c. The number of students with medical exemptions on file for MMR.
   d. The number of students with religious exemptions on file for MMR.
   e. The number of students provisionally enrolled.
4. Hepatitis B:
   a. The number of students with 3 doses of pediatric hepatitis B, or, if the alternate hepatitis B vaccination schedule is used, the number of students with 2 doses of a licensed adult hepatitis B vaccine specified for adolescents 11-15 years of age.
   b. The number of students with medical exemptions on file for hepatitis B.
   c. The number of students with religious exemptions on file for hepatitis B.
   d. The number of students provisionally enrolled.
5. Varicella:
   a. The number of students with 2 doses of varicella vaccine with the first dose given no earlier than 4 days before the first birthday and the 2 doses separated by at least 28 days.
   b. The number of students with documented history of varicella disease on file.
   c. The number of students with medical exemptions on file for varicella.
   d. The number of students with religious exemptions on file for varicella.
   e. The number of students provisionally enrolled.
   f. The number of students with a documented clinical diagnosis of shingles.

3-012.04 The abbreviated reporting requirements for entering 7th graders and transferring students do not exempt them from meeting the immunization standards outlined in 173 NAC 3-008.01B.

CONTAGIOUS AND INFECTIOUS DISEASES/CONDITIONS

DISEASE / CONDITION	INCUBATION PERIOD *	SYMPTOMS OF ILLNESS	INFECTION PERIOD	MINIMUM ISOLATION PERIODS AND CONTROL MEASURES
Chickenpox	2-3 weeks	Fever, skin eruption begins as red spots that become small blisters (vesicles) and then scab over.	For up to 5 days before eruption until all lesions are crusted.	Exclude until all lesions are crusted; avoid contact with susceptibles. No exclusion of contacts. Alert parents of immune-suppressed child(ren) of possible exposure.
Conjunctivitis (Pink Eye)	24-72 hours	Redness of white of eye, tearing, discharge of pus.	During active phase of illness characterized by tearing and discharge.	Exclude symptomatic cases. Urge medical care. May return when eye is normal in appearance or with documentation from physician that child is no longer infectious. No exclusion of contacts.
Coryza (Common Cold)	12-72 hours	Nasal discharge, soreness of throat.	One day before symptoms and usually continuing for about 5 days.	Exclusion unnecessary. No exclusion of contacts.
Diphtheria	2-5 days	Fever, sore throat, often gray membrane in nose or throat.	Usually 2 weeks or less. Seldom more than 4 weeks.	Exclude cases. Return with a documented physician approval. Exclude inadequately immunized close contacts as deemed appropriate by school officials following investigation by the local and/or Nebraska Department of Health and Human Services. ***Report immediately by telephone*** all cases to local and/or state health departments.

DISEASE / CONDITION	INCUBATION PERIOD *	SYMPTOMS OF ILLNESS	INFECTION PERIOD	MINIMUM ISOLATION PERIODS AND CONTROL MEASURES
Enterobiasis (Pinworm, Thread-worm, Seatworm)	Life cycle about 3-6 weeks	Irritation around anal region. Visible in stool.	As long as eggs are being laid; usually 2 weeks.	Exclude until treated as documented by physician. No exclusion of contacts. Careful handwashing essential.
Fifth Disease	Estimated at 6-14 days	Minimal symptoms with intense red "slapped cheek" Appearing rash; lace-like rash on body.	Unknown.	Exclude until fever and malaise are gone. May return with rash; no longer contagious once rash appears. No exclusion of contacts; however, alert any students or staff who are pregnant, have chronic hemolytic anemia or immunodeficiency to consult their physician.
Hand, Foot and Mouth	3-5 days	Fever, sore throat, elevated blisters occurring on hands, feet or in the mouth.	During acute illness, usually one week. Spread through direct contact with nose and throat discharge and aerosol droplets.	Exclude cases during acute phase and until fever-free for 24 hours without the use of fever-reducing medication.
Hepatitis A	15-50 days, average 28-30 days	Fever, nausea, loss of appetite, abdominal discomfort and jaundice.	Two weeks before jaundice until about 7 days after onset of jaundice.	Exclude for no less than 7 days after onset of jaundice. Return with documented physician approval. No exclusion of contacts. Immune globulin (IG) or hepatitis A vaccine prevents disease if given within two weeks of exposure. IG to family contacts only. Careful handwashing essential.

DISEASE / CONDITION	INCUBATION PERIOD *	SYMPTOMS OF ILLNESS	INFECTION PERIOD	MINIMUM ISOLATION PERIODS AND CONTROL MEASURES
Herpes Simplex (Type 1)	2-12 days	Onset as clear vesicle, later purulent. Following rupture, scabs and in 1-2 weeks, heals. Commonly about lips and in mouth.	For a few weeks after appearance of vesicle.	Exclusion unnecessary. No exclusion of contacts. Avoid contact with immunesuppressed or eczematous persons. Good personal hygiene, avoid sharing toilet articles.
Impetigo	4-10 days	Running, open sores with slight marginal redness.	As long as lesions draining and case hasn't been treated.	Exclude until brought under treatment and acute symptoms resolved. No exclusion of contacts. Good personal hygiene is essential. Avoid common use of toilet articles.
Influenza	24-72 hours	Fever and chills, often back or leg aches, sore throat, nasal discharge and cough; prostration.	A brief period before symptoms until about a week thereafter.	Exclude for duration of illness. No exclusion of contacts.
Measles (Rubeola)	10-14 days	Begins like a cold; fever, blotchy rash, red eyes, hacking frequent cough.	5 days before rash until 4 days after rash.	Exclude for duration of illness and for no less than 4 days after onset of rash. Exclude unimmunized students on same campus from date of diagnosis of first case until 14 days after rash onset of last known case or until measles immunization received or laboratory proof of immunity is presented or until history of previous measles infection is verified as per records or the Nebraska Department of Health and Human Services. ***Report immediately by telephone*** all cases to local and/or state health departments.

DISEASE / CONDITION	INCUBATION PERIOD *	SYMPTOMS OF ILLNESS	INFECTION PERIOD	MINIMUM ISOLATION PERIODS AND CONTROL MEASURES
Meningitis (bacterial)	3-4 days with a range of 2-10 days	Sudden onset of fever, headache, stiff neck, nausea, vomiting, sensitivity to light, and altered mental status	Infectious until 24 hours into antibiotic course	Local or state health authorities will determine appropriate follow-up and investigation on a case-by-case basis. Student should be excluded from school until antibiotic course has been initiated and symptoms have fully resolved, and may return with medical clearance.
Meningitis (viral)	3-7 days	Sudden onset of fever, headache, stiff neck, nausea, vomiting, sensitivity to light, sleepiness, altered mental status; rubella-like rash may be present.	Infectious until symptoms have fully resolved.	Active illness seldom exceeds 10 days. Student should be excluded from onset of symptoms until full resolution, and may return with medical clearance.
MRSA (staph bacterial infection)	Variable and indefinite.	Skin lesion; can take on different forms.	As long as purulent lesions drain or the carrier state persists.	Exclusion unnecessary unless directed by physician. Keep lesions covered at school. Good handwashing and sanitation practices; no sharing of personal items.
Mumps (Epidemic Parotitis)	2-3 weeks	20-40% of those infected do not appear ill or have swelling. 60-70% have swelling with pain above angle of lower jaw on one or both sides.	About 7 days before gland swelling until 9 days after onset of swelling or until swelling has subsided.	Exclude 5 days from onset of swelling in the neck. No exclusion of contacts. Inform parents of unimmunized students on campus of possible exposure and encourage immunization.
Pediculosis (Infestation with head or body lice)	Eggs of lice hatch in about a week; maturity in about 2-3 weeks	Itching; infestation of hair and/or clothing with insects and nits (lice eggs).	While lice remain alive and until eggs in hair and clothing have been destroyed. Direct and indirect contact with infested person	Nits are not a cause for school exclusion. Parents of students with live lice are to be notified and the child treated prior to return to school. Only persons with active infestation need be treated. Avoid head-to-head contact. No exclusion of contacts.

DISEASE / CONDITION	INCUBATION PERIOD *	SYMPTOMS OF ILLNESS	INFECTION PERIOD	MINIMUM ISOLATION PERIODS AND CONTROL MEASURES
			and/or clothing required.	
Pertussis (Whooping Cough)	7 days – usually within 10 days	Irritating cough – symptoms of common cold usually followed by typical whoop in cough in 2-3 weeks.	About 7 days after exposure to 3 weeks after typical cough. When treated with erythromycin, 5-7 days after onset of therapy.	Exclude until physician approves return per written documentation. Exclude inadequately immunized close contacts as deemed appropriate by school officials following investigation by the local and/or state Department of Health and Human Services. Chemoprophylaxis may be considered for family and close contacts. ***Report immediately by telephone*** all cases to local and/or state health departments.
Poliomyelitis (Infantile Paralysis)	3-35 days; 7-14 days for paralytic cases	Fever, sore throat, malaise, headache, stiffness of neck or back, muscle soreness.	Not accurately known. Maybe as early as 36 hours after infection; most infectious during first few days after onset of symptoms.	Exclude until physician approves return. Report immediately by telephone.
Ringworm (Tinea Infections)	10-14 days	Scaly oval patches of baldness of scalp; brittle and falling hair, scaly oval lesions of skin.	As long as infectious lesions are present, especially when untreated.	No exclusion of contacts. Good sanitation practices and don't share toilet articles. If affected areas cannot be covered with clothing/dressing during school, exclude until treatment started.
Rubella (German Measles)	14-21 days	Low-grade fever, slight general malaise; scattered Measles-like rash; duration of approximately 3 days.	About one week before rash until 7 days after onset of rash.	Exclude for duration of illness and for no less than 4 days* after onset of rash. Exclude unimmunized students on same campus from date of diagnosis of first case until 23* days after rash onset of last known case or until rubella immunization received or laboratory proof of immunity is presented. ***Report immediately by telephone*** all cases to local and/or state health departments.

DISEASE / CONDITION	INCUBATION PERIOD *	SYMPTOMS OF ILLNESS	INFECTION PERIOD	MINIMUM ISOLATION PERIODS AND CONTROL MEASURES
Scabies	Infection caused by almost invisible mite. Lesions symptomatic after 4-6 weeks.	Severe itching; lesions around loose fleshy tissue (e.g., finger webs, elbows, crotch, etc.)	Until mites and eggs destroyed.	Exclude until the day after treatment is started. No exclusion of contacts.
Shingles / Herpes Zoster	Latent form after primary infection with chickenpox.	Grouped small blisters (vesicles) often accompanied by pain localized to area	Physical contact with vesicles until they become dry.	Exclude children with shingles / zoster if the vesicles cannot be covered until after the vesicles have dried. Individuals with shingles /zoster should be instructed to wash their hands if they touch the potentially infectious vesicles.
Streptococcal Infection; (Scarlet Fever, Scarlatina, Strep Throat)	1-3 days	Sore throat, fever, headache. Rough rash 12-48 hours later.	Until 24-48 hours after treatment begun.	Exclude until afebrile and under treatment for 24 hours. No exclusion of contacts. Early medical care important and usually requires 10 days of antibiotic treatment. Screening for asymptomatic cases not recommended.
Tuberculosis Pulmonary	Highly variable – depends on age, life style, immune status. Primary: 4-12 weeks. Latent: 1-2 years after infection. Life-long risk.	Weakness, cough, production of purulent sputum, loss of weight, fever. Urinary tract symptoms if this system involved.	Until sputum is free from tuberculosis bacteria. Generally after a few weeks of effective treatment.	Exclude. Physician treatment essential. May return with documented physician approval. No exclusion of contacts. Skin test contacts and chemoprophylaxis with INH if positive (in absence of disease). Exclusion of nonpulmonary tuberculosis unnecessary.

* Day of onset of specific symptom is counted as "day zero;" the *day after onset* is "day **1**;" *second day* after onset is "day **2**;" and etc.

NOTE: ***Careful handwashing*** is the most important thing that can be done to prevent the spread of most infectious diseases.

Questions about this chart may be directed to the DHHS Division of Public Health, Lifespan Health Services, Immunization Program (402-471-6423) or School Health Program (402-471-0160).

Nebraska

Local Public Health Department

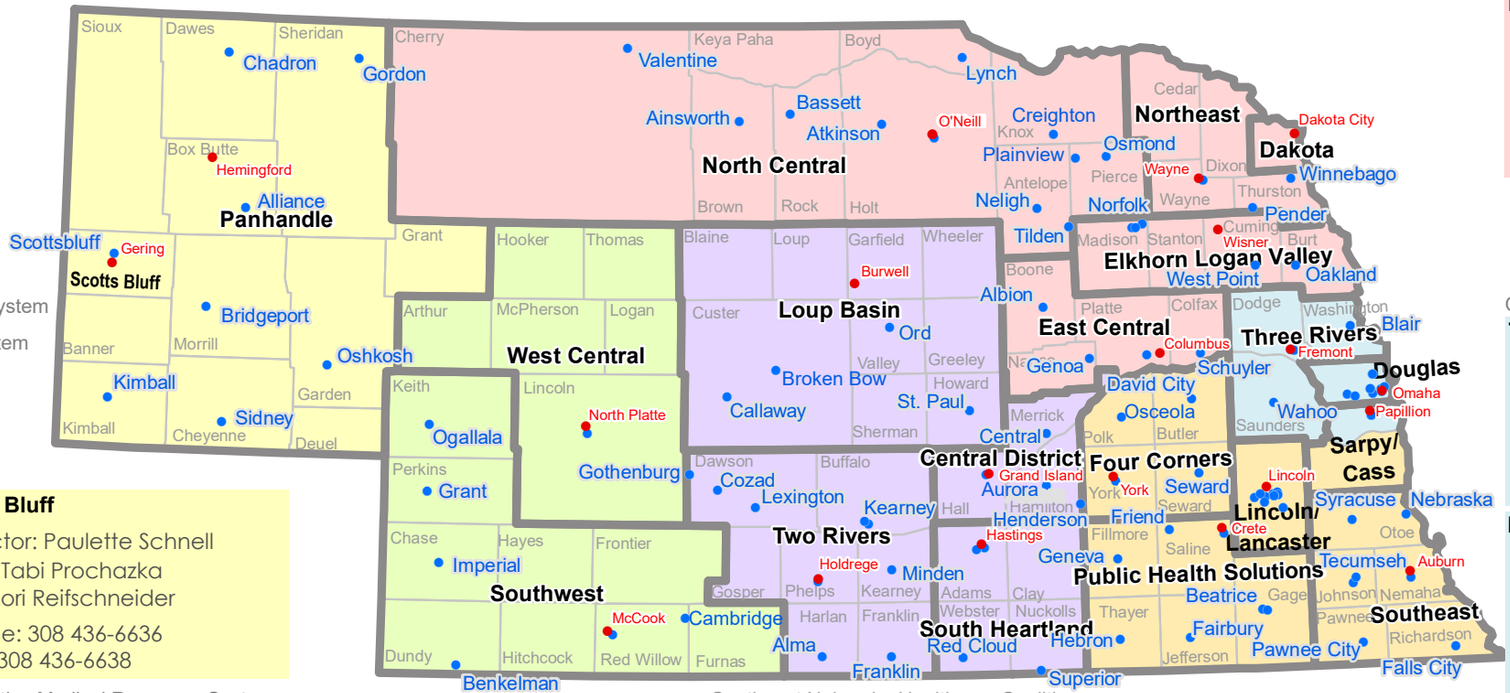
Directors
Emergency Response Coordinators (ERC)
Epi Surveillance Coordinators

Date: 2/25/2021

Main Office Hospitals

Healthcare Coalition Regions:

- Nebraska Plains Healthcare Coalition
- Omaha Metropolitan Healthcare Coalition
- Panhandle Regional Medical Response System
- Rural Region One Medical Response System
- Southeast Nebraska Healthcare Coalition
- TriCities Medical Response System



Rural Region One Medical Response System

North Central
Director: Roger Wiese
ERC: Heidi Hostert
Epi: Elizabeth Parks
Phone: 402-336-2406
Fax: 402-336-1768

Northeast
Director: Julie Rother
ERC: Kim Schultz
Epi: Nicole Hinspeter
Phone: 402-375-2200
Fax: 402-375-2201

Dakota
Director: Natasha Ritchison
ERC: Jennifer Ankerstjerne
Epi: Theresa Grove
Phone: 402-987-2164
Fax: 402-987-2163

Elkhorn Logan Valley
Director: Gina Uhing
ERC: Melanie Thompson
Epi: Laura Holtz
Phone: 402-529-2233
Fax: 402-529-2211

East Central
Director: Chuck Sepers
ERC: Libby Finochiaro
Epi:Dana Spindola
Phone: 402-562-8963
Fax: 402-564-0611

Omaha Metropolitian Healthcare Coalition

Three Rivers
Director: Terra Uhing
ERC: Caleb Kuddes
Epi: Amy Roberts
Phone: 402-727-5396
Fax: 402-727-5399

Douglas
Director: Adi Pour
ERC: Terri Morrow
Igor Hadzisulejmanovic
Epi: Justin Frederick
Phone: 402-444-7471
Fax: 402-444- 3287

Sarpy/Cass
Director: Sarah Schram
ERC: Brittney Hensley
Epi: Monica Ulses
Phone: 402-339-4334
Fax: 402-339-4235

Panhandle Regional Medical Response System

Panhandle
Director: Kim Engel
ERC: Tabi Prochazka
Epi: Kendra Lauruhn
Phone: 308-487-3600
Fax: 308-487-3682

Scotts Bluff
Director: Paulette Schnell
ERC: Tabi Prochazka
Epi: Lori Reifschneider
Phone: 308 436-6636
Fax: 308 436-6638

Nebraska Plains Healthcare Coalition

West Central
Director:
Shannon Vanderheiden
ERC: Jennifer Marchlewski
Epi: Vacant
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Fax: 308 696-1204

Southwest
Director: Myra Stoney
ERC: Kathie Skeen
Epi: Melissa Propp
Phone: 308-345-4223
Fax: 308-345-4289

TriCities Medical Response System

LoupBasin
Director: Chuck Cone
ERC: Catie Larsen
Epi: Ashley Jeffres
Phone: 308-346-5795
Fax: 308-346-9106

Two Rivers
Director: Jeremy Eschliman
ERC: Katie Mulligan
Epi: Susan Puckett
Phone: 888-669-7154
Fax: 308-455-4182

Central District
Director: Teresa Anderson
ERC: Andrew Hills
Epi: Jonna Mangeot
Phone: 308-385-5175
Fax: 308-385-5181

South Heartland
Director: Michele Bever
ERC: Jim Morgan
Epi: Jessica Warner
Phone: 402-462-6211
Fax: 402-462-6219

Southeast Nebraska Healthcare Coalition

Four Corners
Director: Laura McDougall
ERC: Thomas Barnett
Epi: Suzanne Phinney
Phone: 402-362-2621
Fax: 402-362-2687

Public Health Solutions
Director: Kim Showalter
ERC & Epi: Kate Lange
Phone: 402-826-3880
Fax: 402-826-4101

Lincoln/Lancaster
Director: Pat Lopez
ERC: Gina Egenberger
Epi: Tim Timmons
Phone: 402-441-8056
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Southeast
Director: Grant Brueggeman
ERC: Stephanie Vinson
Epi: Vacant
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Fax: 402-274-3967

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

CONCUSSION SIGNS AND SYMPTOMS

Checklist

CDC HEADS UP
SAFE BRAIN. STRONGER FUTURE.

Student's Name: _____ **Student's Grade:** _____ **Date/Time of Injury:** _____

Where and How Injury Occurred: *(Be sure to include cause and force of the hit or blow to the head.)* _____

_____

Description of Injury: *(Be sure to include information about any loss of consciousness and for how long, memory loss, or seizures following the injury, or previous concussions, if any. See the section on Danger Signs on the back of this form.)* _____

_____

_____

DIRECTIONS:

Use this checklist to monitor students who come to your office with a head injury. Students should be monitored for a minimum of 30 minutes. Check for signs or symptoms when the student first arrives at your office, 15 minutes later, and at the end of 30 minutes.

Students who experience one or more of the signs or symptoms of concussion after a bump, blow, or jolt to the head should be referred to a healthcare professional with experience in evaluating for concussion. For those instances when a parent is coming to take the student to a healthcare professional, observe the student for any new or worsening symptoms right before the student leaves. Send a copy of this checklist with the student for the healthcare professional to review.

OBSERVED SIGNS	0 MINUTES	15 MINUTES	30 MINUTES	☐ MINUTES JUST PRIOR TO LEAVING
Appears dazed or stunned				
Is confused about events				
Repeats questions				
Answers questions slowly				
Can't recall events *prior* to the hit, bump, or fall				
Can't recall events *after* the hit, bump, or fall				
Loses consciousness (even briefly)				
Shows behavior or personality changes				
Forgets class schedule or assignments				
PHYSICAL SYMPTOMS				
Headache or "pressure" in head				
Nausea or vomiting				
Balance problems or dizziness				
Fatigue or feeling tired				
Blurry or double vision				
Sensitivity to light				
Sensitivity to noise				
Numbness or tingling				
Does not "feel right"				
COGNITIVE SYMPTOMS				
Difficulty thinking clearly				
Difficulty concentrating				
Difficulty remembering				
Feeling more slowed down than usual				
Feeling sluggish, hazy, foggy, or groggy				
EMOTIONAL SYMPTOMS				
Irritable				
Sad				
More emotional than usual				
Nervous				

To download this checklist in Spanish, please visit cdc.gov/HEADSUP. Para obtener una copia electrónica de esta lista de síntomas en español, por favor visite cdc.gov/HEADSUP.

→ More

Danger signs:

Be alert for symptoms that worsen over time. The student should be seen in an emergency department right away if she or he has one or more of these danger signs:

- ❑ One pupil (the black part in the middle of the eye) larger than the other
- ❑ Drowsiness or cannot be awakened
- ❑ A headache that gets worse and does not go away
- ❑ Weakness, numbness, or decreased coordination
- ❑ Repeated vomiting or nausea
- ❑ Slurred speech
- ❑ Convulsions or seizures
- ❑ Difficulty recognizing people or places
- ❑ Increasing confusion, restlessness, or agitation
- ❑ Unusual behavior
- ❑ Loss of consciousness (even a brief loss of consciousness should be taken seriously)

Additional information about this checklist:

This checklist is also useful if a student appears to have sustained a head injury outside of school or on a previous school day. In such cases, be sure to ask the student about possible sleep symptoms. Drowsiness, sleeping more or less than usual, or difficulty falling asleep may indicate a concussion.

To maintain confidentiality and ensure privacy, this checklist is intended for use only by appropriate school professionals, healthcare professionals, and the student's parent(s) or guardian(s).

Resolution of injury:

- ❑ Student returned to class
- ❑ Student sent home
- ❑ Student referred to healthcare professional with experience in evaluating for concussion

SIGNATURE OF SCHOOL PROFESSIONAL COMPLETING THIS FORM: _____

TITLE:_____

COMMENTS:

Revised August 2019

To learn more, go to cdc.gov/HEADSUP

CDC HEADS UP
SAFE BRAIN. STRONGER FUTURE.

Nebraska Suicide Guidelines for Schools

Suicide Prevention Resource

JULY 2021

APEx PROJECT BY
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UNIVERSITY OF NEBRASKA MEDICAL CENTER

Introduction

Suicide is the second leading cause of death for Nebraska youths (10-19),[1] and the third leading cause of death in the U.S. for youths ages 15-24. [2,3] The number of Nebraska youths (10-19) deaths have been steadily rising since 2009. [1] According to the 2017 Nebraska Vital Records, the youth suicide rate was 11.4 per 100,000, while the National Suicide rate was 7.2 per 100,000.[1]

In the 2018 Nebraska Youth Risk Behaviour Survey, 32% of youth stated feeling hopeless or sad almost every day for 2 weeks. [1] A psychiatric illness is usually present for about 90% (nationally) f youths who die by suicide – most diagnosed with conduct disorder, depression, and substance abuse.[2]

Nationally, of American high school students: [2]

- 20% have seriously considered suicide (within the last 12 months)
- 8% make suicide attempts
- 70% of attempts have involved alcohol and/or other drugs (frequent abusers)

Suicide Prevention: Stopping the Initial Thought

What is Physical Dissociation?

Physical Dissociation is defined as "the detachment from one's body and its sensations, including pain, a process that may be associated with allowing physical assaults on the body among individuals who feel unable to cope with mental pain." [4]

Mental pain and physical dissociation both contribute to suicide:

- Mental pain can be the cause
- Physical dissociation is the facilitatory of the act

The intense and negative emotions youths may feel include shame, guilt, and rage caused by mental pain with the idea of no immediate change in the future. Mental pain can also be broken down into 9 dimensions: [4]

1. Lack of control
2. Irreversibility of pain
3. Emotional flooding
4. Narcissistic wounds
5. Estrangement
6. Freezing
7. Confusion
8. Social distancing
9. Emptiness

Warning Signs

Though suicide is the second leading cause of death for youths, it is preventable, especially if one can detect the warning signs. Some warning signs everyone should look out for include the following:

- Creating plans for suicide[2] or direct threats ("I want to kill myself") [5,6]
- Display of emotional pain (feeling hopeless, trapped, no reason to live, feeling like a burden to others) [2,6]

- Change in behaviour (withdrawal or dissociation, hostility, irritability, funeral planning, mood swings) [2,5,6]
- Online suicidal posts or a letter [5]
- Prior suicidal behaviour [5]
- Actively seeking ways to die by suicide (gun purchases, unusually online search history) [6]
- Change in sleep pattern (too much or too little) [2,6]
- An increase in drug or alcohol usage [6]

Majority of the warning signs are often attached to a past or recent painful event or change. [6]

What to Do After Seeing Warning Signs

First, it is highly important to remain calm and always take every suicidal "talk" seriously. [5] Additionally, do NOT try to use argumentative or persuasive wording such as "You have so much to live for," or "Do you know how much your suicide will hurt your family." [6] Instead, do the following:

- Ask the youth if they are thinking of suicide or planning to die by suicide/killing themselves [2,5]
- Listen to the youth intently, ask them what is distressing them, and refrain from judging or accusing them [2,5]
- Do not leave the youth alone and take action by removing any weapons, drugs, alcohol, and any means of self-harm [2,5,6]
- Reassure the youth that this feeling will not be present forever and that there is help that you can offer [2,5]
- Get Help!
    - Call 9-1-1
    - Take youth to nearest walk-in clinic and talk with a health professional (never keep this a secret)
    - Call the National Suicide Prevention Hotline: 1-800-273-TALK (8255)

It is important to understand that youths will spend most of their day at school under the supervision of the adults there. [5] Therefore, it is crucial to not only establish effective suicide prevention practices and implement them within the school early on, but to also apply them within the surrounding community. This includes establishing school-wide programs, having staff and faculty emergency training, promoting mental health services and emergency hotlines (therefore making them well-known to the school and surrounding community), and creating a positive school environment where student's feel safe and can trust the adults around them. [5]

Suicide Prevention for Suicide Attempt Survivors

Tips for Schools and Families

The first thing everyone (family, friends, school staff and faculty) needs to do is check their own emotions prior to approaching the surviving youth. It is understandable that, if there was a close relationship with the youth, that the surrounding community would too experience emotions such as confusion, anger, fear, sadness, and trauma. [7] Not only does the youth need support and resources to aid them within this recovery process, but it is equally important for the close community to take steps into taking care of their well-being and mental health.

The youth may be confused after the attempt and during recovery. They may be filled with questions as to why they were led to consider suicide or how they should express their thoughts and feelings. They should be constantly reminded that it is okay to not understand everything that second, but to know that those around them care for them and are there to support the youth. [8]

It is also important to understand that the recovery process is different for everyone. This includes the function of the recovery as well as the steps taken. Therefore, it is important to never discourage the youth as the first six months of recovery is crucial as the risk of suicide remains for the first year. [7] Be there for the youth as they may feel that they are alone or as a burden to those around them. [7] Additionally, make time to talk with a mental health professional or provider on how to make the environment safer for the youth (i.e., remove firearms, medications, etc.). [7]

It is important for the youth to create a safety plan induced with resources and trusted individuals. This should be completed by them with the assistance of a behavioural health provider or other health professional if needed. The following is an example of a **Safety Plan** provided by Nebraska Medicine:

Safety Plan

Patient Name:
Completed by:
Reviewed by/Date:

Step 1: Warning Signs (thoughts, images, mood, situation, and behavior) that a crisis may be developing.

1.
2.
3.

Step 2: Internal coping strategies - Things I can do to take my mind off my problems without contacting another person (e.g., relaxation techniques, physical activity or hobby).

1.
2.
3.

Step 3: People and social settings that provide distraction
Name / Phone
Name / Phone
Place / Phone

Step 4: People whom I can ask for help
Name / Phone
Name / Phone
Name / Phone

Step 5: Professionals or agencies I can contact during a crisis
Name / Phone
Name / Phone
Suicide Prevention Lifeline: 1-800-273-TALK (8255)
Crisis Text Line: Text "start" to 741741
Call 911

Step 6: Making the environment safe (e.g., remove weapons)
1.
2.

Step 7: One thing that is most important to me and worth living for is:
1.

A safety plan is a listen coping resource that is meant to support the individual whenever they are feeling suicidal but do not want to act on those feelings. Its main purpose is to prevent any suicidal crisis from escalating. The way this plan is set up personalizes it to where everyone and ever place on the plan is trusted by the individual. The individual may choose to share their safety plan with others so those close to them can help them whenever the individual needs support.

Lastly, within the recovery process, constantly remind the youth that they should be kind to themselves and to not overwork. They are in the process of healing and that takes time.

Information for School and Families: Sigma and Disclosure

It is crucial to understand that suicide and **suicidality** (strong suicidal thoughts, plans, and attempts) are connected. [9] This is relevant to suicide attempt survivors and those close to the survivor. Likewise, the three groups with a high risk of suicidality include: people with mental illness, suicide attempt survivors, and suicide loss survivors. [10]

Speaking with the youth after a suicide attempt may be difficult as they need time to process what has happened. They may refuse to disclose any information to

certain people but talk to some. Their disclosure decision making should not be shamed, as you do not know the reasons as to why they choose to disclose. This is simply how they are working through their emotions, feelings, and the process of recovery. [8] And though there are unknown factors that may prevent a survivor from disclosing, one known factor is the **stigma** (which contributes to suicidality)[10] that is associated with suicide:

The stigma around suicide and those who have experienced **suicide ideation** (thinking about taking one's life) is sometimes shows to hinder disclosure of suicidal behavior by suicide attempt survivors. This causes the individual to limit their disclosure to a few trusted individuals or to no one at all to avoid the stigma. [11] Some examples of suicide stigma include the following: [10]

- Stereotypes ("I think those who attempt suicide are crazy")
- Prejudice ("Those who attempt suicide scare me because they are crazy")
- Discrimination, such as ignoring or mistrust, because of prior suicidality

Additionally, because of this stigma associated to suicide, survivors often hide their suicidality which makes suicide prevention difficult. [10] However, disclosure can help decrease stigma and possible future suicidality, especially if the person who is trusted responds and reacts to the suicide survivor positively and appropriately. Specifically, if family members, friends, and close community members are supportive and offer encouragement. [11] This reduces the risk factors for suicide (i.e., perceived burden). [11] Disclosure of suicidal behavior can also be viewed as a coping mechanism that counters the feeling of being isolated or alone. [11]

It is also important to note that some friends and family members may become aware of the individuals suicidal behavior not from the person (without attempter's permission), but from learning about it from others (i.e., hospital staff, family members) or witnessing the process of the attempt. [11]

Research is yet to be completed on how the survivor chooses to disclose or not disclose information. [11] However, it is important to never force information from the youth, but to simply reassure the youth that you are there and that they are never alone in this process. It is also equally important to understand what to do and how to talk to the youth about further prevention measures and to remind them that they are not alone and that they matter. It is crucial to not only be there for the youth but to also try to eradicate the stigma associated with suicide and suicide attempt survivors.

After a Suicide

When a suicide occurs within a school community, a proper crisis response must be already in place and understood by those within the school to smoothly assist staff members, other students, the family of the student who died, and the community.[6] It is understood that when such matters take place the environment of the school shifts, so it is important to set it back in its focus of education.[6] This crisis response will also be followed by questions from parents concerned about the risk of other student suicides occurring.[12] Therefore, leaders, starting with the school psychologists should be the best resource for parents and families.

Open communication within the school is also an important requirement for after a suicide. This is mostly because schools are often close to a larger community. This open communication happens between the school administration and community partners such as the police department, mental health professionals, and medical examiners. [6] Open communications must also work between the school and the family of the student who has died to offer support. Not only should this be done immediately to let the family know that they are not alone in these times, but it is also needed so that the school is not misinformed on crucial information. [12] This is more to understand the warning signs (to increase prevention) and to give the family relevant and helpful resources. This is to assure the family that, though rumors may spread within the school, the faculty and staff will acknowledge these as only rumors and address the students about then stating that these statements can be hurtful and unfair to the individual and their family. [6] With that, parents should also be assured that no discussion concerning the suicide (i.e., why it happened) will take place, but instead will focus on the student's confusion and grief. Therefore, until any information is made known, the schools should determine the cause of death as "still being determined." 6

If the family chooses for the information about the suicide to not be disclosed, a close contact and good relations with the family should contact them informing them that students are already discussing the death and that having a respectful and education discussion about suicide with the students could help reduce further suicides. [6] However, if the family still choses to keep the information disclosed, the school should state the following: "The family has requested that the information about the cause of death not be shared at this time." [6]

Suicide Contagion

There have been some speculations around the theory that suicidality is *suicide contagion*, meaning that in the events of one suicide others would contemplate or attempt to die by suicide.[9] Ecological studies have seen an increase in suicide rates that have occurred after a publicized suicide.[6,9] Though suicide contagion mainly contributes to 1-5% of all suicides annually (making it quite rate), adolescence and youth are seen to be more vulnerable to imitative suicide than older adults, as some suicide cases concerning adolescents was due to the result of clustering.[6,9] Studies have also found that exposure to suicide is a predictor of suicide attempts or ideation, in that, the higher the suicidality rare, the higher the suicidal ideation.[13] Condition is where we see the difference between youth and adult suicides.[12]

After a Suicide: Suicide Postvention

The death of a classmate, friend, or family member can affect others emotionally and psychologically. And in some cases, it may be difficult to rationalize and

organize one's thoughts. Therefore, checking one's **emotional regulation**, one's ability to appropriately conceptualize and handle intense emotions like grief and fear, is very important.[6] Students should be given have a safe and healthy environment and method of expressing these emotions, this goes for staff and faculty as well. Usually at adolescence, youth know the basic skills on how to handle these emotions, however it is difference in the case of suicide.[6] Staff and faculty members should also support each other and try to establish a positive environment and outlook.[12] Different forms of coping should be addressed as well to help staff members during this time, knowing that other personal factors could have already been stressors prior to the suicide occurring. Therefore, professional help is highly recommended during the entire process.[12]

Suicide prevention is a 3-step process: prevention, intervention, and postvention, where postvention is often missing or looked over.[14] **Postvention** is defined as activities and planning materials meant to reduce the risk of another suicide and assist in the healing process for everyone after a suicide has occurred.[14] These planning/promotional materials can range from training seminars for staff, awareness and warning signs presentations and open discussions for students, and open resources for everyone who need any form of assistance. It all depends on the need of the person and the situation. It is also important to be in regular contact with those of the medical field such as EMS and mental health professionals. Another form of postvention includes therapy for family, survivors, and the community, where the focus is to alleviate the **psychache**, or psychological pain such as pain and grief.[15] Postvention has been found useful by suicide survivors (those who have lost a loved one), as it gives them a safe environment to let out the negative emotions and psychache from the event though social support from others.[15]

Postvention planning and activities are also created to combat suicide contagion. The overall goal is to prevent another suicide from occurring, and one way to identify the risk at which the students are after the suicide, often known as **psychological triage**.[12] Studies have stated that after a death by suicide, schools

should immediately try to identify youth who may be at risk, and to assist, researchers have categorised students into three groups based on risk level:[12]

1. Proximity to the event (witnesses)
2. Emotionally close to student (friend, family member, teammate)
3. Vulnerable youth (student with a past of depression, stress, and trauma) – often harder to find and identify – these events may increase sense of loss and suicidality

Schools can also choose to memorialize the student in an appropriate way without risking the cause of suicide contagion, among others. However, whichever way a school chooses to do reduce contagion, it should be done the same way for all deaths.[6]

These preparations are meant to assist everyone who has been exposed to the death, hence completed after a suicide has happened.[14] However, they should be prepared in advanced as postvention is prevention. No one wants a suicide to take place, and no one ever predicts for it to happen, but knowing what to do after it does happen can help prevent other suicide from occurring.

Terms to Know

Physical Dissociation
Safety Plan
Suicidality
Stigma
Suicidal Ideation
Emotional Regulation
Postvention
Psychache

Suicide Contagion
Psychological triage

Suicide Prevention Resources

National Suicide Prevention Lifeline

Call: 1-800-273-8255
1-888-628-9454 (En Español)
1-800-799-4889 (For Deaf + Hard of Hearing)
suicideprevneitonlifeline.org

Crisis Text Line

Text: TALK, HOME, SIGNS, or BRAVE to 741741 for anonymous 24/7 Counseling

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The Boys Town National Hotline

Call: 1-800-448-3000
1-800-448-1833 (TTY Line for Hearing-impaired)

Nebraska Rural Response Hotline

Call: 1-800-464-0258

Substance Abuse & Mental Health Services Administration (SAMHSA) National Helpline

Call: 1-800-662-4357
1-800-487-4889 (TTY line)

CALL 9-1-1

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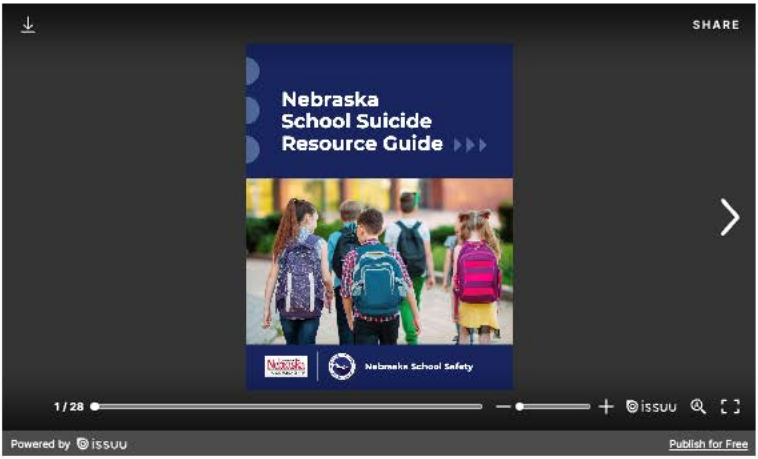
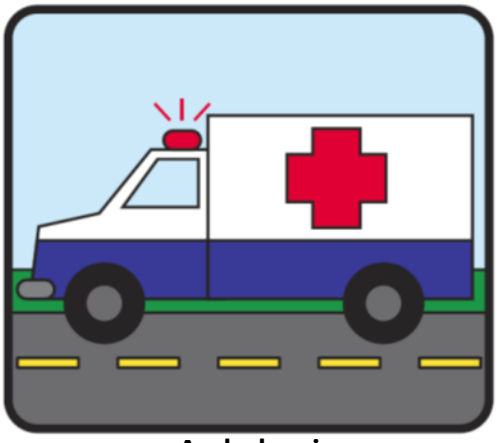
Questions, Comments, or Corrections? Let us know!

Suicide Prevention



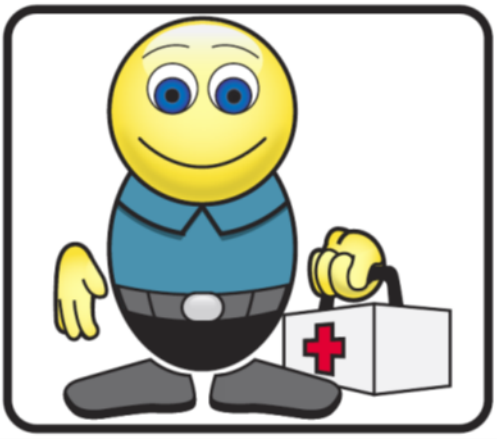
COMMUNICATION CARDS

Ambulance



Ambulancia

Paramedic



Técnico de Emergencias Medicas

Happy

Feliz

Sad

Triste

Yes

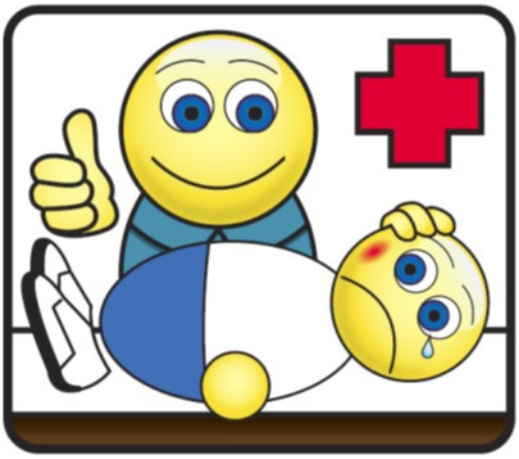
Sí

No

No

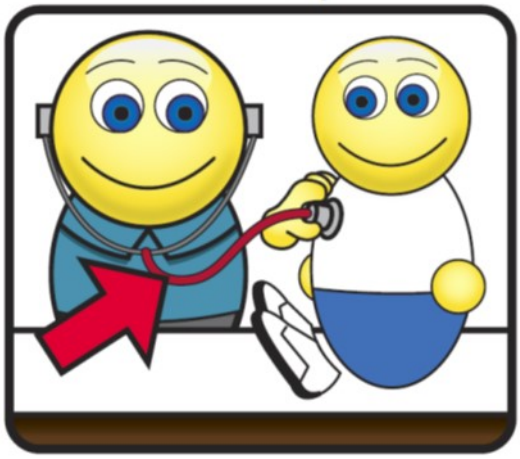
COMMUNICATION CARD

Examination



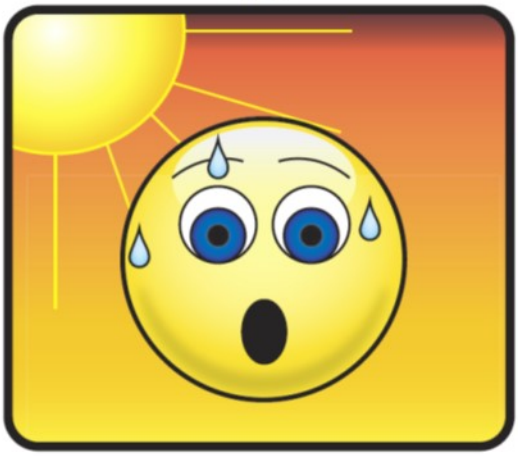
Examen médico

Stethoscope



Estetoscopio

Hot



Tiene calor

Cold

Tiene Frio

Sick

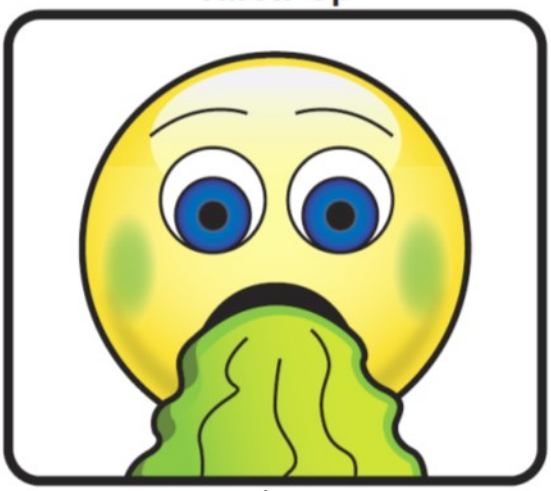
Enfermo

Dizzy

Mareado

COMMUNICATION CARDS

Throw Up



Vómitos

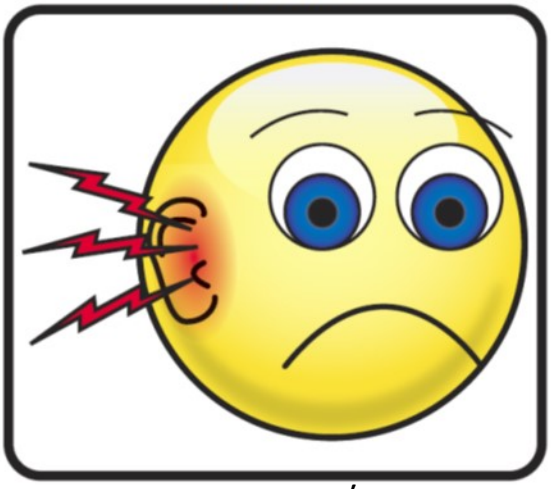
Diarrhea

Diarrea

Head Hurts

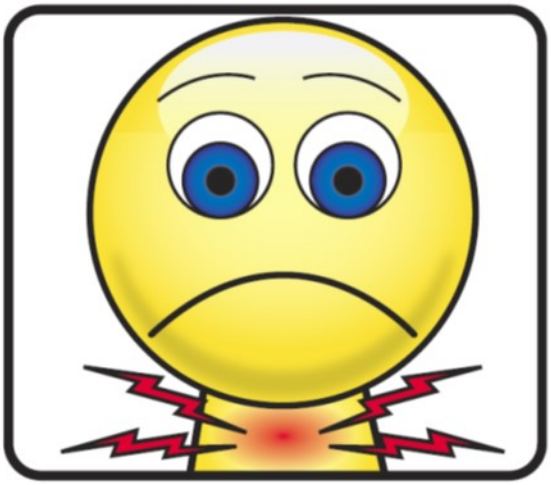
Le duele la cabeza

Ear Hurts



Le duele el oído

Throat Hurts

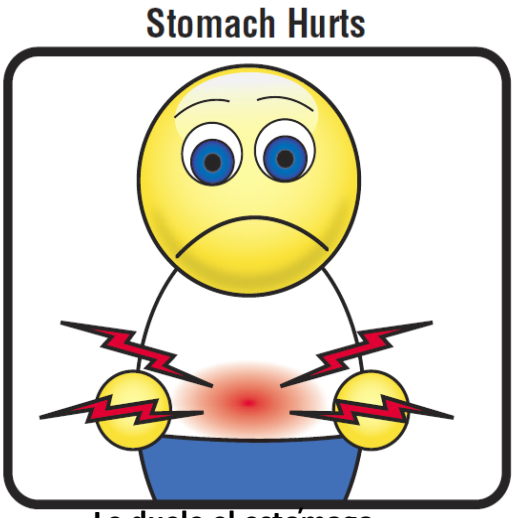


Le duele la garganta

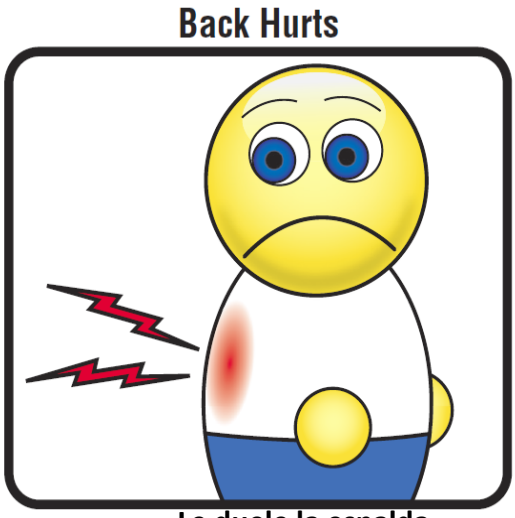
Cough

Tos

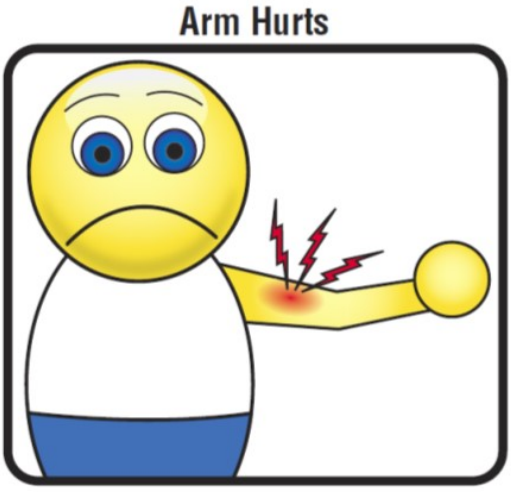
COMMUNICATION CARDS



Le duele el estómago

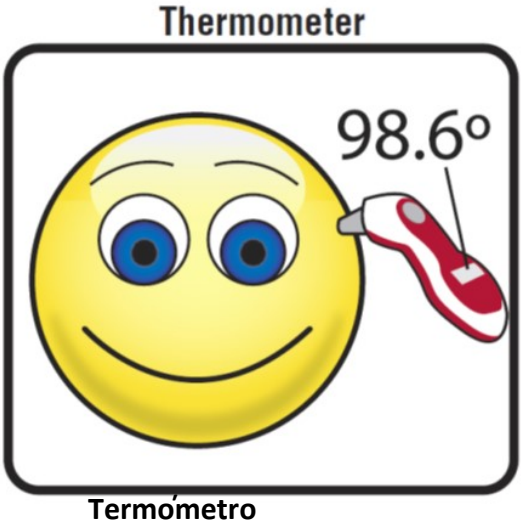


Le duele la espalda

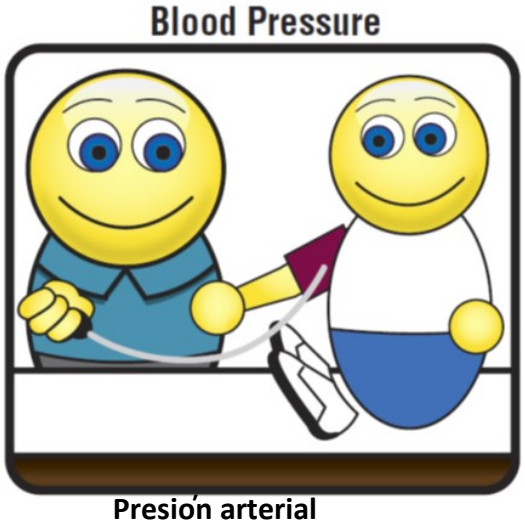


Le duele el brazo

Le duele la pierna



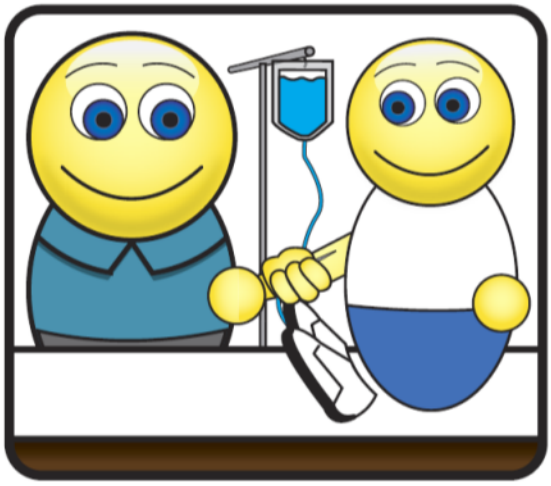
Termómetro



Presión arterial

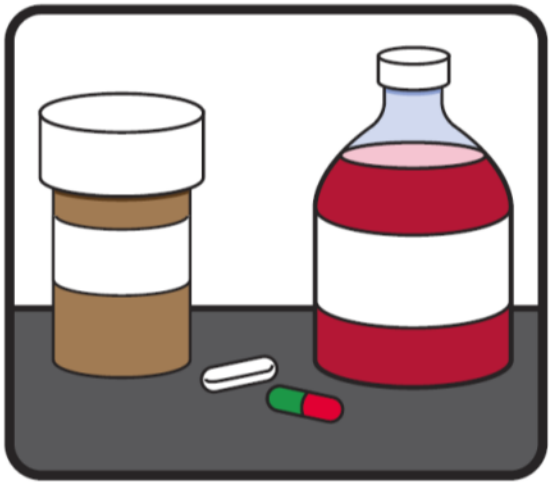
COMMUNICATION CARDS

IV Fluid



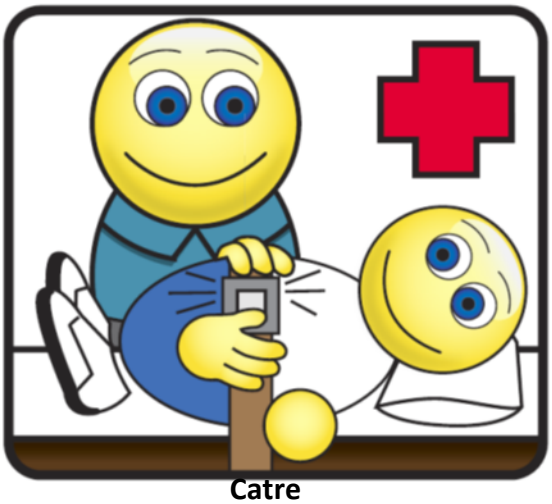
Fluido intravenoso (IV)

Medicine



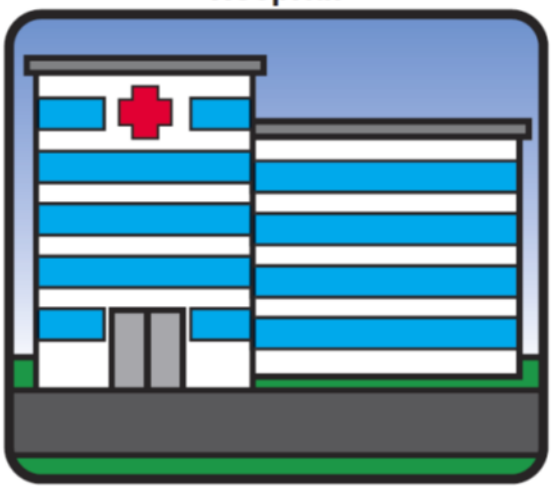
Medicamento

Cot



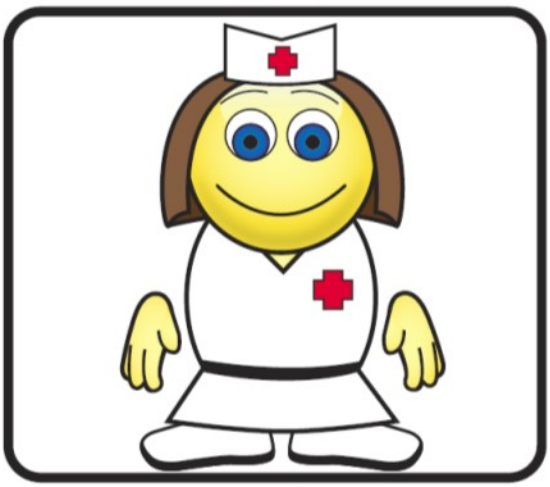
Catre

Hospital



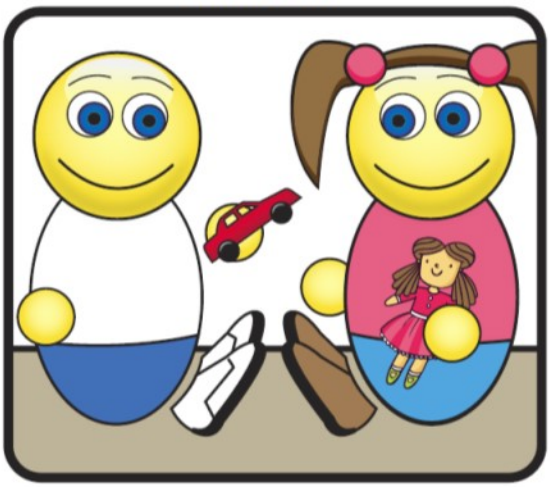
Hospital

Nurse



Enfermera

All Better



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