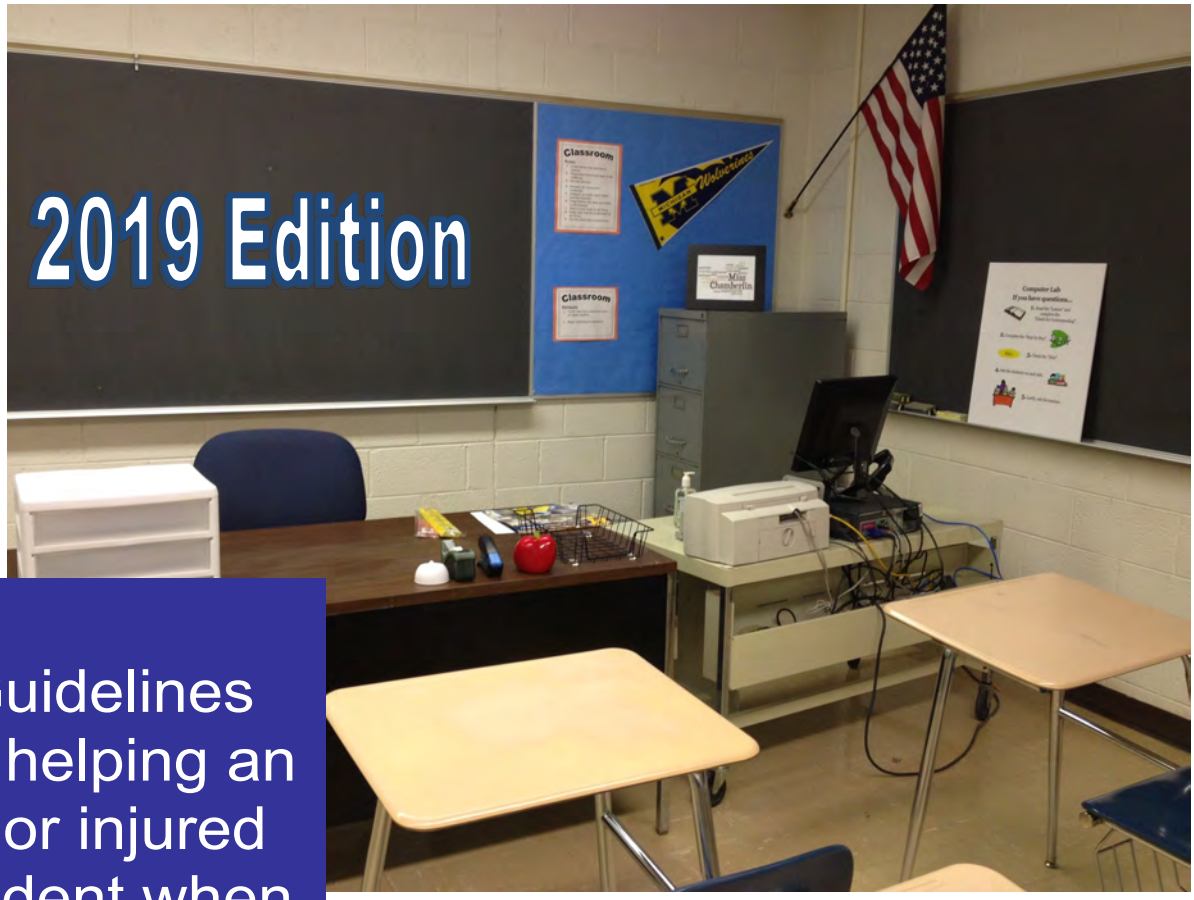
Emergency Guidelines For Nebraska Schools



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

Program Manager

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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.

Corolla Lauck, South Dakota EMS for Children Manager and Brenda Jackson EHS Support II for providing assistance with these guidelines. We could not have done it without their expertise.

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.

For more information contact:

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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.

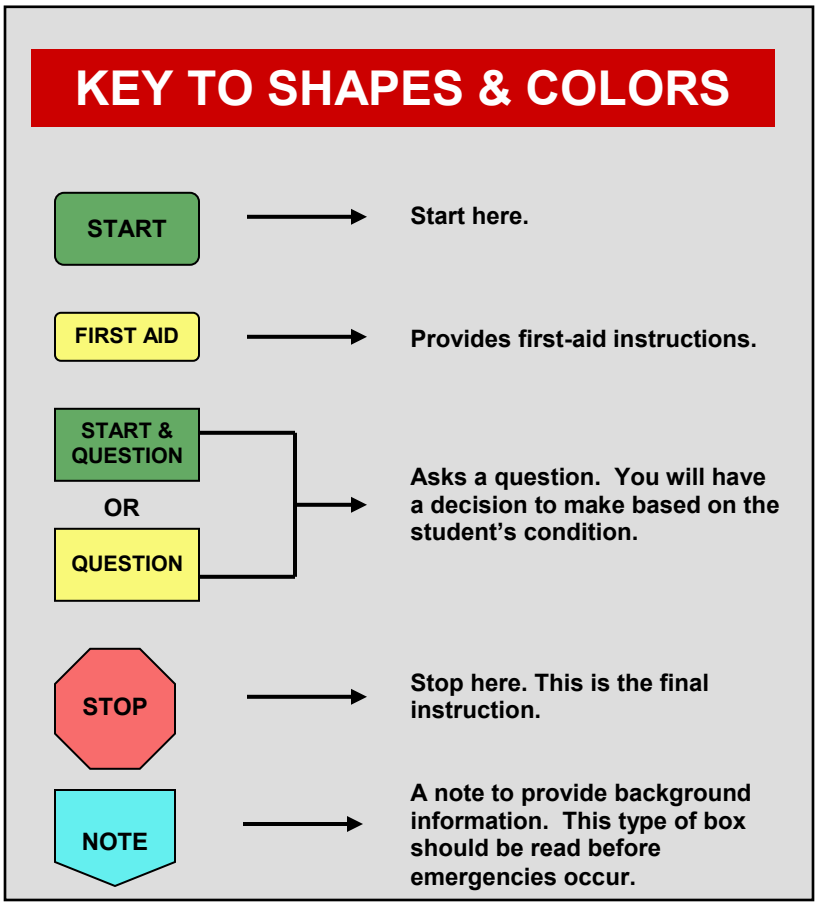
- The Resource Section contains important information about key emergency numbers in your area. It is important to complete this information as soon as you receive the guidelines, as you will need to have this information ready in an emergency situation.

- 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, Fall 2010.*

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.

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.

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

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.

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

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

NO → Contact responsible school authority & parent/legal guardian.

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

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

BEHAVIORAL EMERGENCIES

Behavioral or psychological emergencies may take many forms (e.g., depression, anxiety/panic, phobias, destructive or assaultive behavior, talk of suicide, etc.).
Intervene only if the situation is safe for you.

Students with a history of behavioral problems, emotional problems or other special needs should be known to appropriate school staff. An action plan should be developed.

Refer to your school's policy for addressing behavioral emergencies.

Does student have visible injuries?

YES → See appropriate guideline to provide first aid. **CALL EMS 9-1-1 if any injuries require immediate care.**

NO

- Does student's behavior present an immediate risk of physical harm to persons or property?
- Is student armed with a weapon?

YES → **CALL THE POLICE.**

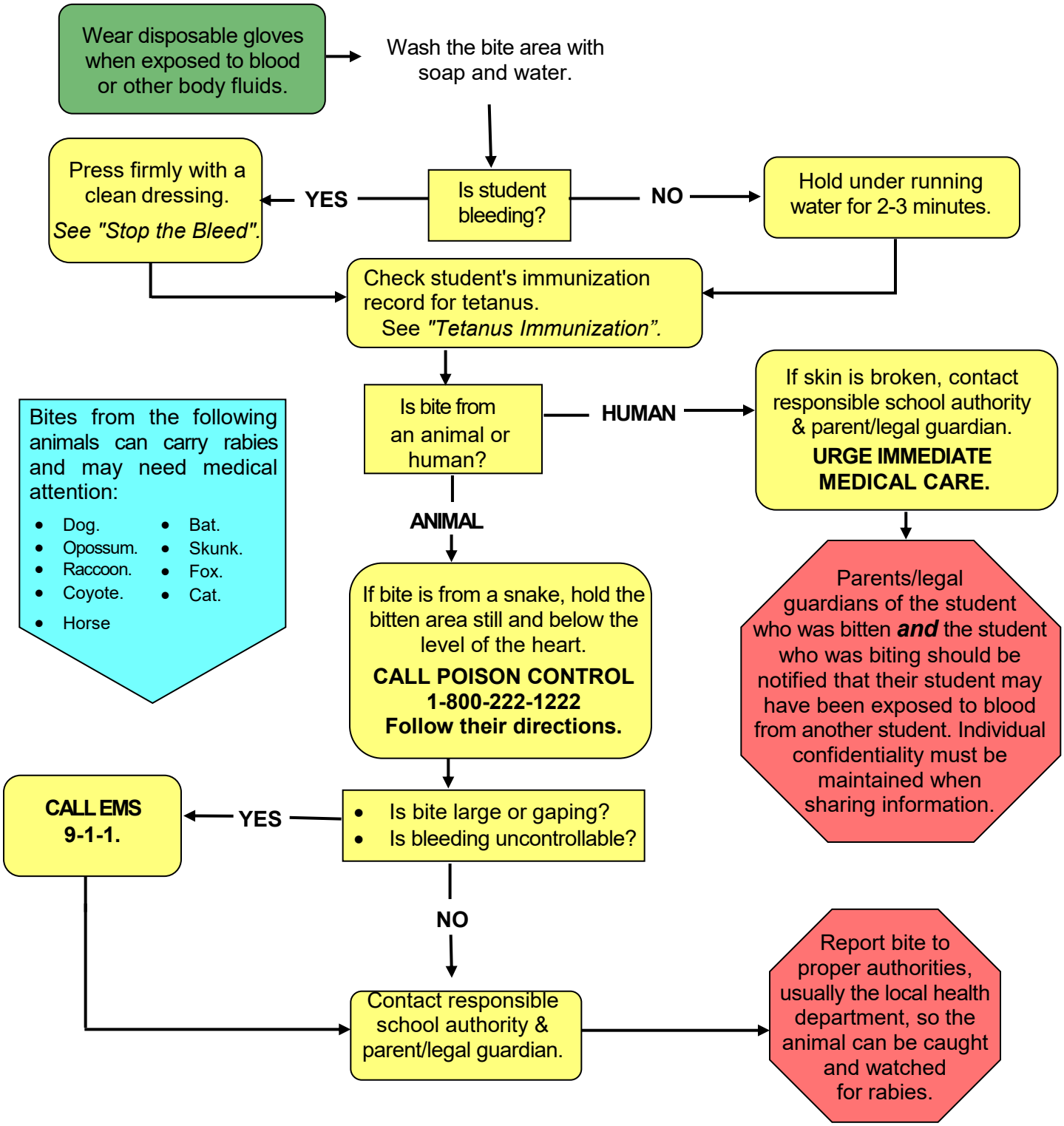
NO

The cause of unusual behavior may be psychological, emotional or physical (e.g., fever, diabetic emergency, poisoning/overdose, alcohol/drug abuse, head injury, etc.). The student should be seen by a health care provider to determine the cause.

Suicidal and violent behavior should be taken seriously.
If the student has threatened to harm him/herself or others, contact the responsible school authority immediately.

Contact responsible school authority & parent/legal guardian.

BITES (HUMAN & ANIMAL)



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

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THE COMMITTEE ON TRAUMA

HARTFORD CONSENSUS™ SAVE A LIFE STOP THE BLEEDING

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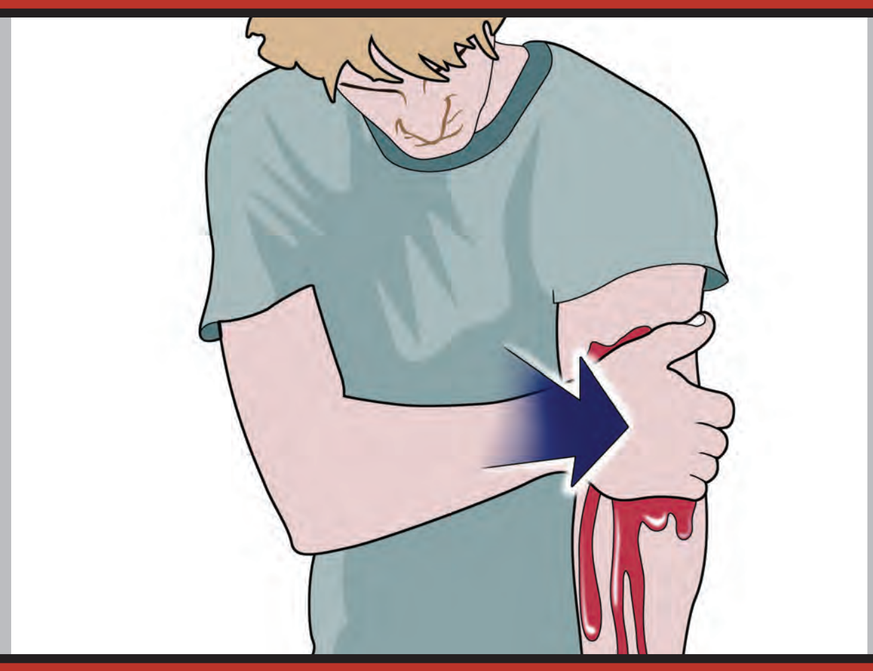
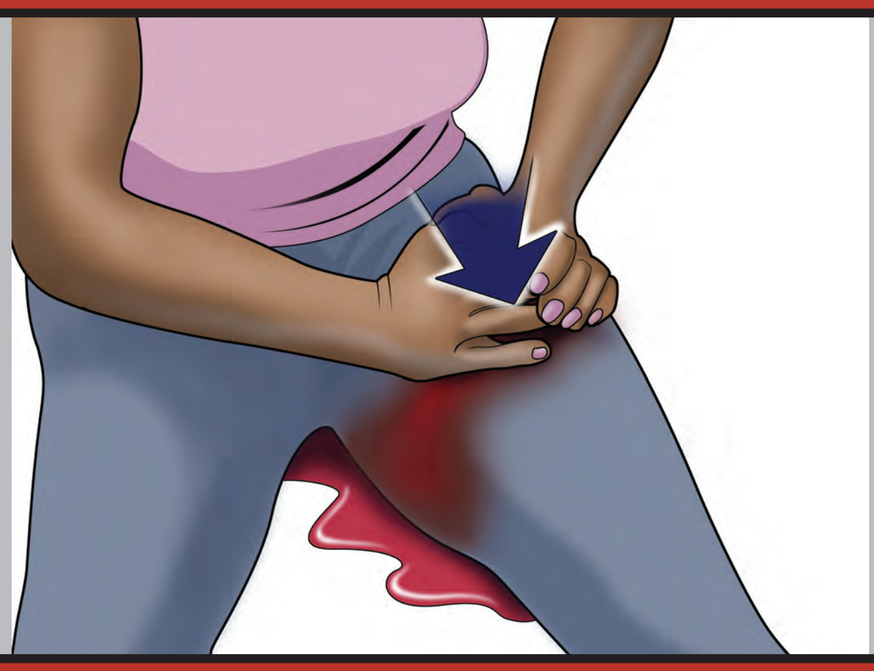
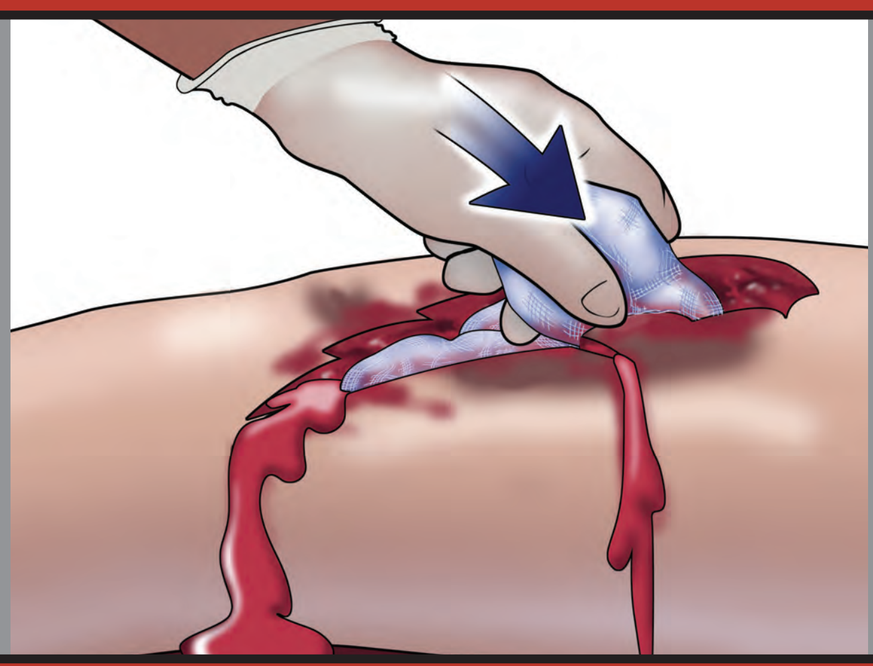
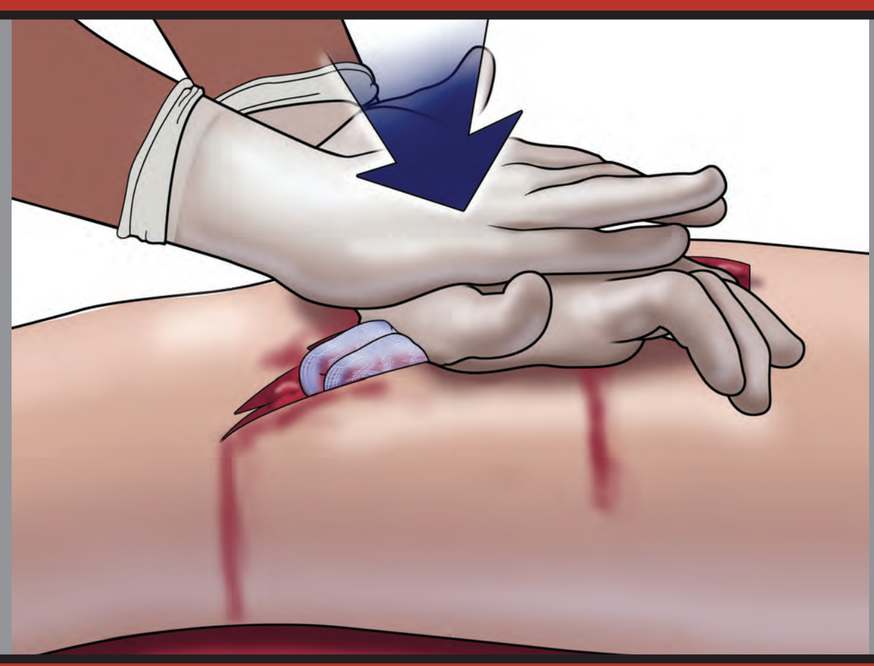
1 APPLY PRESSURE WITH HANDS



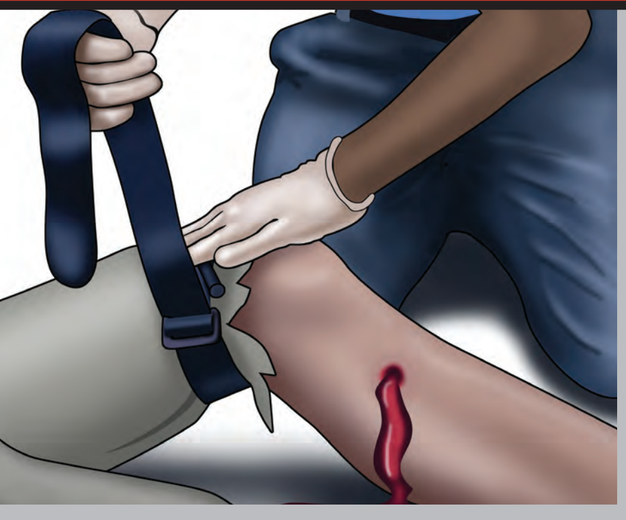


2 APPLY DRESSING AND PRESS





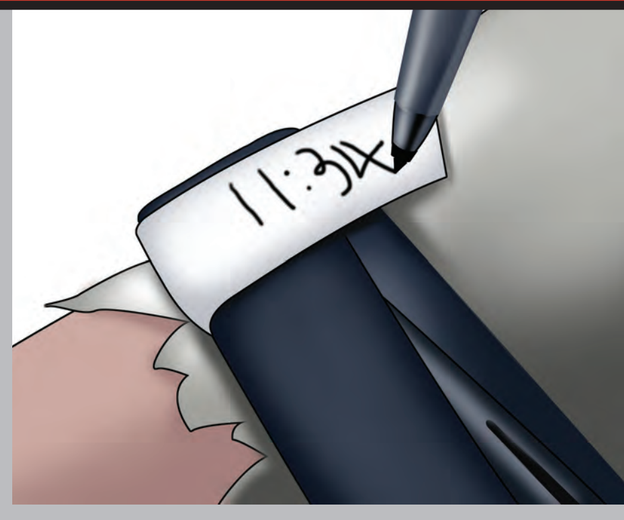
3 APPLY TOURNIQUET



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.

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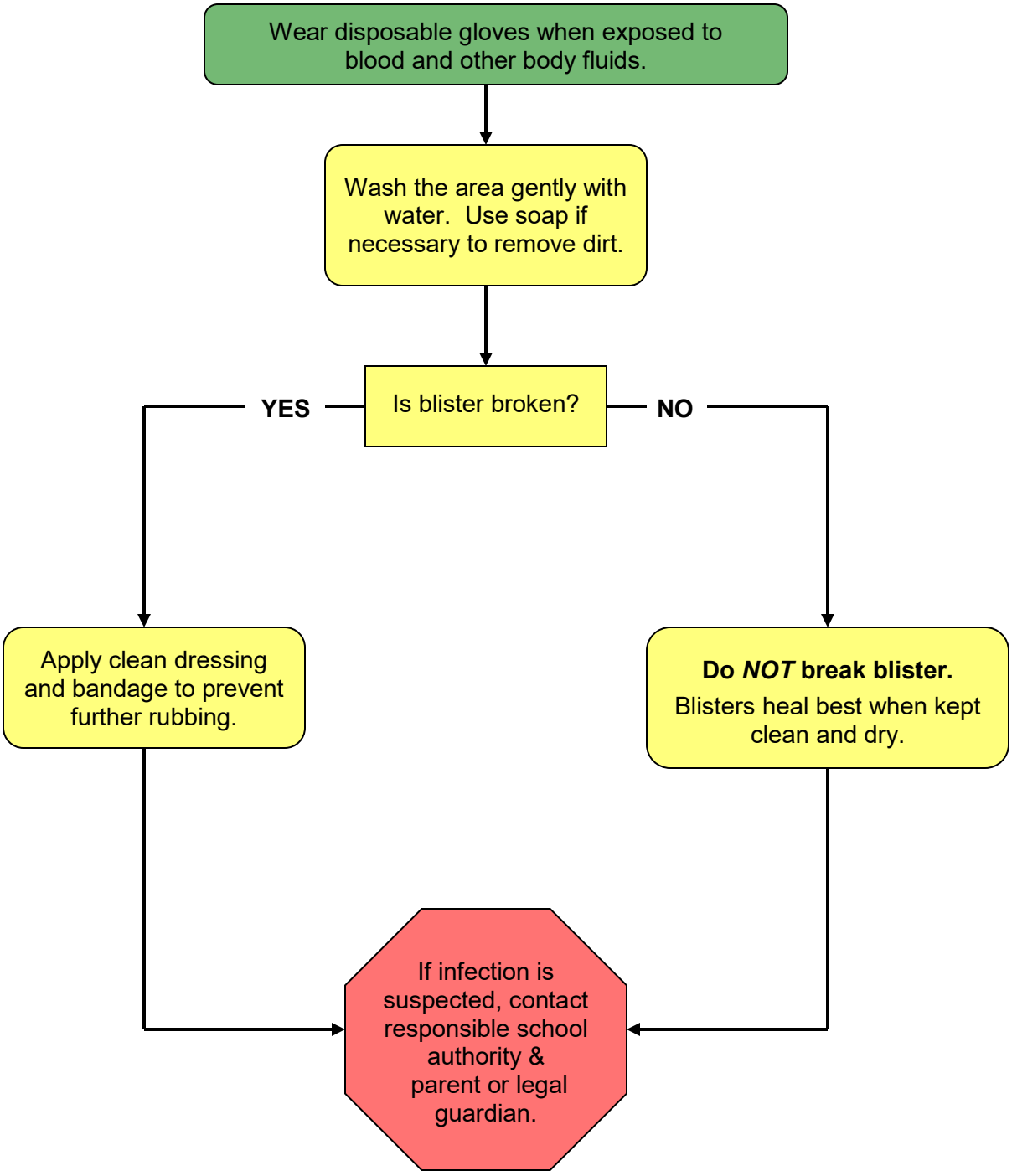
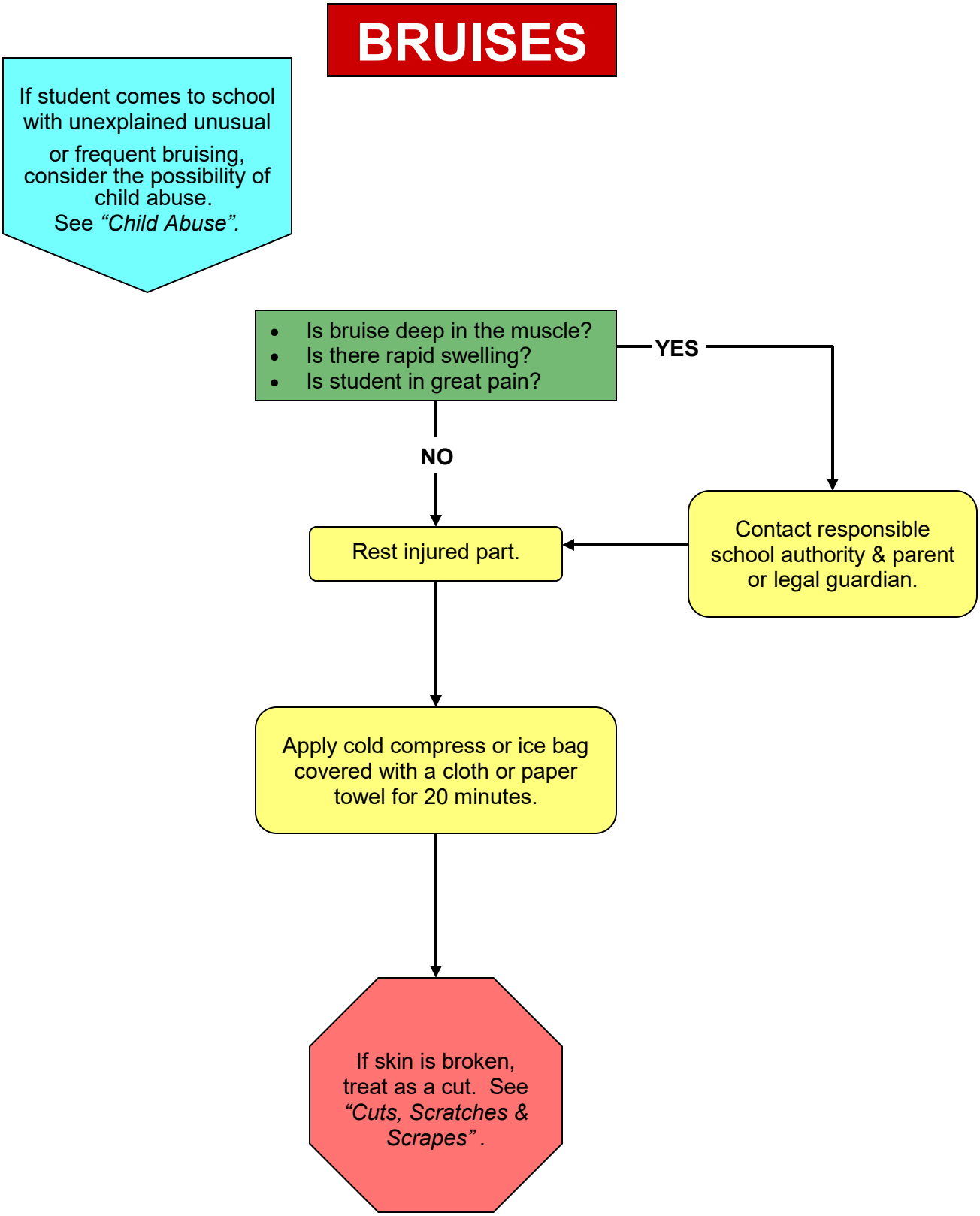
BLISTERS
(FROM FRICTION)



BRUISES


If student comes to school with unexplained unusual or frequent bruising, consider the possibility of child abuse.
See *"Child Abuse"*.
• Is bruise deep in the muscle?
• Is there rapid swelling?
• Is student in great pain?
YES
NO
Contact responsible school authority & parent or legal guardian.
Rest injured part.
Apply cold compress or ice bag covered with a cloth or paper towel for 20 minutes.
If skin is broken, treat as a cut. See *"Cuts, Scratches & Scrapes"*.

BURNS

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"* .

Always make sure the situation is safe for you before helping the student.

What type of burn is it?

ELECTRICAL

Is student unconscious or unresponsive?

YES

See *"Electric Shock"*.

NO

HEAT

Flush the burn with large amounts of cool running water or cover it with a clean, cool, wet cloth. **Do *NOT* use ice.**

- 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 EMS 9-1-1

NO

Cover/wrap burned part loosely with a clean dressing.

Check student's immunization record for tetanus. See *"Tetanus Immunization"*.

Contact responsible school authority & parent or legal guardian.

CHEMICAL

- 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"* if necessary.
- Rinse for 20-30 minutes.

CALL POISON CONTROL
1-800-222-1222
while flushing burn and follow instructions.

NOTES ON PERFORMING CPR

The American Heart Association (AHA) issued new CPR guidelines for laypersons in 2015.* 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 Academy of 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, Fall 2015.*

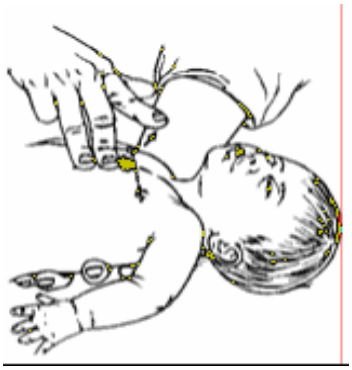
CARDIOPULMONARY RESUSCITATION (CPR)
FOR INFANTS UNDER 1 YEAR

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.

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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.)

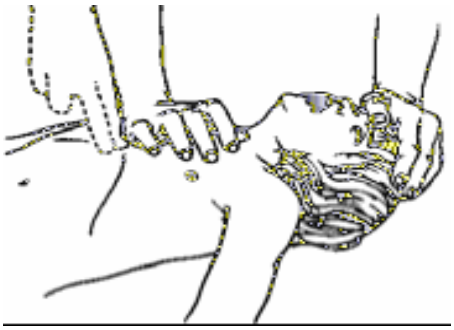
7. Compress chest hard and fast 30 times in 15-18 seconds with the heel of **1 or 2 hands.*** Compress at least 2" or 1/3 of the child's chest. Allow the chest to return to normal position between each compression.

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.

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

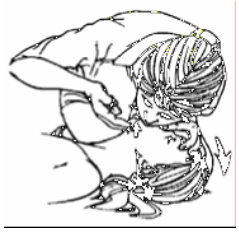
CPR is to be used when a person is unresponsive or when breathing or heart beat stops.

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.

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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.

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.

FOR OBESE OR PREGNANT PERSONS:

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

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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.

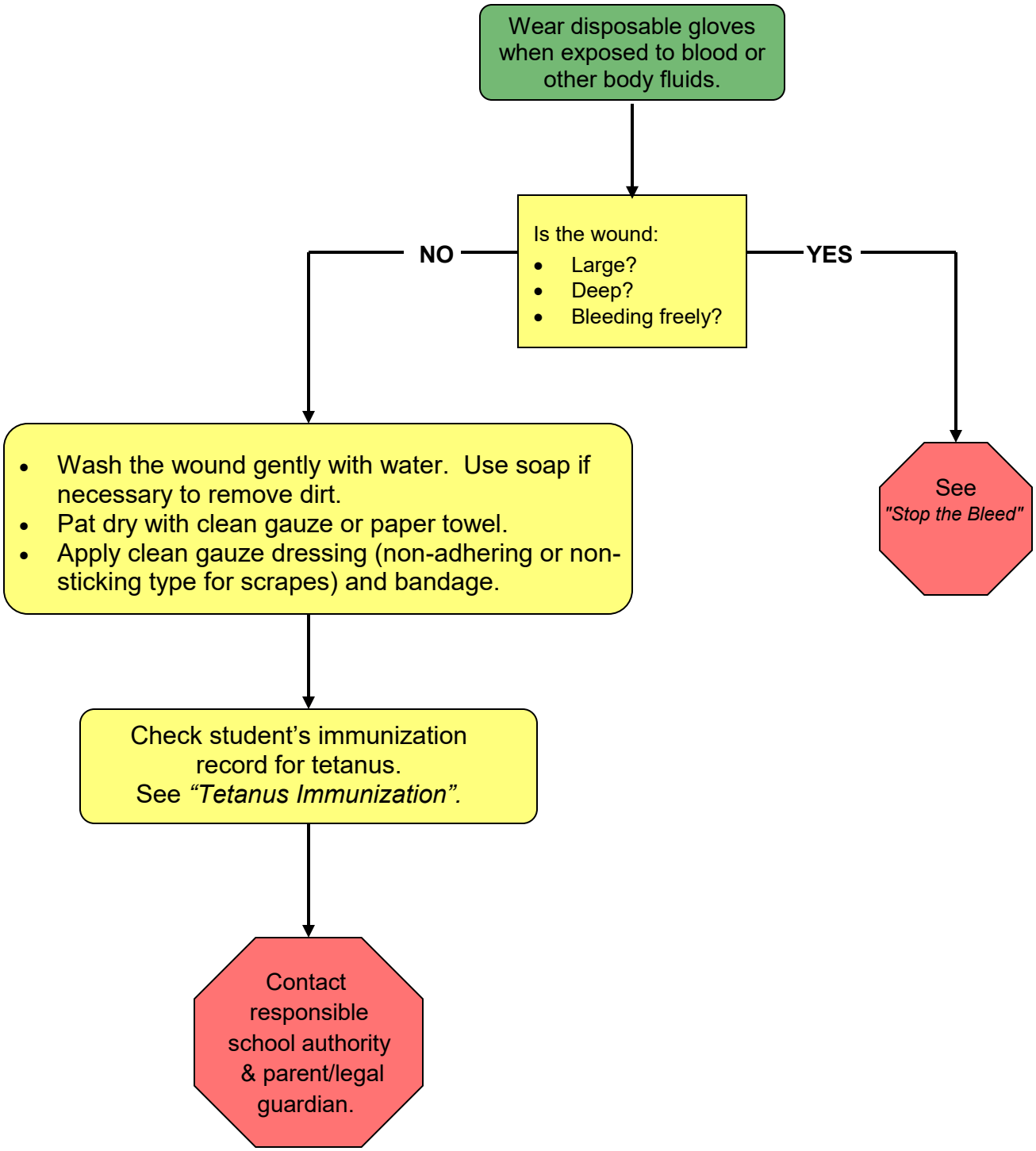
Signs of POSSIBLE illness:

- 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 Diabetic Action plan.

Is the student:

- Unconscious or losing consciousness?
- Having a seizure?
- Unable to speak?
- Having rapid, deep breathing?

YES → **CALL EMS 9-1-1.**

NO → Does student have a blood sugar monitor available?

NO → Give the student "sugar" such as:

- Fruit juice or soda pop (not diet) 6-8 ounces.
- Hard candy (6-7 lifesavers) or ½ candy bar.
- Sugar (2 packets or 2 teaspoons).
- Cake decorating gel (½ tube) or icing.
- Instant glucose.

- Continue to watch the student in a quiet place. The student should begin to improve within 10 minutes.
- Allow student to re-check blood sugar.

Continue to watch the student. Is student improving?

YES → Contact responsible school authority & parent/legal guardian.

NO → **CALL EMS 9-1-1.**

If the student is unconscious, See *"Unconsciousness"*.

YES → Allow student to check blood sugar.

Is blood sugar ***less than 60 or "LOW"*** according to action plan?
or
Is blood sugar ***"HIGH"*** according to action plan?

LOW → Give the student "sugar" such as:

HIGH → Contact responsible school authority & parent/legal guardian.

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".*
- Blood present in the stool?
- Severe stomach pain?
- Student is dizzy and pale?

YES

Contact responsible school authority & parent/legal guardian.

URGE MEDICAL CARE.

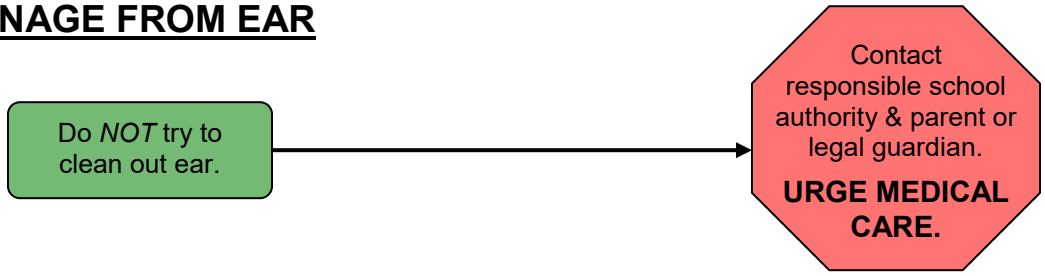
NO

- Allow the student to rest if experiencing any stomach pain.
- Give the student water to drink.

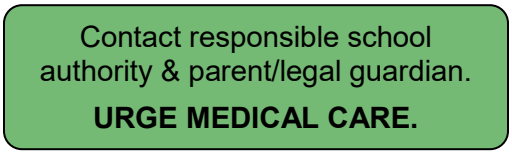
If the student's clothing is soiled, wear disposable gloves and double-bag the clothing to be sent home. Wash hands thoroughly.

EAR PROBLEMS

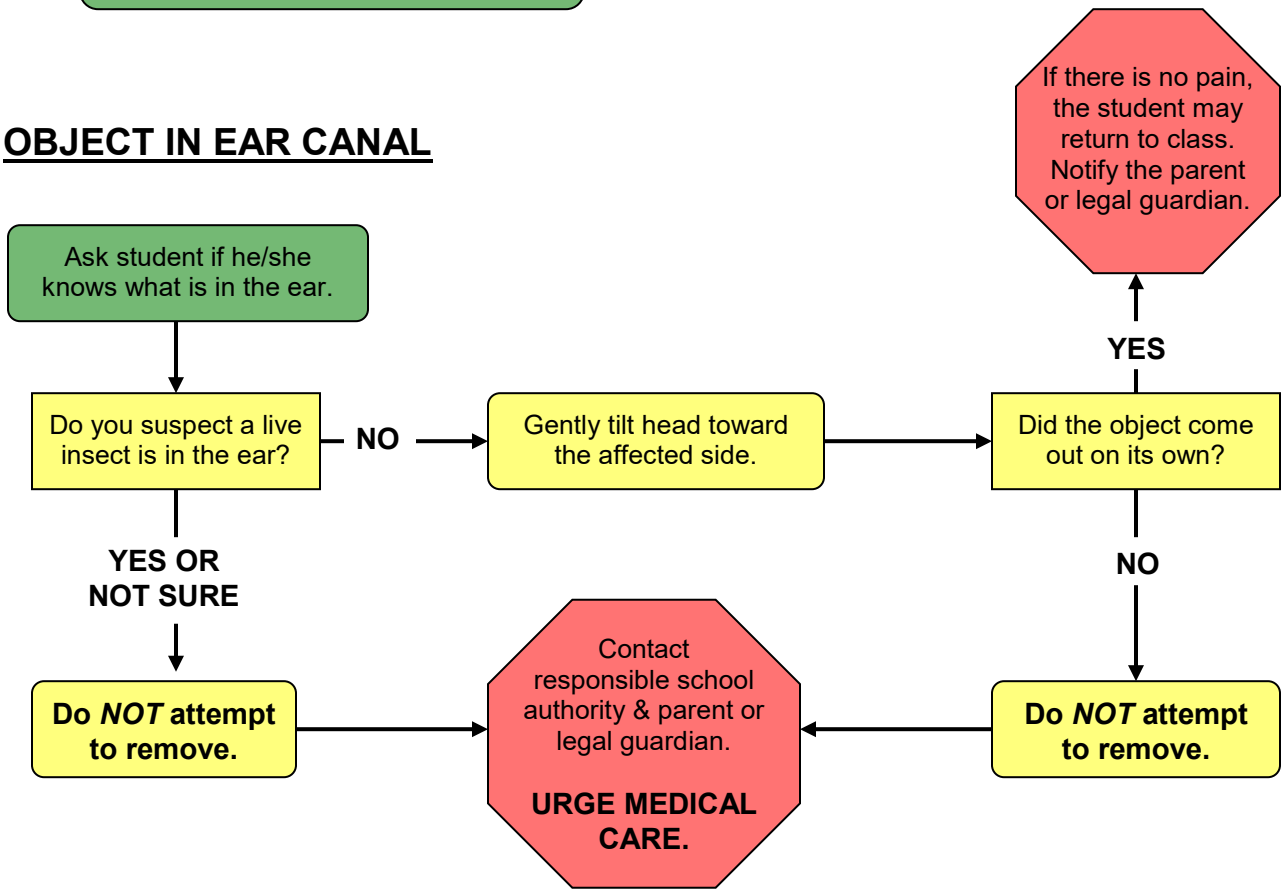
DRAINAGE FROM EAR



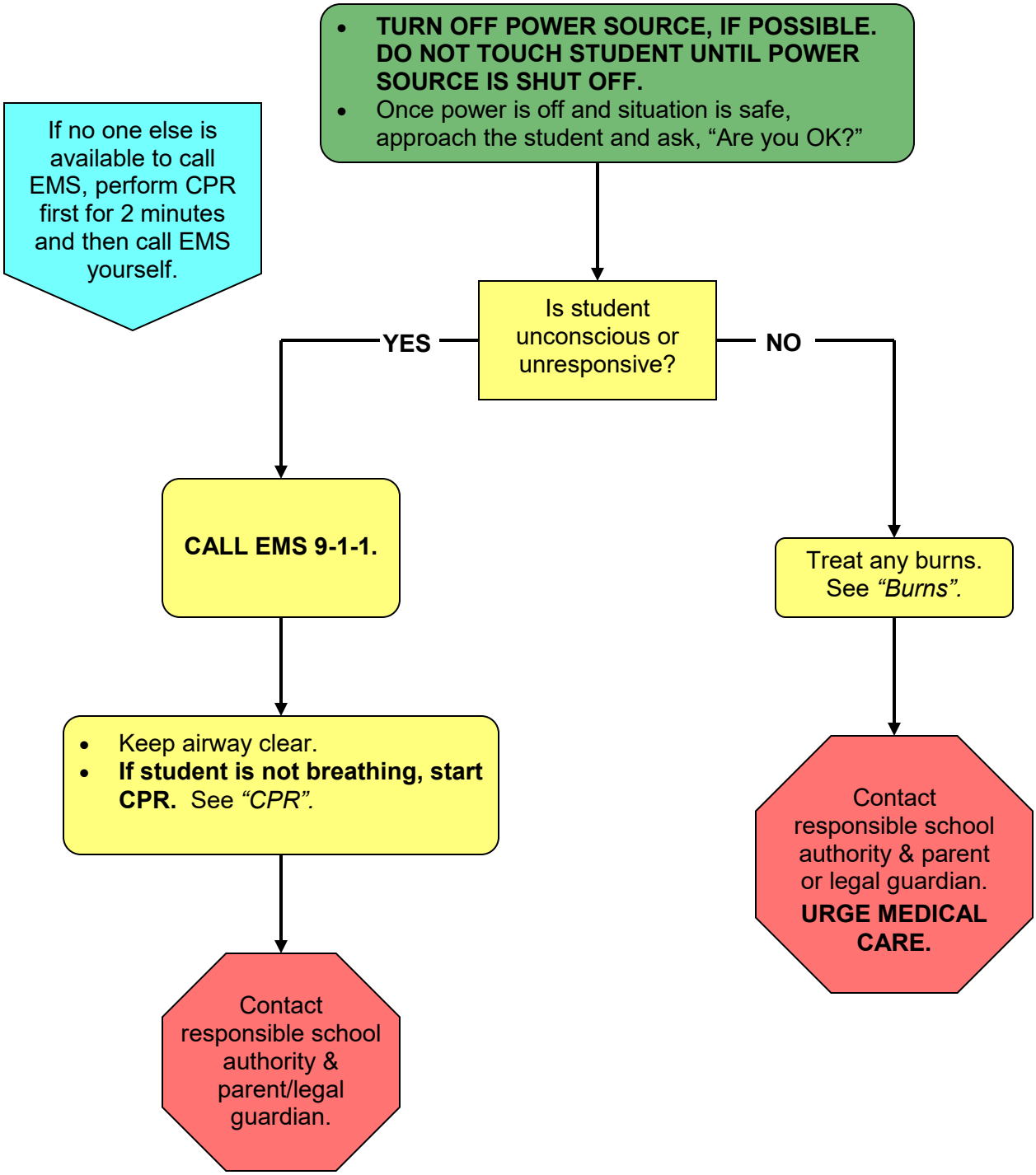
EARACHE



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:

Keep student lying flat and quiet.

- Is injury severe?
- Is there a change in vision?
- Has object penetrated eye?

YES

If an object has penetrated the eye, **do *NOT* remove object.**

Cover eye with a paper cup or similar object to keep student from rubbing, **but do *NOT* touch eye or put any pressure on eye.**

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

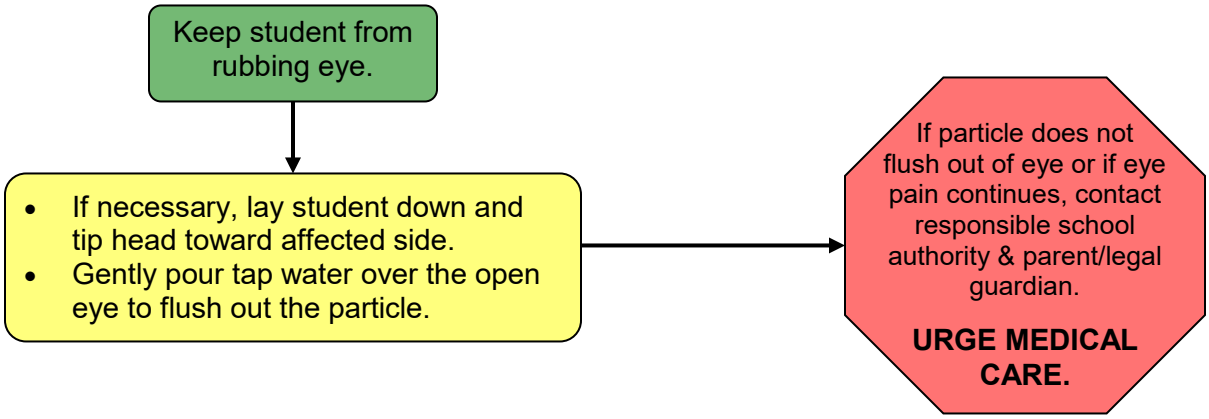
NO

Contact responsible school authority & parent or legal guardian.

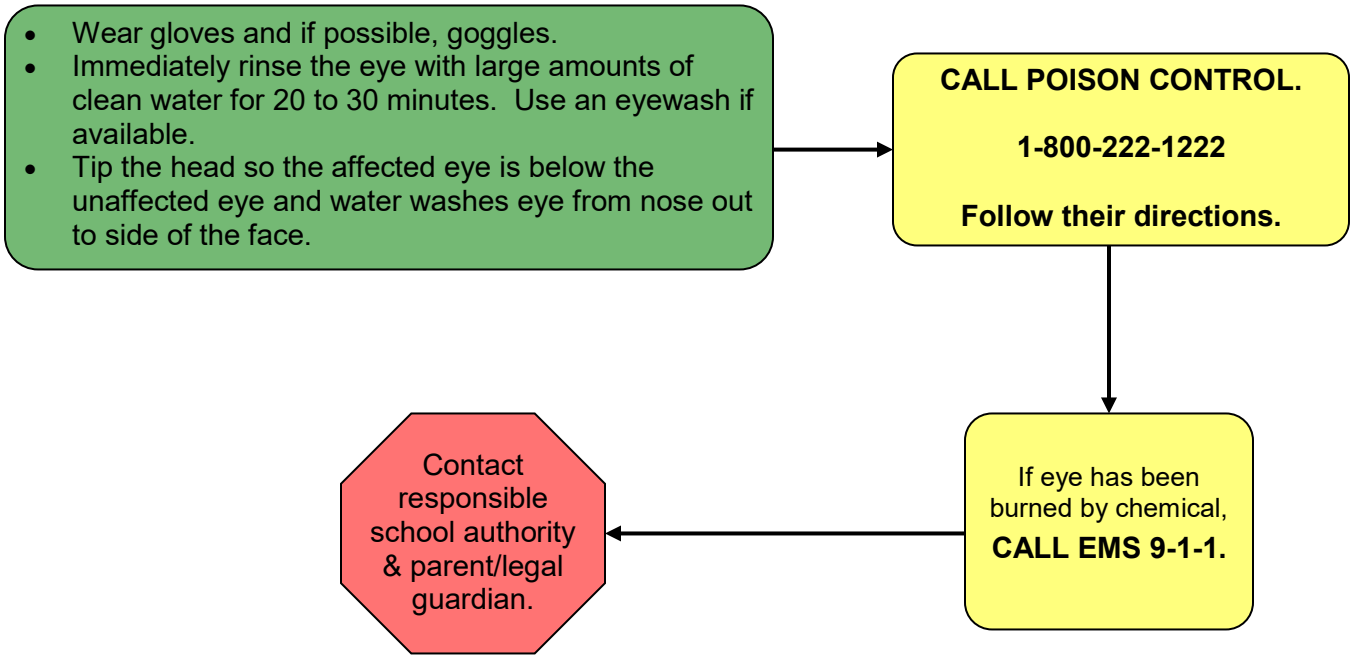
URGE IMMEDIATE MEDICAL CARE.

EYE PROBLEMS

PARTICLE IN EYE



CHEMICALS IN EYE



FAINTING

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.

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.

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

- 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".*

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.

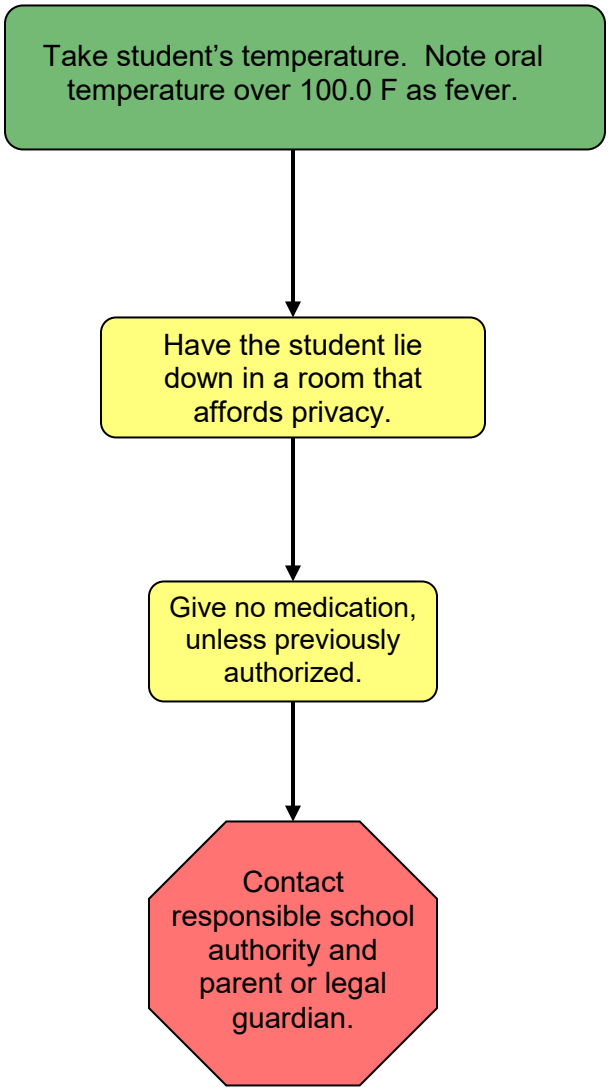
NO

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

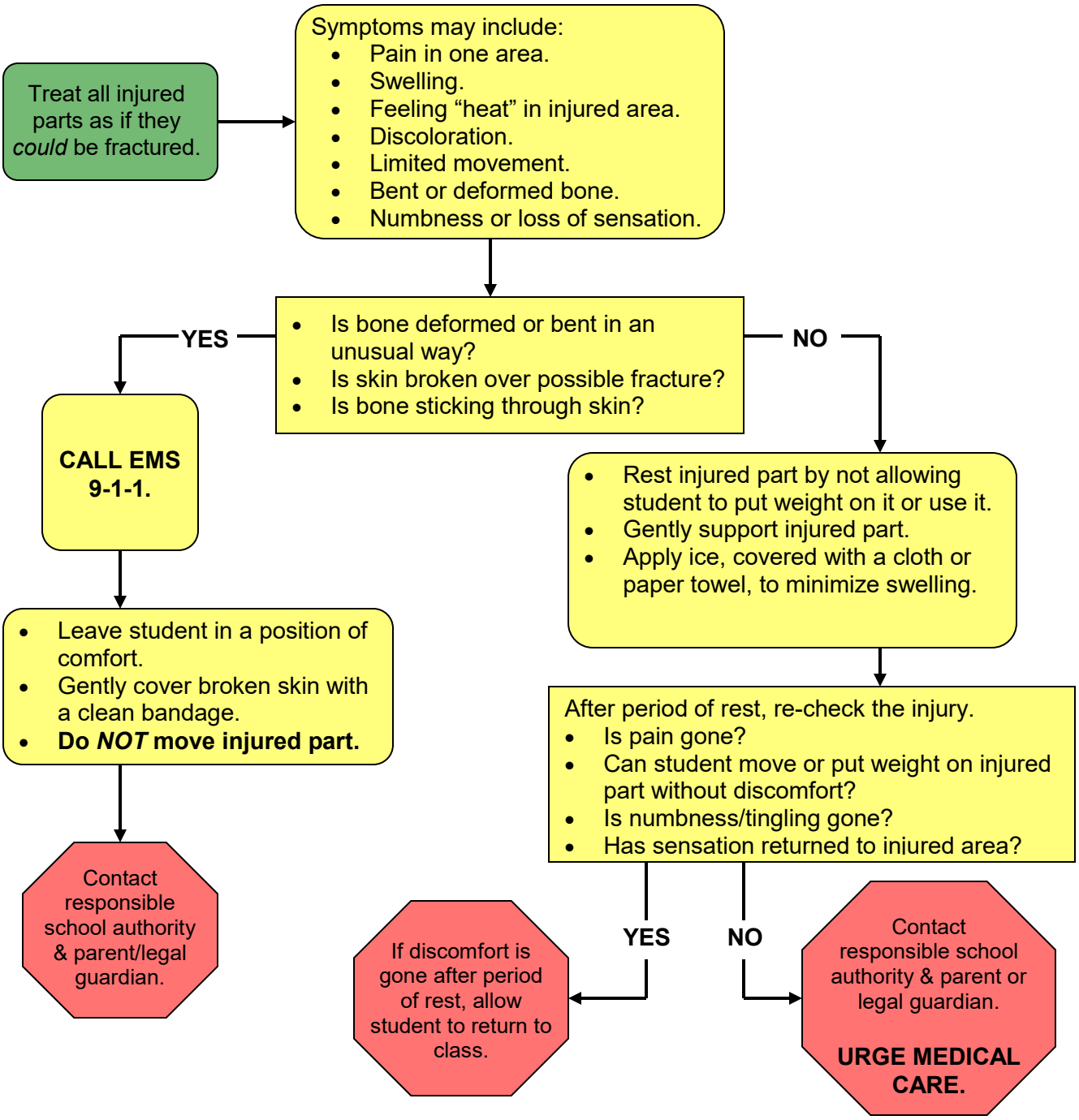
Contact responsible school authority & parent/legal guardian.

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"*. 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.

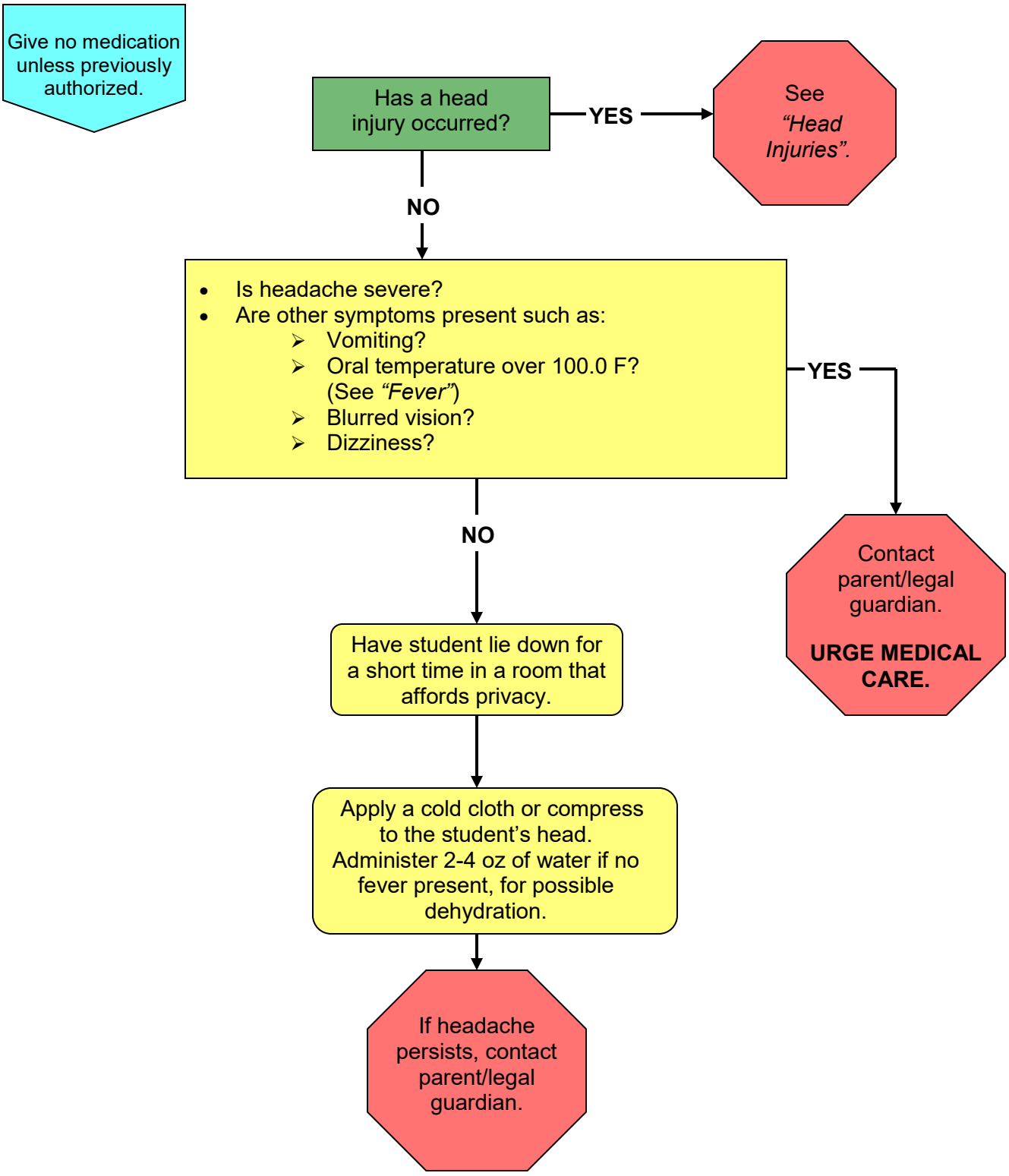
NO

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".
NO
Is headache severe?
Are other symptoms present such as:
Vomiting?
Oral temperature over 100.0 F? (See "Fever")
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 *"Stop the Bleed"*.

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

- 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"* 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"*.

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 Return to Learn & Return to Play in Resources Section

HEAT STROKE – HEAT EXHAUSTION

Heat emergencies are caused by spending too much time in the heat. Heat emergencies can be life-threatening situations.

Strenuous activity in the heat may cause heat-related illness. Symptoms may include:

- Red, hot, dry skin.
- Weakness and fatigue.
- Cool, clammy hands.
- Vomiting.
- Loss of consciousness.

Is student unconscious or losing consciousness?

NO

- Remove student from the heat to a cooler place.
- Have student lie down.

- Does student have hot, dry, red skin?
- Is student vomiting?
- Is student confused?

YES

Cool rapidly by completely wetting clothing with room temperature water.

Do *NOT* use ice water.

NO

Give clear fluids such as water, 7Up or Gatorade frequently in small amounts if student is fully awake and alert.

Contact responsible authority & parent/legal guardian.

YES

- Quickly remove student from heat to a cooler place.
- Put student on his/her side to protect the airway.
- **If student stops breathing, start CPR.** See *"CPR" (pp.21-24).*

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

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?

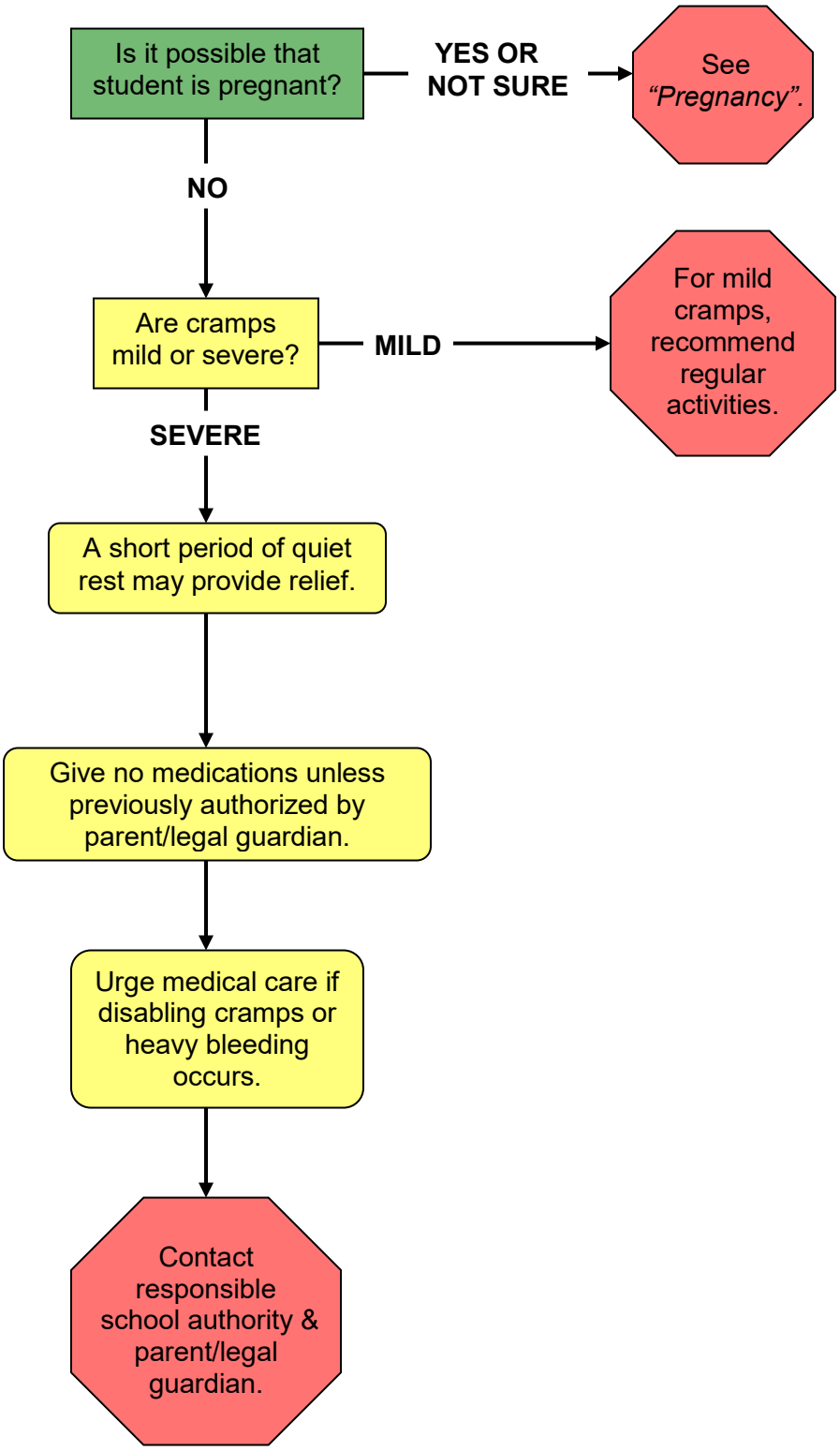
NO → Continue to warm student with blankets. If student is fully awake and alert, offer warm (***NOT HOT***) fluids, but no food. → Contact responsible authority & parent or legal guardian. **Encourage medical care.**

YES ↓

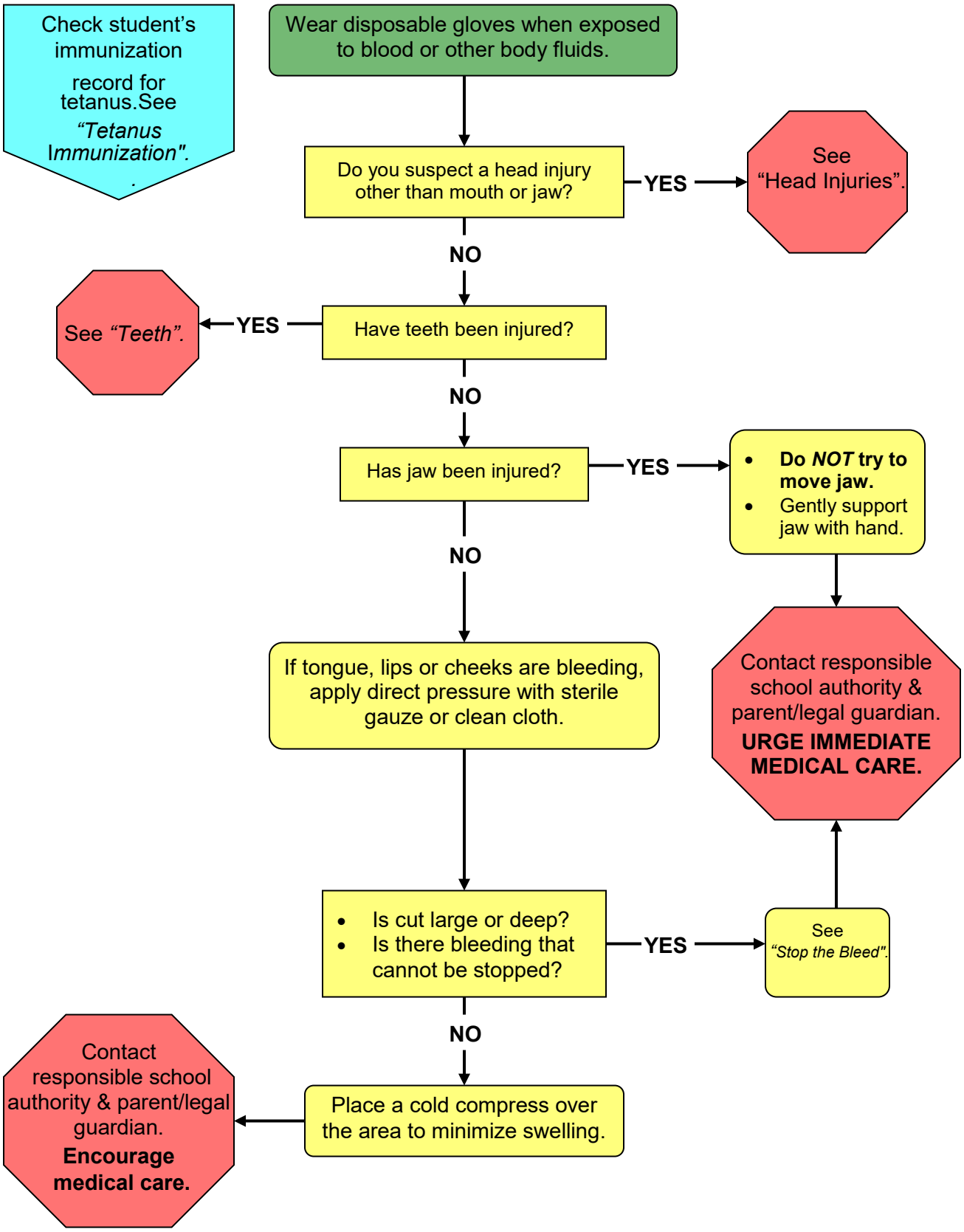
- **CALL EMS 9-1-1.**
- Give nothing by mouth.
- Continue to warm student with blankets.
- If student is asleep or losing consciousness, place student on his/her side to protect airway.
- **If student stops breathing, start CPR.** See *"CPR".*

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

MENSTRUAL DIFFICULTIES



MOUTH & JAW INJURIES



NECK & BACK PAIN

Suspect a neck/back injury if pain results from:

- Falls over 10 feet or falling on head.
- Being thrown from a moving object.
- Sports.
- Violence.
- Being struck by a car or fast moving object.

Has an injury occurred?

NO → A stiff or sore neck from sleeping in a "funny" position is different than neck pain from a sudden injury. A non-injured stiff neck with neurological symptoms or fever could be an emergency.

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

YES → Did student walk in or was student found lying down?

WALK IN → Have student lie down on his/her back. Support head by holding it in a face up position.

Try *NOT* to move neck or head.

LYING DOWN →

- **Do *NOT* move student unless there is *immediate* danger of further physical harm.**
- If student must be moved, support head and neck and move student in the direction of the head without bending the spine forward.
- **Do *NOT* drag the student sideways.**

- Keep student quiet and warm.
- Hold the head still by gently placing one of your hands on each side of the head.

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

NOSE PROBLEMS

See *"Head Injuries"*, 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.

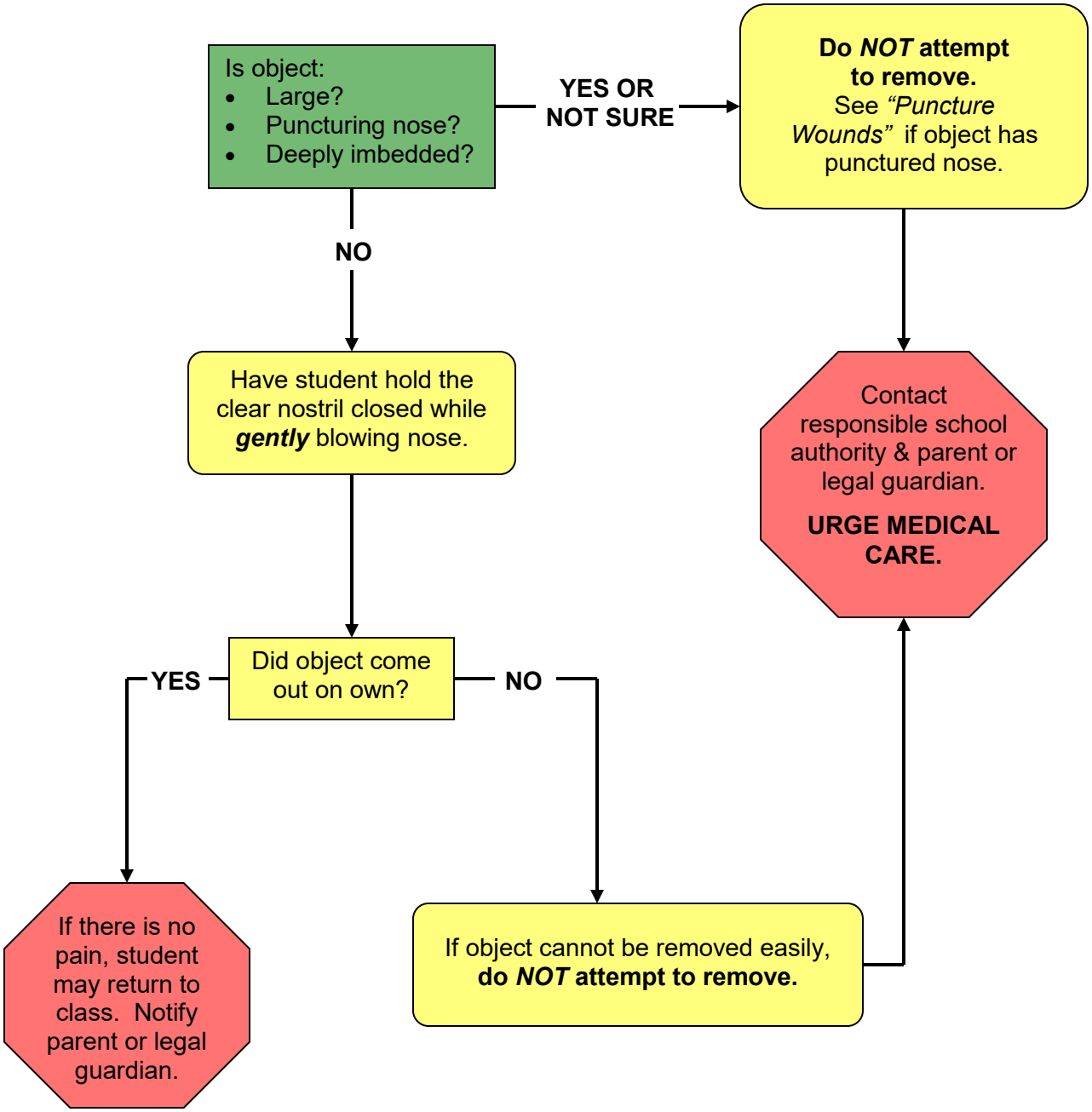
If blood is still flowing freely after applying pressure and ice, contact responsible school authority & parent/legal guardian.

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".*

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.

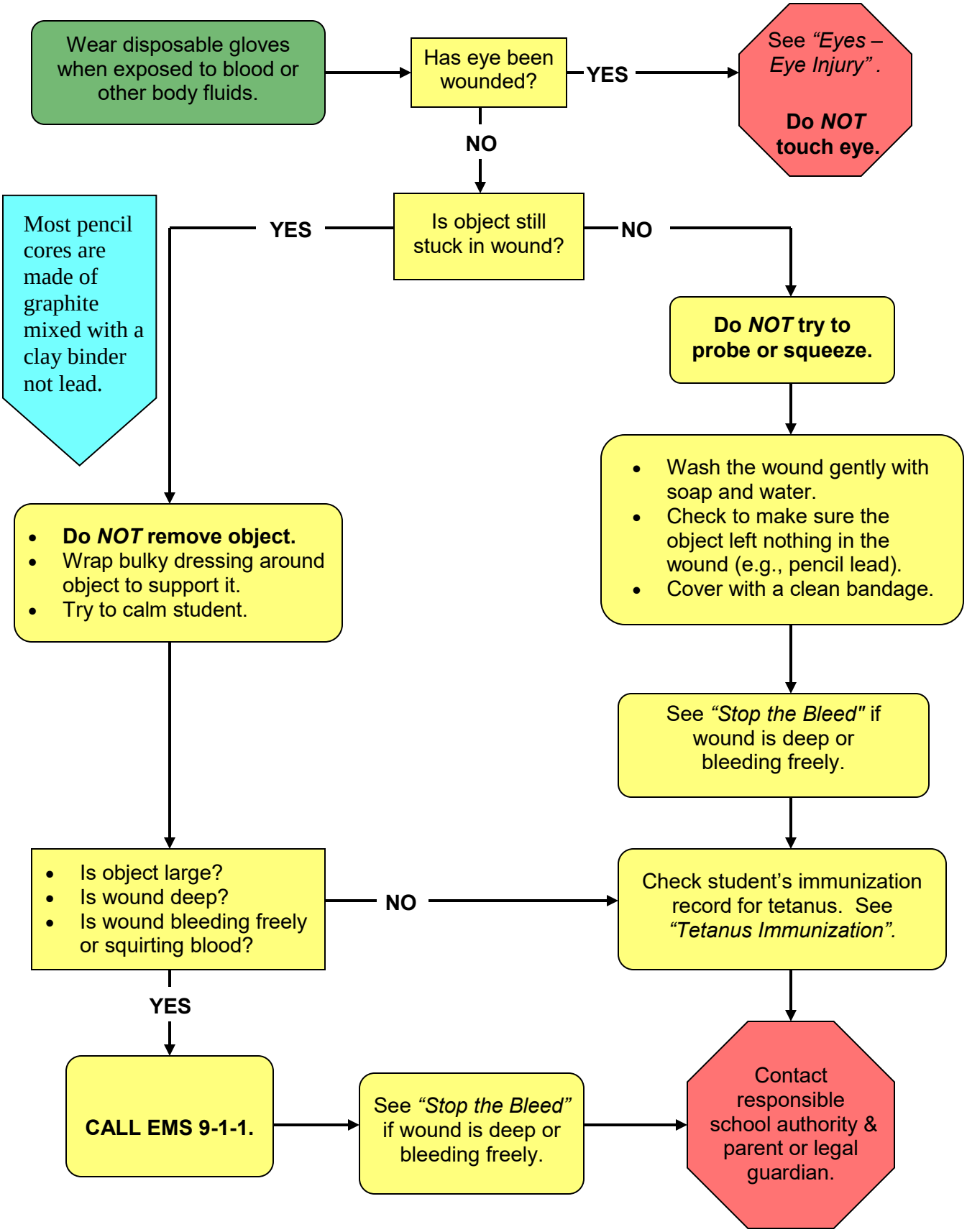
URGE IMMEDIATE MEDICAL CARE.

AMNIOTIC FLUID LEAKAGE
This is ***NOT*** normal and may indicate the beginning of labor.

MORNING SICKNESS
Treat as vomiting. See *"Vomiting".*

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".*
- 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"* 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.

- 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?

NO

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.

YES

CALL EMS 9-1-1.

Contact responsible school authority & parent or legal guardian.

SHOCK

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.

If injury is suspected, see *"Neck & Back Pain"* 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"* and/or
- *Choking"* .
- Unconscious? See *"Unconsciousness".*
- Bleeding profusely? See *"Stop the Bleed".*

YES → **CALL EMS 9-1-1.**

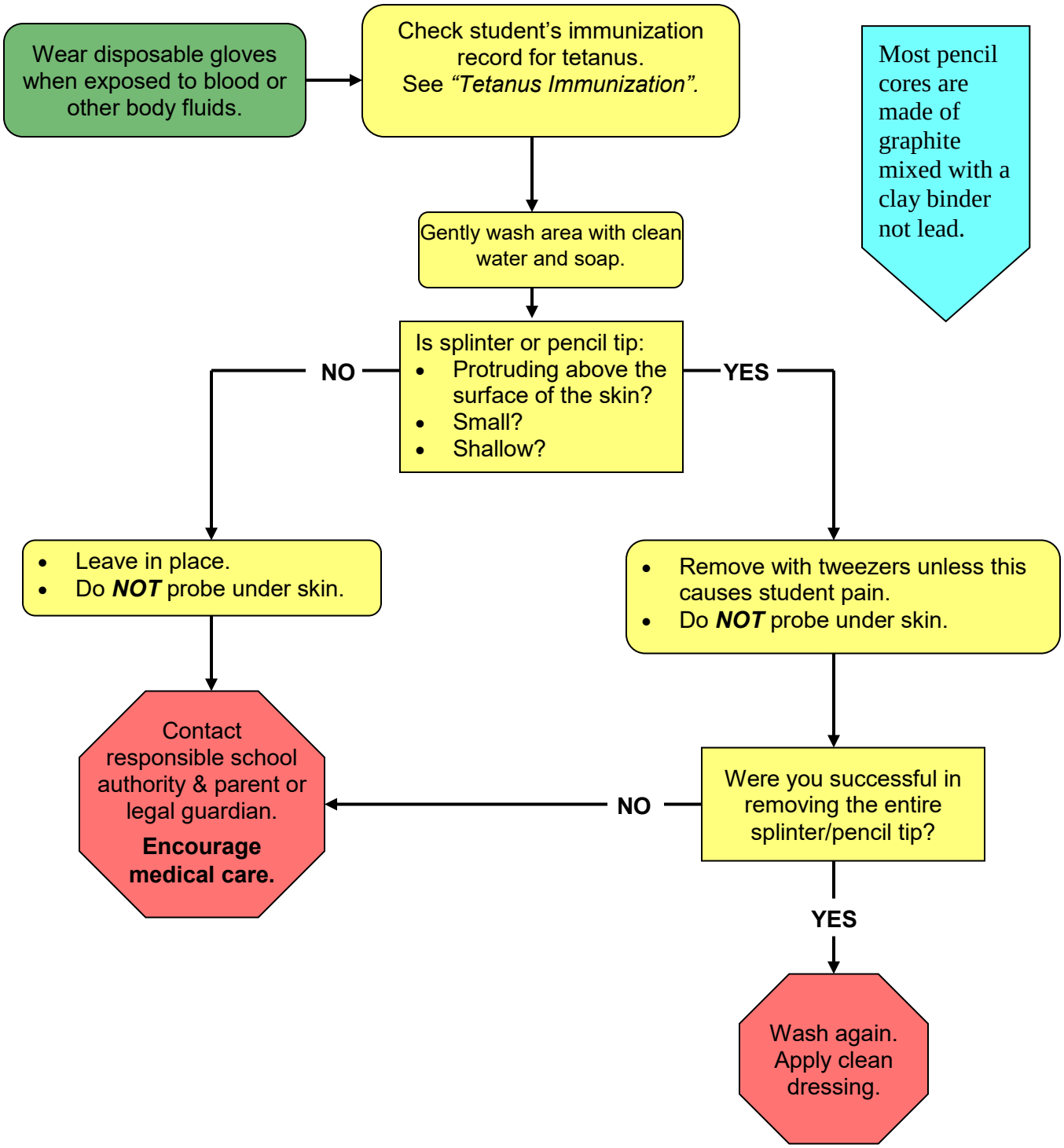
NO →

- 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.

SPLINTERS OR IMBEDDED PENCIL TIP



STABBING & GUNSHOT INJURIES

- **CALL EMS 9-1-1 for injured student.**
- Call the police.
- Intervene only if the situation is safe for you to approach.

Refer to your school's policy for addressing violent incidents.

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

Is the student:
- Losing consciousness?
- Having difficulty breathing?
- Bleeding uncontrollably?

YES

- Check student's airway.
- **If student stops breathing start CPR.** See *"CPR".*

NO

- Lay student down in a position of comfort if he/she is not already doing so.
- Elevate feet 8-10 inches, unless this causes pain or a neck/back injury is suspected.
- Press injured area firmly with a clean bandage to stop bleeding.
- Elevate injured part gently, if possible.
- Keep body temperature normal. Cover student with a blanket or sheet.

Check student's immunization record for tetanus.
See *"Tetanus Immunization".*

Contact responsible school authority & parent or legal guardian.

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.

Contact responsible school authority & parent or legal guardian.

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?

STOMACH ACHES/PAIN

Stomachaches/pain may have many causes including:

- Illness.
- Hunger.
- Overeating.
- Diarrhea.
- Food poisoning.
- Injury.
- Menstrual difficulties.
- Psychological issues.
- Stress.
- Constipation.
- Gas pain.
- Pregnancy.

Has a serious injury occurred resulting from:

- Sports?
- Violence?
- Being struck by a fast moving object?
- Falling from a height?
- Being thrown from a moving object?

YES → Suspect neck injury. See *"Neck and Back Pain"* . → Contact responsible school authority & parent/legal guardian. **URGE PROMPT MEDICAL CARE.**

NO → Take the student's temperature. Note temperature over 100.0 F as fever. See *"Fever".*

Does student have:

- Fever?
- Severe stomach pains?
- Vomiting?

YES → Contact responsible school authority & parent/legal guardian. **URGE PROMPT MEDICAL CARE.**

NO → Allow student to rest 20-30 minutes in a room that affords privacy.

Does student feel better?

YES → Allow student to return to class.

NO → If stomachache persists or becomes worse, contact responsible school authority & parent or legal guardian.

TEETH PROBLEMS

BLEEDING GUMS

Bleeding gums:

- Are generally related to chronic infection.
- Present some threat to student's general health.

→ No first aid measure in the school will be of any significant value.

→ Contact responsible school authority & parent/legal guardian.

URGE DENTAL CARE.

TOOTHACHE OR GUM INFECTION

See *"Mouth & Jaw"* for tongue, cheek, lip, jaw or other mouth injury not involving the teeth.

These conditions can be direct threats to student's general health, not just local tooth problems.

↓

No first aid measure in the school will be of any significant value.

↓

Relief of pain in the school often postpones dental care. **Do *NOT* place pain relievers (e.g., aspirin, Tylenol) on the gum tissue of the aching tooth. They can burn tissue.**

↓

Contact responsible school authority & parent/legal guardian.

URGE DENTAL CARE.

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"*.

NO ↓

Is unconsciousness due to injury?

YES →

- See *"Neck & Back Pain"* 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".* → **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"* (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"*.

- 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

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, PHYSICAL EXAMINATION, VISUAL EVALUATION, AND IMMUNIZATION STANDARDS

3-001 SCOPE AND AUTHORITY: These regulations are intended to implement Neb. Rev. Stat. §§ 79-214 and 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 PHYSICAL EXAMINATION AND VISUAL EVALUATION STANDARDS: School boards must require evidence of a physical examination and a visual evaluation within six months prior to the entrance of a child into the beginner grade or, in the case of a transfer from out of state, to any other grade of the local school. The visual evaluation must consist of testing for amblyopia, strabismus, and internal and external eye health, with testing sufficient to determine visual acuity.

3-007.01 Evidence of Physical Examination: A printed or typewritten statement signed by a physician, physician assistant, or advanced practice registered nurse indicating that a physical examination was administered on a specific date within the previous six months on a specifically named child constitutes sufficient evidence of a physical examination within six months prior to the entrance of the child into the beginner grade and the seventh grade or, in the case of a transfer from out of state, to any other grade of the local school.

3-007.02 Evidence of Visual Evaluation: A printed or typewritten statement signed by a physician, physician assistant, advanced practice registered nurse, or optometrist indicating that a visual evaluation was administered on a specific date within the previous

six months on a specifically named child constitutes sufficient evidence of a visual evaluation within the six months prior to the entrance of the child into the beginner grade or, in the case of a transfer from out of state, to any other grade of the local school. The statement must verify that the visual evaluation consisted of testing:

1. For amblyopia;
2. For strabismus;
3. For internal and external eye health; and
4. Sufficient to determine visual acuity.

3-007.03 Objection by Parent or Guardian: As a substitute for the evidence specified in 173 NAC 3-007.01 and 3-007.02, an objection in writing to a physical examination or visual evaluation of a child signed and dated by a parent or guardian of the child may be submitted to the local school.

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
1 dose of varicella vaccine given before the 13th birthday, or 2 doses of varicella vaccine with the first dose given on or after the 13th birthday and the second dose given no less than 28 days later. Beginning July 1, 2011 and thereafter, 2 doses of varicella vaccine.

Beginning July 2010 and thereafter, 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 10 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 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
Beginning July 1, 2011 and thereafter, 2 doses of varicella vaccine.

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.

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 personal 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 1st 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 1 dose of varicella vaccine, and beginning July 1, 2011 and thereafter, 2 doses of varicella vaccine.
   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.

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 1st 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 1 dose of varicella vaccine given before the 13th birthday, or 2 doses of varicella vaccine with the first dose given on or after the 13th birthday and the second dose given no less than 28 days later. Beginning July 1, 2011 and thereafter, the number of students with 2 doses of varicella vaccine.
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.

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 1st 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 1 dose of varicella vaccine given before the 13th birthday or 2 doses with the first dose given on or after the 13th birthday and the doses separated by 28 days. Beginning July 1, 2011 and thereafter, the number of students with 2 doses of varicella vaccine.
   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.

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) <u>or hepatitis A vaccine</u> 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.
Meningitis (Bacterial and Viral)	Varies depending on causative agent; 2-10 days	Sudden onset of fever. Intense headache, nausea, often vomiting. Stiff neck, delirium or petechial rash, shock.	Variable.	Exclude for duration of illness. Return with documented physician approval. No exclusion of contacts. Chemoprophylaxis appropriate for family and intimate 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

DISEASE / CONDITION	INCUBATION PERIOD *	SYMPTOMS OF ILLNESS	INFECTION PERIOD	MINIMUM ISOLATION PERIODS AND CONTROL MEASURES
				Department of Health and Human Services. ***Report immediately by telephone*** all cases to local and/or state health departments.
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 and/or clothing required.	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.
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

DISEASE / CONDITION	INCUBATION PERIOD *	SYMPTOMS OF ILLNESS	INFECTION PERIOD	MINIMUM ISOLATION PERIODS AND CONTROL MEASURES
				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.
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

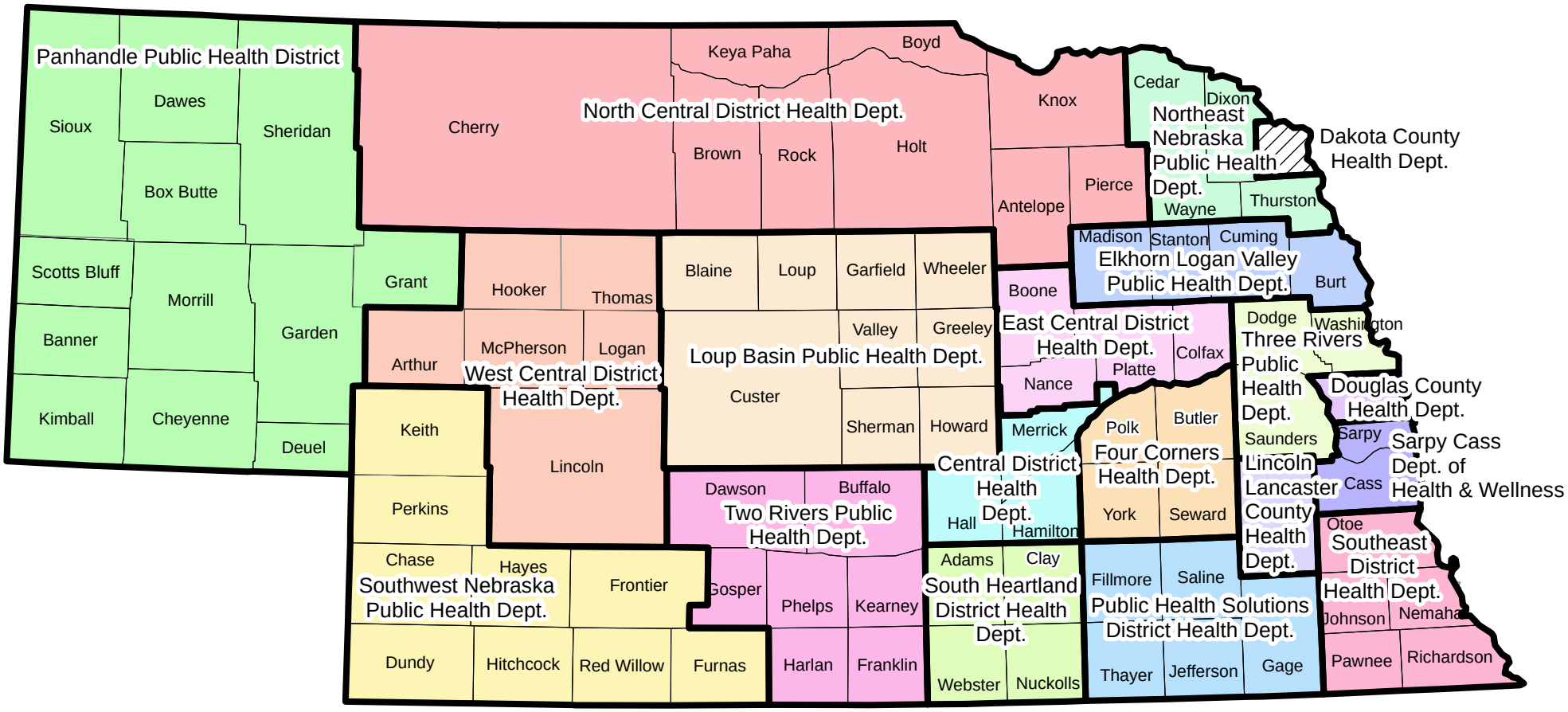
DISEASE / CONDITION	INCUBATION PERIOD *	SYMPTOMS OF ILLNESS	INFECTION PERIOD	MINIMUM ISOLATION PERIODS AND CONTROL MEASURES
				be instructed to wash their hands if they touch the potentially infectious vesicles.
Streptococcal Infection; (Scarlet Fever, Scarlatina, Strep Throat)	1-3 days	Sore throat, 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 Health Departments



0 45 90 Miles

Legend

Local Health Department that does not Qualify for LB 692* Funding

*LB 692 passed during the 2001 Legislative Session and provides funds to qualifying local public health departments.

Source: Nebraska Department of Health and Human Services

Map updated by:
Public Health GIS Analyst
DHHS GIS 12/16

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NEBRASKA HEALTH DEPARTMENTS

COUNTY HEALTH DEPARTMENTS

Clay County Health Department
Laurie Sheridan, Director
209 North Calvary Avenue
Clay Center, NE 68933-1200
Phone: (402) 762-3571
Fax: (402) 762-3573
Email: claycohealth@windstream.net
Web site: www.claycounty.ne.gov
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Dakota County Health Department
Tiffany Hansen, Director
1601 Broadway Street/Box 155
Dakota City, NE 68731-5065
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Fax: (402) 987-2163
Email: thansen@dakotacountyne.org
Web site: www.dakotacountyne.org
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Douglas County Health Department
Adi Pour, Director
1111 South 41st Street
Omaha, NE 68105-1803
Phone: (402) 444-7471
Fax: (402) 444-6267
Email: adi.pour@douglascounty-ne.gov
Web site: www.douglascountyhealth.com
(Douglas County/Omaha)

Polk County Health Department
Darla Winslow, Director
330 North State Street/Box 316
Osceola, NE 68651-5522
Phone: (402) 747-2211
Fax: (402) 747-7241
Email: darlawins@yahoo.com
Web site: https://polkcounty.nebraska.gov/county-offices/health-department
(Polk County/Osceola)

Red Willow County Health Department
Pamela Harsh, Director
1400 West 5th
McCook, NE 69001-2664
Phone: (308) 345-1790
Fax: (308) 345-1794
Email: rwchdpam@mccooknet.com
Web site: http://redwillowhealth.com
(Red Willow County/McCook)

Scotts Bluff County Health Department
Paulette Schnell, Director
1825 10th Street
Gering, NE 69341-2445
Phone: (308) 436-6636; Cell: (308) 631-6074
Fax: (308) 436-6638
Email: paulette.schnell@rwhs.org
Web site: www.scottsbluffcounty.org/health-department/health-department.html
(Scotts Bluff County/Gering)

CITY-COUNTY HEALTH DEPARTMENT

Lincoln-Lancaster County Health Department
Shavonna Lausterer, Health Director
3131 "O" Street
Lincoln, NE 68510-1523
Phone: (402) 441-8001
Email: slausterer@lincoln.ne.gov
Web site: www.lincoln.ne.gov/city/health
(Lancaster County/Lincoln)

DISTRICT HEALTH DEPARTMENTS

Central District Health Department
Teresa Anderson, Director
1137 South Locust Street
Grand Island, NE 68801-6771
Phone: (308) 385-5175 x178; Toll Free: (877) 216-9092
Fax: (308) 385-5181
Email: tanderson@cdhd.ne.gov
Web site: www.cdhd.ne.gov
(Hall County/Grand Island, Hamilton County/Aurora, Merrick County/Central City)

East Central District Health Department
Will McInnis, Health Director & CEO
4321 41st Avenue/Box 1028
Columbus, NE 68602
Phone: (402) 562-8950
Fax: (402) 563-0544
Email: wmcinnis@ecdhd.ne.gov
Web site: http://ecdhd.ne.gov
(Boone County/Albion, Colfax County/Schuyler, Nance County/Fullerton, Platte County/Columbus)

Elkhorn Logan Valley Public Health Department
Gina Uhing, Director
Box 779
Wisner, NE 68791-0779
Phone: (402) 529-2233; Toll-Free: (877) 379-4400; LHD 24/7 Cell: (402) 841-8110
Fax: (402) 529-2211
Email: gina@elvphd.org
Web site: www.elvphd.org
(Burt County/Tekamah, Cuming County/West Point, Madison County/Madison, Stanton County/Stanton)

Four Corners Health Department
Laura McDougall, Executive Director
2101 North Lincoln Avenue
York, NE 68467-1027
Phone: (402) 362-2621; Toll-Free: (877) 337-3573; Cell: (402) 366-6485
Fax: (402) 362-2687
Email: lauram@fourcorners.ne.gov
Web site: www.fourcorners.ne.gov
(Butler County/David City, Polk County/Osceola, Seward County/Seward, York County/York)

Loup Basin Public Health Department
Chuck Cone, Director
934 "I" Street/Box 995
Burwell, NE 68823-0995
Phone: (308) 346-5795; Toll-Free: (866) 522-5795; Cell: (308) 214-1066
Fax: (308) 346-9106
Email: ccone@nctc.net
Web site: www.loupbasinhealth.com
(Blaine County/Brewster, Custer County/Broken Bow, Garfield County/Burwell, Greeley County/Greeley, Howard County/St Paul, Loup County/Taylor, Sherman County/Loup City, Valley County/Ord, Wheeler County/Bartlett)

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North Central District Health Department
Roger Wiese, Director
422 East Douglas Street
O'Neill, NE 68763-1852
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Fax: (402) 336-1768
Email: roger@ncdhd.ne.gov
Web site: www.ncdhd.ne.gov
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Northeast Nebraska Public Health Department
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215 North Pearl Street
Wayne, NE 68787-1975
Phone: (402) 375-2200
Fax: (402) 375-2201
Email: phndirector@nnphd.org
Web site: www.nnphd.org
(Cedar County/Hartington, Dixon County/Ponca, Thurston County/Pender, Wayne County/Wayne)

Panhandle Public Health District
Kim Engel, Director
808 Box Butte Avenue
Box 337
Hemingford, NE 69348-9700
Phone: (308) 487-3600; Cell: (308) 760-2415
Fax: (308) 487-3682
Email: kengel@pphd.org
Web site: www.pphd.org
(Banner County/Harrisburg, Box Butte County/Alliance, Cheyenne County/Sidney, Dawes County/Chadron, Deuel County/Chappell, Garden County/Oshkosh, Grant County/Hyannis, Kimball County/Kimball, Morrill County/Bridgeport, Scotts Bluff County/Gering, Sheridan County/Rushville, Sioux County/Harrison)

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Public Health Solutions District Health Department
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Sarpy/Cass Health Department
Sarah Schram, Health Director
701 Olson Drive/Suite 101
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Fax: (402) 339-4235
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Web site: www.sarpycasshealthdepartment.org
(Cass County/Plattsmouth, Sarpy County/Papillion)

South Heartland District Health Department
Michele Bever, Executive Director
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Hastings, NE 68901-5256
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Email: michele.bever@shdhd.org
Web site: http://southheartlandhealth.org
(Adams County/Hastings, Clay County/Clay Center, Nuckolls County/Nelson, Webster County/Red Cloud)

Southeast District Health Department
Grant Brueggemann, Health Director
2511 Schneider Avenue
Auburn, NE 68305-3054
Phone: (402) 274-3993; Toll Free: (877) 777-0424
Fax: (402) 274-3967
Email: grant@sedhd.org
Web site: www.sedhd.org
(Johnson County/Tecumseh, Nemaha County/Auburn, Otoe County/Nebraska City, Pawnee County/Pawnee City, Richardson County/Falls City)

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Fax: (308) 345-4289
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Web site: www.swhealth.ne.gov
(Chase County/Imperial, Dundy County/Benkelman, Frontier County/Stockville, Furnas County/Beaver City, Hayes County/Hayes Center, Hitchcock County/Trenton, Keith County/ Ogallala, Perkins County/Grant, Red Willow/McCook)

Three Rivers Public Health Department
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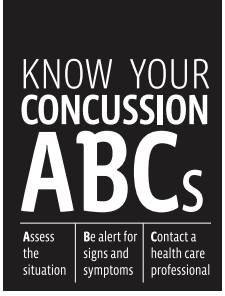
Fax: (402) 727-5399
Email: terra@3rphd.org
Web site: https://threeriverspublichealth.org
(Dodge County/Fremont, Saunders County/Wahoo, Washington County/Blair)

Two Rivers Public Health Department
Jeremy Eschliman, Director
701 4th Avenue/Suite 1
Holdrege, NE 68949-2255
Phone: (308) 995-4778; Toll Free: (888) 669-7154; Cell: (308) 999-7093
Fax: (308) 995-4073
Email: jeschliman@trphd.org
Web site: http://trphd.org
(Buffalo County/Kearney, Dawson County/Lexington, Franklin County/Franklin, Gosper County/Elwood, Harlan County/Alma, Kearney County/Minden, Phelps County/Holdrege)

West Central District Health Department
Shannon Vanderheiden, Director
111 N Dewey/Suite A
North Platte, NE 69103-5439
Phone: (308) 696-1201; Cell: (308) 520-0158
Fax: (308) 696-1204
Email: vanderheidens@wcdhd.org
Web site: http://wcdhd.org
(Arthur County/Arthur, Hooker County/Mullen, Lincoln County/North Platte, Logan County/Stapleton, McPherson County/Tryon, Thomas County/Thedford)
NOTE: After each county name is the county seat.

Concussion Signs and Symptoms

Checklist



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, fifteen 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 health care professional with experience in evaluating for concussion. For those instances when a parent is coming to take the student to a health care 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 health care 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				
Feeling sluggish, hazy, foggy, or groggy				
EMOTIONAL SYMPTOMS				
Irritable				
Sad				
More emotional than usual				
Nervous				

To download this checklist https://www.cdc.gov/headsup/pdfs/schools/TBI_schools_checklist. Also available in Spanish

May 2010

→ More

Danger Signs:

Be alert for symptoms that worsen over time. The student should be seen in an emergency department right away if s/he has:

- ❒ 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 only for use by appropriate school professionals, health care professionals, and the student's parent(s) or guardian(s).

For a free tear-off pad with additional copies of this form, or for more information on concussion, visit: www.cdc.gov/Concussion.

Resolution of Injury:

__ Student returned to class

__ Student sent home

__ Student referred to health care professional with experience in evaluating for concussion

SIGNATURE OF SCHOOL PROFESSIONAL COMPLETING THIS FORM: _____

TITLE: _____

COMMENTS:

For more information on concussion and to order additional materials for school professionals **FREE-OF-CHARGE**, visit:
https://www.cdc.gov/headsup/schools/nurses

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

Returning to the Classroom

Concussion injuries can directly impact a student's learning ability. Conversely, the cognitive learning process can adversely affect a student's recovery from a concussion. Therefore, concussed students may need varying levels of instructional modifications and academic accommodations during their symptom recovery, particularly early on in the acute stage, but can extend several weeks or months.

Current concussion management guidelines recommend concussed students remain at rest, both physically and cognitively to facilitate their recovery from symptoms. Cognitive rest refers to the reduction in mentally taxing activities, i.e. analytical problem solving, mathematical equation work, focused or prolonged reading, computer use, as well as activities involving saccadic eye movements such as using eyes to track objects, read, and smart-board work. Playing video games, texting, watching TV, and listening to music with earphones may also be discouraged during the symptomatic phase.

Just as concussed athletes follow a stepwise progression for "Return To Play," a progression back to the learning environment is equally important. A "Return To Learn" process emphasizes a collaborative team approach between

school administration, school nurses, counselors, teachers, parents, and athletic staff (including a school's athletic training staff when student-athletes are involved). Because concussions occurring in athletics are less prevalent than those occurring on playgrounds, during recreational activities such as biking or skateboarding, accidents at home, falls, and motor vehicle accidents, a Concussion Management Team can be beneficial for recovery and returning all concussed students, athletic and non-athletic, to the classroom.

School staff should be familiar with the signs and symptoms of concussions. Additionally, school staff should know how to monitor students knowingly having a concussion, as well as recognize those possibly having a concussion unknowingly. There is greater concern for how long symptoms last, more so than which ones or how many might exist, but all three elements are important to the proper management of the concussed student.

Signs To Look For After A Concussion

When students return to school after a concussion, school staff should watch for:

- Increased problems paying attention or concentrating
- Increased problems remembering or learning new information
- Longer time needed to complete tasks or assignments
- Difficulty organizing tasks or shifting between tasks
- Inappropriate or impulsive behavior during class
- Greater irritability
- Less ability to cope with stress
- More emotional than usual
- Difficulty handling a stimulating school environment (lights, noise, etc.)

Symptoms of a Concussion Indicated by the Student

Physical

- Headache
- Nausea
- Vomiting
- Balance Problems
- Dizziness
- Visual problems
- Fatigue
- Sensitivity to light
- Sensitivity to noise
- Dazed or stunned

Emotional

Congnitive

- Feeling mentally "foggy"
- Feeling slowed down
- Difficulty concentrating
- Difficulty remembering
- Forgetful of recent information or conversations
- Confused about recent events
- Answers questions slowly

- Physical symptoms (headache, dizziness, nausea, visual problems)

Source: CDC Heads Up to Schools. "Returning to School After a Concussion: A Fact Sheet for School Professionals."

- Irritability
- Sadness
- More emotional
- Nervousness
- Asks same question repeatedly

Sleep Related

- Drowsiness
- Sleeping less than usual
- Sleeping more than usual
- Trouble falling asleep

General Considerations for "Return to Learn" Progression

In most cases, a concussion will not significantly limit a student's participation in school and usually involve temporary, informal instructional modifications and academic accommodations. The "Return to Learn" process encompasses Step 1 of the "Return to Play" progression during the entire time one remains symptomatic. Completion of the "Return to Learn" process precedes the start of "Step 2 - Return to Play" progression.

In approximately 75 percent of cases, recovery from symptoms occurs within seven days, while roughly 90 percent recover from symptoms within 10 days. But nearly 5-10 percent percent of cases may take several weeks or months to recover from symptoms that experience Post-Concussion Syndrome, a chronic condition where symptoms persist long-term.

The school's athletic trainer or other licensed healthcare provider will help guide decisions for the Concussion Management Team about a student's need for and level of modifications and accommodations, or adjustments, and their readiness to resume various school activities.

Symptoms are monitored at regular intervals using a Graded Symptom Scale. Symptom scale scores can remain elevated or increased by exceeding levels of physical and cognitive activity where school activity should then be reduced when symptoms increase as a result. Members of the Concussion Management Team are to help identify

triggers that cause symptoms to worsen, and modify school activity accordingly. Thereafter, school activities can be gradually increased as symptoms subside or decrease.

If recovery becomes more prolonged (more than three to four weeks), there should be greater concern for a student feeling isolated or depressed and experiencing anxiety from not attending school, falling behind, and missing out on playing sports and other extracurricular activities. Additionally, a 504 Plan or an IEP may need to be considered for those having prolonged recovery extending beyond several months.

School Accommodation Options Based on Symptom Type

Headaches	Allow to lay head down at desk Allow frequent breaks Identify triggers that cause headaches to worsen
Sensitivity to Noise (phonophobia)	No PE, band, chorus, shop class; meet in library Avoid lunch room; eat in quiet setting Avoid attending athletic events, gymnasiums Allow early hall pass to class avoiding loud corridors Refrain from using cell phone, headphones/ear buds
Sensitivity to Light (photophobia)	Allow to wear sunglasses Move to area with low-lighting, dimly-lit room Avoid seating with direct sunlight from windows Avoid or minimize bright projector/computer screens
Other visual problems *i.e. blurred or double–vision saccadic eye movements*	Limit computer use Reduce/shorten reading assignments Record lectures, use auditory learning apps Allow for more listening & discussion vs. Reading Increase font size on computer screens Desktop work only

(tracking) *near–point convergence (close–up)*	Refrain from texting, video gaming Refrain from watching TV close–up or from a distance
Concentration or Memory (Cognitive) Problem	Place main focus on essential academic content/concepts Postphone major tests or participation in standardized testing Allow extra time for assignments, quizzes Allow extra time to complete tests, projects Reduce class assignments, homework
Sleep Difficulties	Allow late start to school Allow frequent rest breaks

Levels of Instructional Modifications and Academic Accommodations

1	**No School (Stay Home)** Initial 24-48 hrs. relative rest; typically no more than 5 days away from school. Three or more ImPACT Summary Composite Scores exceed RCI *Exceedingly high Graded Symptom Scale Score, i.e., >25-30	Sympton-limited activity after initial 24-48 hrs. of rest can help speed recovery. Limit texting, video gaming, watching TV, cell phone use, listening to music with headphones if any trigger symptoms coming-on or getting worse. No homework or computer use Cognitive "shut-down" Use darkened, quiet room Start symptom-limited activity with 5-15 min. at a time, and gradually build up.
2	**Limited School Attendance (Half Days/Part-Time)** **Maximum Accommodations** Able to tolerate up to 30 minutes mental extertion Symptoms have begun to decrease	Limit/partial class attendance; no PE, band, chorus, Shop classes Periodic rest breaks away from class in a quiet area Allow to lay head down at desk Limit/modify academic classwork

		No major/standardized testing Provide extra help; peer note taking "Clear desk" and listen Extra time for quizzes in a quiet area Extra time for assignments; modify assignments Minimal or no homework
3	**Full-Day Attendance (Limit Class Attendance)** **Moderate Accommodations** Able to tolerate up to 45 minutes mental extertion No more than 1-2 ImPACT Summary Composite Score exceeding RCI Symptoms continue to decrease	No PE Limit class attendance in academically challenging classes. No major/standardized testing; modified testing. Rest periods in classroom as needed Extra time for assignments; quizzes as needed. Limited homework, i.e., less than 30 minutes.
4	**Full Class Attendance** **Minimal Accommodations** Able to tolerate up to 60 minutes mental extertion *Graded Symptom Scale Score: <10	No PE Increase return to normal class workload Begin working on missed work/assignments Moderate homework, i.e., less than 60 minutes.
5	**Full Academics** **No Accommodations** *Graded Symptom Scale Score: <5 Academic work does not trigger symptoms	Resume normal homework assignments Identify essential content and assignments to make up. Develop realistic timeline for completing assignments. Re-evaluate weekly until assignments are completed. When indicated by school's athletic trainer or a licensed health care provider, start Step 2, "Return to Play" progression. No PE until completion of "Return to Play" progression.

*Graded Symptom Scale Score ranges shown are a general guide and are not intended as objective criteria for dilineating stages of recovery or indication for specific instructional modifications or academic accommodations. Graded Symptom Scale Score ranges are extremely subjective and vary dramatically by individual, and also dependent on the selected Grading Symptom Scale used to derive a symptom score.

REFERENCES:

Oregon Concussion Awareness and Management Program, Max's Law: Concussion Management Implementation Guide for School Administrators. Center on Brain Injury Research & Training, Western Oregon University. http://www.ode.state.or.us/teachlearn/subjects/pe/ocampguide.pdf

Halstead ME, McAvoy K, Devore CD, Carl R, Lee M, Logan K, Council on Sports Medicine and Fitness, and Council on School Health. Returning to Learning Following Concussion. Am Acad Pediatrics, 132 (5) 948–957, Nov 2013. http://pediatrics.aappublications.org/content/132/5/948.full.pdf+html.

ImPACT Applications, Inc., September 2013. [Webinar] Almquist J, Connecting the Dots Between Clinical Assessment and Academic Accommodations.

Center for Disease Control, US Dept. of Health and Human Services, 2013. Heads Up to Schools: Know Your Concussion ABC's. Returning to School After a Concussion: A Fact Sheet for School Professionals. http://www.cdc.gov/concussion/pdf/TBI_Returning_to_School-a.pdf.

The REAP Project. McAvoy K. REAP The Benefit of Good Concussion Management. Rocky Mountain Hospital for Children, Center for Concussion. http://issuu.com/healthone/docs/reap_oct21/1?e=1811185/5400960.

Nebraska Sports Concussion Network

www.NebSportsConcussion.org

Return to Play Progression
Following Sports-Related Concussion (August 2017)

Return to Play protocol following a concussion should follow a stepwise process. Step 1 represents the timeframe while post-concussion symptoms persist, and then begin to resolve (see Concussion Symptom Inventory Form/Sideline Assessment Tool). This phase will vary considerably among individuals, and is affected by age, prior history of head injury, injury severity, number of symptoms, and possibly gender among other clinical considerations. During Step 1, one should follow **Return to Learn Guidelines** where the resolution of symptoms generally occur within 10-14 days on average, but may extend longer for others. As symptoms begin to subside, one can gradually become more active, provided the activity does not bring on or worsen symptoms. Progression to Step 2 and each step thereafter require remaining symptom-free. Generally, a minimum span of 24-48 hours should transpire between steps (after completing Step 2), with each exercise bout being at least 30 minutes or more in duration unless noted otherwise. The athlete should be continually monitored for any symptoms worsening during exercise and afterwards. If at any time an athlete experiences symptoms coming on or worsening, they are to stop and resume the progression at the previous step after being symptom-free at rest for 24-48 hours.

Step 1 **Symptom-Limited Activity;** restrict vigorous exertion**;** follow Return to Learn Guidelines

- An initial 24-48 hrs. of relative rest is recommended, including rest from both physical activity and cognitive/mentally taxing activity (refer to bottom of page).
- If neurocognitive testing is not available, begin counting the number of days once being symptom-free at rest.

Step 2 **Light, Aerobic Activity, 10-20 minutes** (<70% max. heart rate); Symptom-Free at Rest

- This can include walking, swimming, or stationary bike.
- No resistance training or weight lifting.

Step 3 **Sport/Position/Event Specific Exercises, Conditioning Drills**

- Restricted, individual workout: light-moderate conditioning drills; running drills, agility drills; shooting, throwing, catching, kicking, ball control, passing drills; light-moderate intensity resistance training; shadow mat drills (no stand-ups, take-downs, partners). No head impacts.

Step 4 **Non-Contact Practice**

- Athlete must have written authorization from an appropriate licensed healthcare provider (i.e. MD/DO, neuropsychologist, athletic trainer), and have written permission from a parent before resuming practice participation.
- Athlete is able to participate in non-contact practice once neurocognitive post-test composite scores are near or return to baseline, or where testing is otherwise considered acceptable; or
- If neurocognitive testing is not available, the athlete may resume non-contact practices in 7-10 days after being symptom-free only as directed by an approved licensed healthcare provider.
- No live, full-speed, scrimmaging, or full-court activity; no activity that involves using the head.

Step 5 **Full-Contact Practice**

- The athlete is able to fully participate in practices without restrictions.
- Assess readiness to play and compete. Monitor for return of post-concussion symptoms.

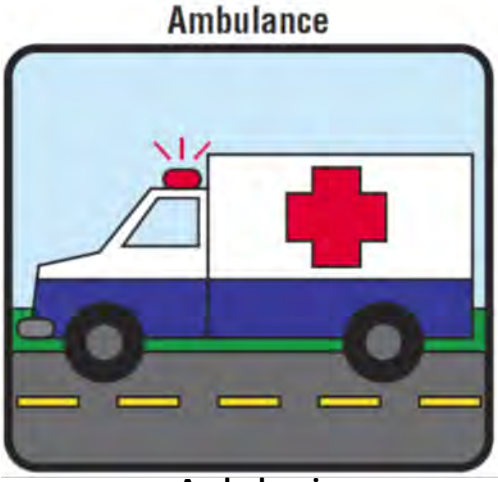
Step 6 **Resume Competition**

- The athlete is able to compete without restrictions. Monitor for symptom reoccurrence.

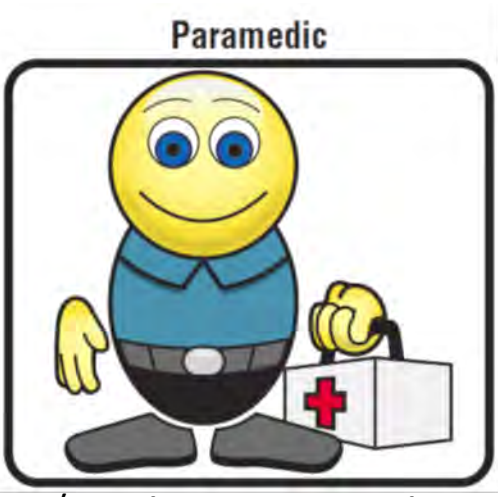
Completion Date/Initials
Step 1
Step 2
Step 3
Step 4
Step 5
Started Step 6

**Cognitive Rest includes limiting mathematical/analytical problem solving, focused/prolonged reading, texting, video gaming, or prolonged TV watching that trigger symptoms coming on or getting worse.*

COMMUNICATION CARDS



Ambulancia



Técnico de Emergencias Medicas

Feliz

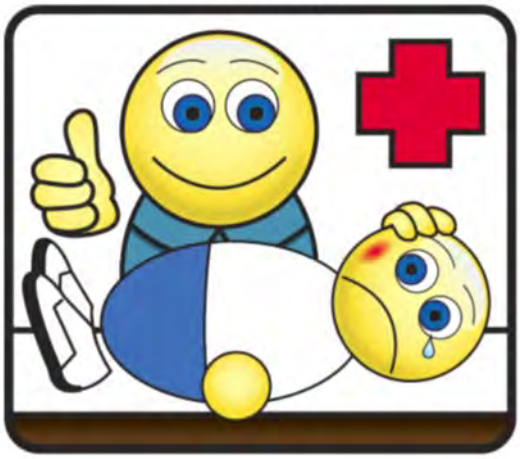
Triste

Sí

No

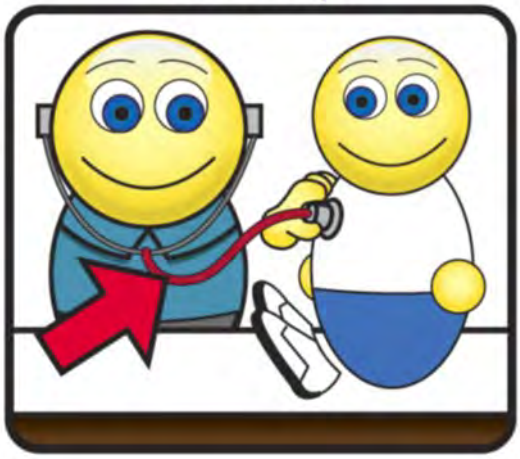
COMMUNICATION CARD

Examination



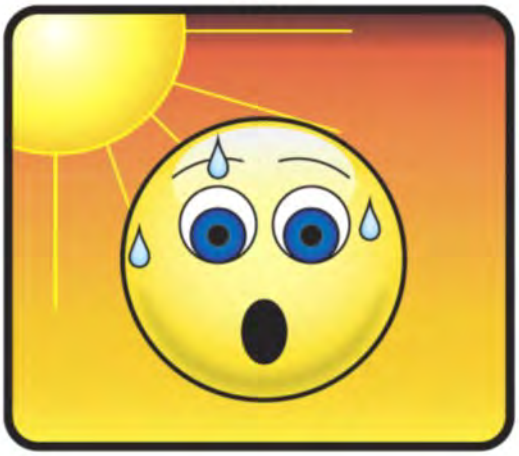
Examen médico

Stethoscope



Estetoscopio

Hot



Tiene calor

Cold

Tiene Frio

Sick

Enfermo

Dizzy

Mareado

COMMUNICATION CARDS

Throw Up

Vómitos

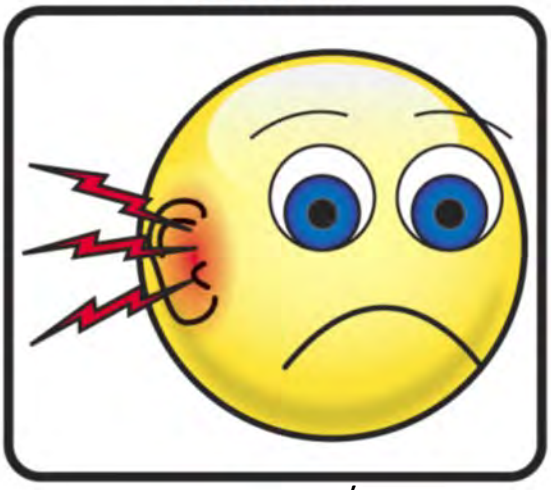
Diarrhea

Diarrea

Head Hurts

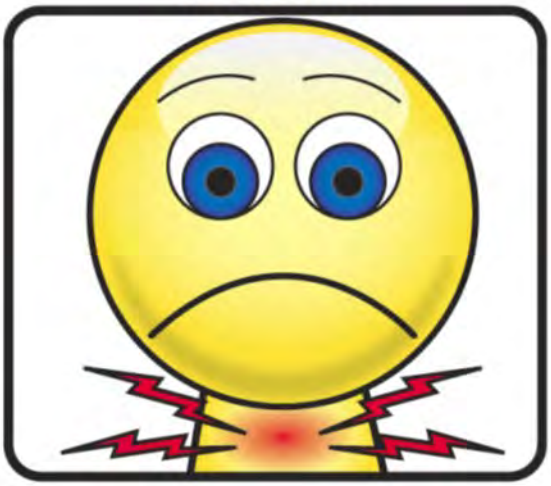
Le duele la cabeza

Ear Hurts



Le duele el oído

Throat Hurts



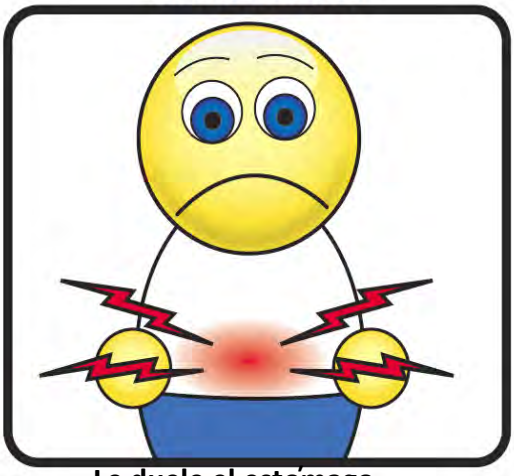
Le duele la garganta

Cough

Tos

COMMUNICATION CARDS

Stomach Hurts

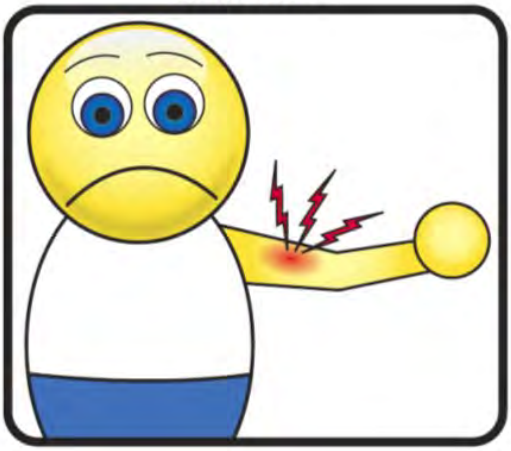


Le duele el estómago

Back Hurts

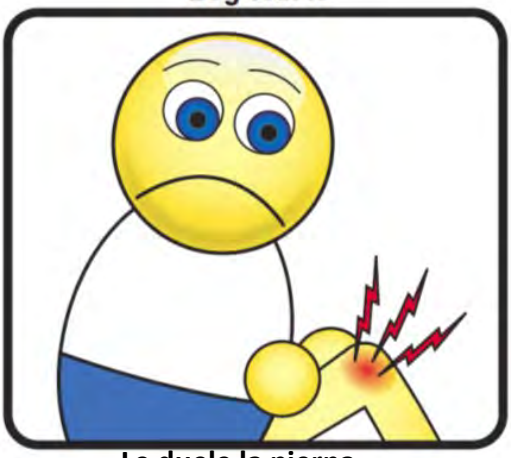
Le duele la espalda

Arm Hurts



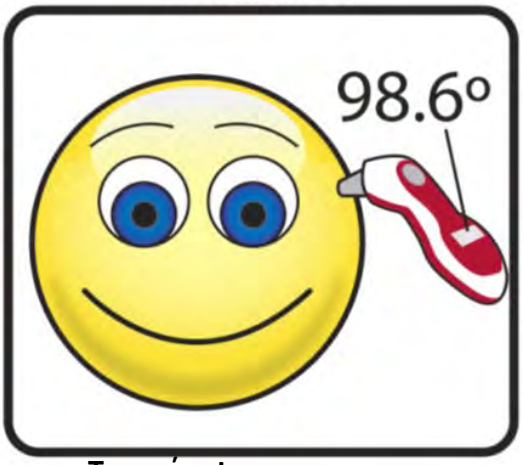
Le duele el brazo

Leg Hurts



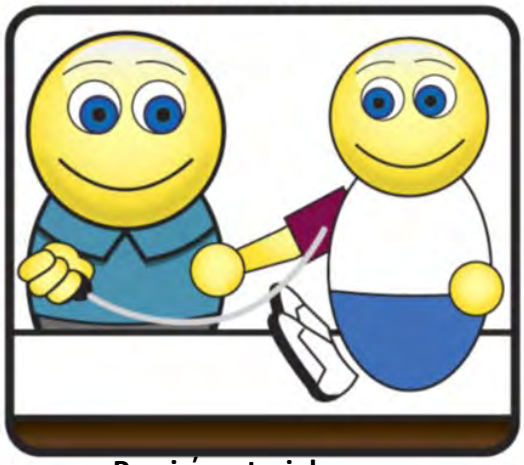
Le duele la pierna

Thermometer



Termómetro

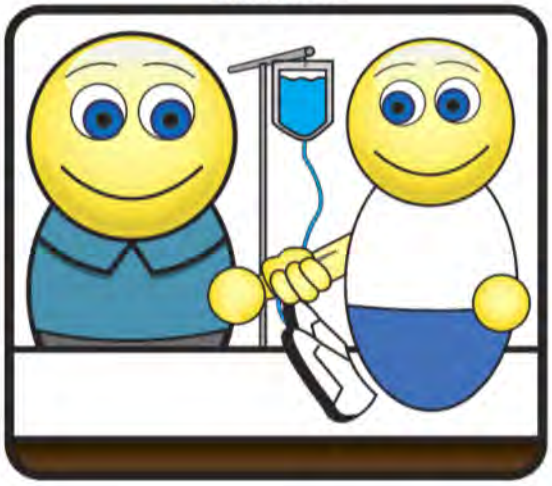
Blood Pressure



Presión arterial

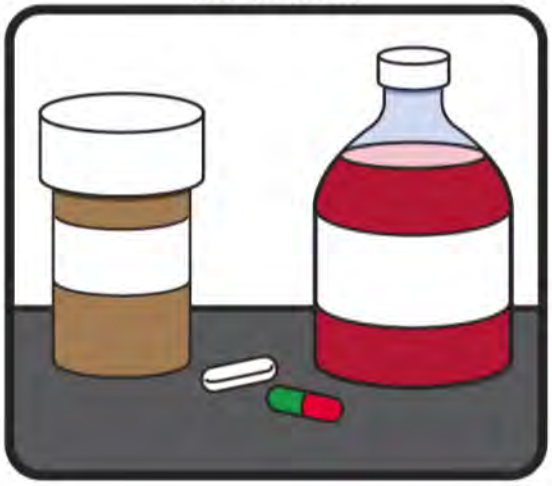
COMMUNICATION CARDS

IV Fluid



Fluido intravenoso (IV)

Medicine

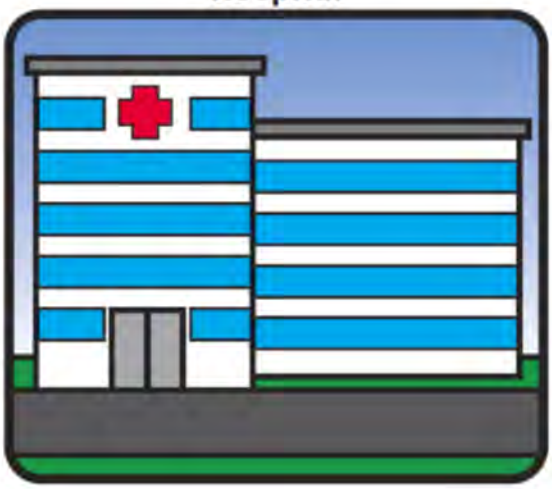


Medicamento

Cot

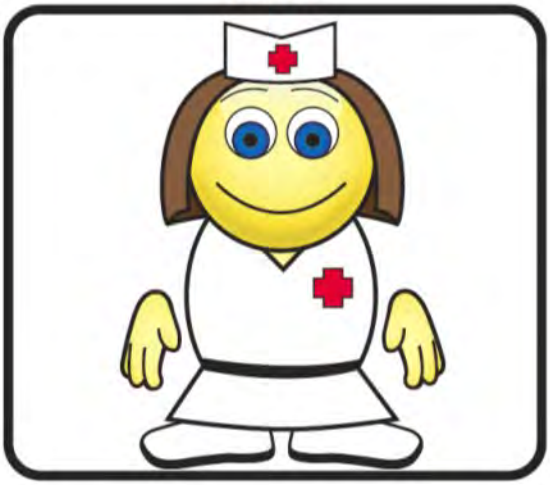
Catre

Hospital



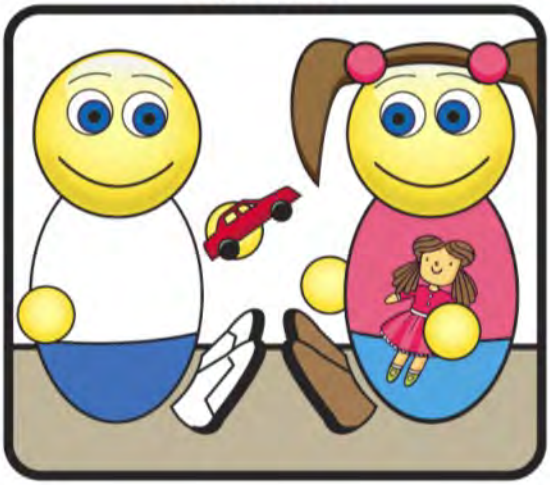
Hospital

Nurse



Enfermera

All Better



Mejorado por completo

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