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

Also Includes:
- Emergency Response to life threatening Asthma or Anaphylaxis
- Concussions. Return to Learn. Return to Play
- Communicable Disease Resources
- Nebraska Local Health Departments
- Recommended First Aid Equipment and Supplies
- Emergency Phone Numbers
- School Safety Planning & Emergency Preparedness Section, including Pandemic Flu Preparedness and School Shooting

AEDs
Allergic Reaction
Asthma & Difficulty Breathing
Behavioral Emergencies
Bites
Bleeding
Blisters
Bruises
Burns
CPR (Infant, Child, & Adult)
Choking
Child Abuse
Communicable Diseases
Cuts, Scratches, & Scrapes
Diabetes
Diarrhea
Ear Problems
Electric Shock
Eye Problems
Fainting
Fever
Fractures & Sprains
Frostbite
Headache
Head Injuries
Heat Emergencies
Hypothermia
Menstrual Difficulties
Mouth & Jaw Injuries
Neck & Back Pain
Nose Problems
Poisoning & Overdose
Pregnancy
Puncture Wounds
Rashes
Seizures
Shock
Sprinters
Stabs/Gunshots
Stings
Stomachaches & Pain
Teeth Problems
Tetanus Immunization
Ticks
Unconsciousness Vomiting
Funding for this publication has been made possible, in part, through support from the U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau, Emergency Medical Services for Children Program, grant #H33MC07876 and the Nebraska Department of Health and Human Service, Emergency Medical Services Program for Children.
Nebraska Department of Health and Human Services
Division of Public Health
Emergency Medical Services Program
Emergency Medical Services for Children

Project Manager
Debbie Kuhn, EMS for Children Program Manager

Endorsed by
Emergency Medical Services for Children Advisory Committee
Andrea Holka, Executive Director, AIRE Nebraska
Susan Puckett, RN, Kearney Public Schools
Dr. Thomas Deegan, Children’s Hospital & Medical Center

Acknowledgements
Special thanks go to the following organizations for the original development of this resource:

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.
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:

Debbie Kuhn
EMS for Children Program Manager
402-471-0119
Debbie.kuhn@nebraska.gov

Julie Smithson
South Central EMS Specialist
308-946-3409
Julie.Smithson@nebraska.gov

...
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.
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.
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.
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 in about 20 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 and training method.

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 in about 18 seconds followed by 2 normal rescue breaths. See age-appropriate CPR guideline.

7. Complete 5 cycles of CPR (30 chest compressions in about 18 seconds to 2 breaths for a rate of at least 100 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 RESPONSES 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 18 seconds to 2 breaths at a rate of at least 100 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 RESPONSES OR HELP ARRIVES.
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 auto-injectable epinephrine in schools. Staff in a position to administer the Epi-Pen and/or Albuterol should receive instruction.

ALLERGIC REACTION

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?

Does student have an Allergy Action plan?

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.

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

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

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.
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 an asthma inhaler in school. Staff in a position to administer the Epi-Pen and/or Albuterol should receive instruction.

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

Follow Rule 59 protocol for students with severe asthma symptoms.

NO

Refer to student’s Asthma Action plan.

Has a quick-relief inhaler already been used? If yes, when and how often?

YES

Administer medication as directed in Action Plan

NO

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.

CALL EMS 9-1-1

NO
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 stings), 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
- Breathing difficulty 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 require several hours of monitoring:
- Skin: warmth, itching, and/or tingling of underarms/grain, 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 epiPen 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 twice, back-to-back
- Administer CPR if indicated

<table>
<thead>
<tr>
<th>(PHYSICIAN)</th>
<th>Date</th>
<th>(PHYSICIAN)</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>(PHYSICIAN)</td>
<td>Date</td>
<td>(PHYSICIAN)</td>
<td>Date</td>
</tr>
</tbody>
</table>

Nebraska Emergency Guidelines for Schools 2015 Edition
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.

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

CALL THE POLICE.  
YES  
• Does student’s behavior present an immediate risk of physical harm to persons or property?  
• Is student armed with a weapon?

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.
Wash the bite area with soap and water.

Press firmly with a clean dressing. See “Bleeding” (p. 17).

Is student bleeding?

Hold under running water for 2-3 minutes.

Check student’s immunization record for tetanus. See “Tetanus Immunization” (p. 60).

If skin is broken, contact responsible school authority & parent/legal guardian.

If bite is from a snake, hold the bitten area still and below the level of the heart.

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

If bite is large or gaping?

Is bleeding uncontrollable?

Contact responsible school authority & parent/legal guardian.

Parents/legal guardians of the student who was bitten and the student who was biting should be notified that their student may have been exposed to blood from another student. Individual confidentiality must be maintained when sharing information.

Report bite to proper authorities, usually the local health department, so the animal can be caught and watched for rabies.

Bites from the following animals can carry rabies and may need medical attention:
- Dog.
- Opossum.
- Raccoon.
- Coyote.
- Horse
- Bat.
- Skunk.
- Fox.
- Cat.

CALL EMS 9-1-1.
BLEEDING

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

Is injured part amputated (severed)?

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

CALL EMS 9-1-1.

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

Is there continued uncontrollable bleeding?

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

CALL EMS 9-1-1.

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

**URGE MEDICAL CARE.**

Check student’s immunization record for tetanus. See “Tetanus Immunization.” (p. 60)

Contact responsible school authority & parent or legal guardian.
BLISTERS (FROM FRICTION)

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

Wash the area gently with water. Use soap if necessary to remove dirt.

Is blister broken?

YES
Apply clean dressing and bandage to prevent further rubbing.

NO
Do NOT break blister. Blisters heal best when kept clean and dry.

If infection is suspected, contact responsible school authority & parent or legal guardian.
If student comes to school with unexplained unusual or frequent bruising, consider the possibility of child abuse. See “Child Abuse” (p.26).

**BRUISES**

- Is bruise deep in the muscle?
- Is there rapid swelling?
- Is student in great pain?

If skin is broken, treat as a cut. See “Cuts, Scratches & Scrapes” (p.28).

Rest injured part.

Contact responsible school authority & parent or legal guardian.

Apply cold compress or ice bag covered with a cloth or paper towel for 20 minutes.
If student comes to school with pattern burns (e.g., iron or cigarette shape) or glove-like burns, consider the possibility of child abuse. See “Child Abuse” (p.26).

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

What type of burn is it?

ELECTRICAL

CHEMICAL

HEAT

Is student unconscious or unresponsive?

NO

See “Electric Shock” (p.32).

YES

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

CALL EMS 9-1-1

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

Cover/wrap burned part loosely with a clean dressing.

Check student’s immunization record for tetanus. See “Tetanus Immunization” (p.60).

Contact responsible school authority & parent or legal guardian.

Is burn large or deep?

• Is burn on face or eye?

• Is student having difficulty breathing?

• Is student unconscious?

• Are there other injuries?

YES

YES

NO

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” (p.34) if necessary.

• Rinse for 20-30 minutes.

Is student unconscious or unresponsive?

Is burn large or deep?

Is burn on face or eye?

Is student having difficulty breathing?

Is student unconscious?

Are there other injuries?
The American Heart Association (AHA) issued new CPR guidelines for laypersons in 2010. 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 compressions per minute for all victims.
- Compress about 1/3 to 1/2 the depth of the chest for infants (approximately 1 ½ inches), and 2 inches for children and adults.
- Allow the chest to return to its normal position between each compression.
- Use approximately equal compression and relaxation times.
- Try to limit interruptions in chest compressions.

## 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 2010.*
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, shout 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.
4. Check for BREATHING.

IF NOT BREATHING AND NOT RESPONSIVE:

5. Find finger position near center of breastbone just below the nipple line. (Make sure fingers are NOT over the very bottom of the breastbone.)
6. Compress chest hard and fast at rate of 30 compressions in about 18 seconds with 2 or 3 fingers approximately 1 ½” or about 1/3 of the infant’s chest.
   Use equal compression and relaxation times. Limit interruptions in chest compressions.
7. Give 2 normal breaths, each lasting 1 second. Each breath should make chest rise.
8. REPEAT CYCLES OF 30 COMPRESSIONS TO 2 BREATHS AT A RATE OF 100 COMPRESSIONS PER MINUTE UNTIL INFANT STARTS BREATHING EFFECTIVELY ON OWN OR HELP ARRIVES.
9. Call EMS after 2 minutes (5 cycles of 30 compressions to 2 rescue breaths) if not already called.
CARDIOPULMONARY RESUSCITATION (CPR)
FOR CHILDREN 1 TO 8 YEARS OF AGE

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

1. Gently tap the shoulder and shout, “Are you OK?” If child is unresponsive, shout for help and send someone to call EMS and get your school’s AED if available.
2. Turn the child onto his/her back as a unit by supporting the head and neck. If head or neck injury is suspected, DO NOT BEND OR TURN NECK.
3. Lift chin up and out with one hand while pushing down on the forehead with the other to open the AIRWAY.
4. Check for normal BREATHING.
5. If you witnessed the child’s collapse, first set up the AED and connect the pads according to the manufacturer's instructions. Incorporate use into CPR cycles according to instructions and training method. For an unwitnessed collapse, perform CPR for 2 minutes and then use AED.

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 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. Lift fingers to avoid pressure on ribs. Use equal compression and relaxation times. Limit interruptions in chest compressions.
9. Give 2 normal breaths, each lasting 1 second. Each breath should make the chest rise.
10. REPEAT CYCLES OF 30 COMPRESSIONS TO 2 BREATHS AT A RATE OF AT LEAST 100 COMPRESSIONS PER MINUTE OR 30 COMPRESSIONS IN ABOUT 18 SECONDS UNTIL THE CHILD STARTS BREATHING ON OWN OR HELP ARRIVES.
11. Call EMS after 2 minutes (5 cycles of 30 compressions to 2 rescue breaths) if not already called.

*Hand positions for child CPR:
- 1 hand: Use heel of 1 hand only.
- 2 hands: Use heel of 1 hand with second on top of first.

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

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

1. Gently tap the shoulder and shout, “Are you OK?” If person is unresponsive, shout for help and send someone to call EMS AND get your school’s AED if available.
2. Turn the person onto his/her back as a unit by supporting head and neck. If head or neck injury is suspected, DO NOT BEND OR TURN NECK.
3. Lift chin up and out with one hand while pushing down on the forehead with the other to open the AIRWAY.
4. Check for normal BREATHING. Gasping in adults should be treated as no breathing.
5. If you witnessed the collapse, first set up the AED and connect the pads according to the manufacturer’s instructions. Incorporate use into CPR cycles according to instructions and training method. For an unwitnessed collapse, perform CPR for 2 minutes and then use AED.

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 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 make the chest rise.

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

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

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

INFANTS UNDER 1 YEAR

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

1. Position the infant, with head slightly lower than chest, face down on your arm and support the head (support jaw; do NOT compress throat).

2. Give up to 5 back slaps with the heel of hand between infant’s shoulder blades.

3. If object is not coughed up, position infant face up on your forearm with head slightly lower than rest of body.

4. With 2 or 3 fingers, give 5 chest thrusts near center of breastbone, just below the nipple line.

5. Open mouth and look. If foreign object is seen, sweep it out with the finger.

6. REPEAT STEPS 1-5 UNTIL OBJECT IS COUGHED UP OR INFANT STARTS TO BREATHE OR BECOMES UNCONSCIOUS.

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

IF INFANT BECOMES UNCONSCIOUS, GO TO STEP 5 OF INFANT CPR (p.22).

CHILDREN OVER 1 YEAR OF AGE & ADULTS

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

1. Stand or kneel behind child with arms encircling child.

2. Place thumbside of fist against middle of abdomen just above the navel. (Do NOT place your hand over the very bottom of the breastbone. Grasp fist with other hand).

3. Give up to 5 quick inward and upward abdominal thrusts.

4. REPEAT STEPS 1-2 UNTIL OBJECT IS COUGHED UP, CHILD STARTS TO BREATHE OR CHILD BECOMES UNCONSCIOUS.

IF THE CHILD BECOMES UNCONSCIOUS, PLACE ON BACK AND GO TO STEP 7 OF CHILD, OR STEP 6 OF ADULT CPR (p.23).

FOR OBESE OR PREGNANT PERSONS:

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

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

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

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.

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

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

Nebraska Emergency Guidelines for Schools 2015 Edition
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)

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

Is the wound:
- Large?
- Deep?
- Bleeding freely?

NO

- Wash the wound gently with water. Use soap if necessary to remove dirt.
- Pat dry with clean gauze or paper towel.
- Apply clean gauze dressing (non-adhering or non-sticking type for scrapes) and bandage.

YES

See “Bleeding” (p.17).

Check student’s immunization record for tetanus. See “Tetanus Immunization” (p.60).

Contact responsible school authority & parent/legal guardian.

Nebraska Emergency Guidelines for Schools 2015 Edition
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.

Refer to student’s Diabetic Action plan.

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

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.

Contact responsible school authority & parent/legal guardian.

CALL EMS 9-1-1.

If the student is unconscious, see, “Unconsciousness” (p.62).
A student may come to the office because of repeated diarrhea or after an “accident” in the bathroom.

Does student have any of the following signs of probable illness:
- More than 2 loose stools a day?
- Oral temperature over 100.0 F? See “Fever” (p.36).
- Blood present in the stool?
- Severe stomach pain?
- Student is dizzy and pale?

- 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.

Contact responsible school authority & parent/legal guardian.

URGE MEDICAL CARE.
**EAR PROBLEMS**

**DRAINAGE FROM EAR**

Do NOT try to clean out ear.

Contact responsible school authority & parent or legal guardian.
URGE MEDICAL CARE.

**EARACHE**

Contact responsible school authority & parent/legal guardian.
URGE MEDICAL CARE.

**OBJECT IN EAR CANAL**

Ask student if he/she knows what is in the ear.

Do you suspect a live insect is in the ear?

YES OR NOT SURE

Do NOT attempt to remove.

Gently tilt head toward the affected side.

Did the object come out on its own?

NO

Do NOT attempt to remove.

Contact responsible school authority & parent or legal guardian.
URGE MEDICAL CARE.

If there is no pain, the student may return to class. Notify the parent or legal guardian.

YES
ELECTRIC SHOCK

- TURN OFF POWER SOURCE, IF POSSIBLE. DO NOT TOUCH STUDENT UNTIL POWER SOURCE IS SHUT OFF.
- Once power is off and situation is safe, approach the student and ask, “Are you OK?”

Is student unconscious or unresponsive?

YES

CALL EMS 9-1-1.

- Keep airway clear.
- If student is not breathing, start CPR. See “CPR” (pp.21-24).

NO

Treat any burns. See “Burns” (p.20).

Contact responsible school authority & parent or legal guardian. URGE MEDICAL CARE.

If no one else is available to call EMS, perform CPR first for 2 minutes and then call EMS yourself.
EYE INJURY:

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.

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

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.

URGE IMMEDIATE MEDICAL CARE.
EYE PROBLEMS

PARTICLE IN EYE

- Keep student from rubbing eye.
  - If necessary, lay student down and tip head toward affected side.
  - Gently pour tap water over the open eye to flush out the particle.
  - If particle does not flush out of eye or if eye pain continues, contact responsible school authority & parent/legal guardian.

URGE MEDICAL CARE.

CHEMICALS IN EYE

- Wear gloves and if possible, goggles.
- Immediately rinse the eye with large amounts of clean water for 20 to 30 minutes. Use an eyewash if available.
- Tip the head so the affected eye is below the unaffected eye and water washes eye from nose out to side of the face.

Contact responsible school authority & parent/legal guardian.

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

If eye has been burned by chemical, CALL EMS 9-1-1.
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” (p.62).

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

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.

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

Contact responsible school authority & parent/legal guardian.
FEVER & NOT FEELING WELL

Take student’s temperature. Note oral temperature over 100.0 F as fever.

Have the student lie down in a room that affords privacy.

Give no medication, unless previously authorized.

Contact responsible school authority and parent or legal guardian.
FRACTURES, DISLOCATIONS, SPRAINS OR STRAINS

Treat all injured parts as if they could be fractured.

Symptoms may include:
- Pain in one area.
- Swelling.
- Feeling “heat” in injured area.
- Discoloration.
- Limited movement.
- Bent or deformed bone.
- Numbness or loss of sensation.

CALL EMS 9-1-1.

- Is bone deformed or bent in an unusual way?
- Is skin broken over possible fracture?
- Is bone sticking through skin?

YES

- Rest injured part by not allowing student to put weight on it or use it.
- Gently support injured part.
- Apply ice, covered with a cloth or paper towel, to minimize swelling.

NO

- Leave student in a position of comfort.
- Gently cover broken skin with a clean bandage.
- Do NOT move injured part.

Contact responsible school authority & parent/legal guardian.

After period of rest, re-check the injury.
- Is pain gone?
- Can student move or put weight on injured part without discomfort?
- Is numbness/tingling gone?
- Has sensation returned to injured area?

If discomfort is gone after period of rest, allow student to return to class.

YES

Contact responsible school authority & parent or legal guardian.

URGE MEDICAL CARE.

NO
Frostbite can result in the same type of tissue damage as a burn. It is a serious condition and requires medical attention.

Exposure to cold even for short periods of time may cause “HYPOTHERMIA” in children (see “Hypothermia” p. 42). 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?

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

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

Keep student and part warm.
Has a head injury occurred?

- Is headache severe?
- Are other symptoms present such as:
  - Vomiting?
  - Oral temperature over 100.0 F? (See “Fever”, p.36)
  - Blurred vision?
  - Dizziness?

  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.

See “Head Injuries” (p.40).

Contact parent/legal guardian.

URGE MEDICAL CARE.

Give no medication unless previously authorized.
Many head injuries that happen at school are minor. Head wounds may bleed easily and form large bumps. Bumps to the head may not be serious. Head injuries from falls, sports and violence may be serious. If head is bleeding, see “Bleeding” (p.17).

If student only bumped head and does not have any other complaints or symptoms, see “Bruises” (p.19).

With a head injury (other than head bump), always suspect neck injury as well.

Do NOT move or twist the back or neck.

See “Neck & Back Pain” (p.45) for more information.

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

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

Is student vomiting?

YES

CALL EMS 9-1-1.

• Check student’s airway.
• If student stops breathing, start CPR. See “CPR” (pp.21-24).

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?

• 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.

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

Refer to Concussions Return to Learn & Return to Play in Resources Section

Nebraska Emergency Guidelines for Schools 2015 Edition
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.

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

Is student unconscious or losing consciousness?

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).

NO

- 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.

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

CALL EMS 9-1-1.
Give nothing by mouth.
Continue to warm student with blankets.
If student is asleep or losing consciousness, place student on his/her side to protect airway.
If student stops breathing, start CPR. See “CPR” (pp.21-24).
Is it possible that student is pregnant?

YES OR NOT SURE

See “Pregnancy” (p. 49).

NO

Are cramps mild or severe?

MILD

For mild cramps, recommend regular activities.

SEVERE

A short period of quiet rest may provide relief.

Give no medications unless previously authorized by parent/legal guardian.

Urge medical care if disabling cramps or heavy bleeding occurs.

Contact responsible school authority & parent/legal guardian.
MOUTH & JAW INJURIES

Check student’s immunization record for tetanus. See “Tetanus Immunization, (p.60).

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

Do you suspect a head injury other than mouth or jaw?

YES

See “Head Injuries” (p.40)

NO

Have teeth been injured?

YES

Contact responsible school authority & parent/legal guardian. URGE IMMEDIATE MEDICAL CARE.

NO

Has jaw been injured?

YES

• Do NOT try to move jaw.
• Gently support jaw with hand.

NO

If tongue, lips or cheeks are bleeding, apply direct pressure with sterile gauze or clean cloth.

• Is cut large or deep?
• Is there bleeding that cannot be stopped?

YES

See “Bleeding” (p.17).

NO

Place a cold compress over the area to minimize swelling.

Contact responsible school authority & parent/legal guardian. Encourage medical care.
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

Did student walk in or was student found lying down?  
WALK IN

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.

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.

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.

CALL EMS 9-1-1. Contact responsible school authority & parent or legal guardian.
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.
- Care for nose as in “Nosebleed” above.
- Contact responsible school authority & parent/legal guardian.
- URGE MEDICAL CARE.

BROKEN NOSE

See “Head Injuries” (p.40) if you suspect a head injury other than a nosebleed or broken nose.
**OBJECT IN NOSE**

Is object:
- Large?
- Puncturing nose?
- Deeply imbedded?

**YES OR NOT SURE**

- **NO**
  - Have student hold the clear nostril closed while *gently* blowing nose.

  **YES**
  - Did object come out on own?
    - If there is no pain, student may return to class. Notify parent or legal guardian.

  **NO**
  - If object cannot be removed easily, *do NOT* attempt to remove.

  **Do NOT attempt to remove.**
  - See “Puncture Wounds” (p.50) if object has punctured nose.

  **Contact responsible school authority & parent or legal guardian.**
  - **URGE MEDICAL CARE.**
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.

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

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

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

- If student becomes unconscious, place on his/her side. Check airway.
- If student stops breathing, start CPR. See “CPR” (pp.21-24).
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**
  - CALL EMS 9-1-1. Contact responsible school authority & parent or legal guardian.

- **SEIZURE**
  - This may be a serious complication of pregnancy.

- **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.
  - Contact responsible school authority & parent/legal guardian.

- **MORNING SICKNESS**
  - Treat as vomiting. See “Vomiting” (p.63).
PUNCTURE WOUNDS

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

Has eye been wounded?

NO

Is object still stuck in wound?

NO

Do NOT try to probe or squeeze.

- Wash the wound gently with soap and water.
- Check to make sure the object left nothing in the wound (e.g., pencil lead).
- Cover with a clean bandage.

See “Bleeding” (p.17) if wound is deep or bleeding freely.

Check student’s immunization record for tetanus. See “Tetanus Immunization” (p.60).

Contact responsible school authority & parent or legal guardian.

Most pencil cores are made of graphite mixed with a clay binder not lead.

Do NOT remove object.
- Wrap bulky dressing around object to support it.
- Try to calm student.

- Is object large?
- Is wound deep?
- Is wound bleeding freely or squirting blood?

NO

CALL EMS 9-1-1.

YES

See “Bleeding” (p.17) if wound is deep or bleeding freely.

YES

Has eye been wounded?

NO

Do NOT touch eye.

YES
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?

If any of the following symptoms are present, contact responsible school authority & parent or legal guardian and URGE MEDICAL CARE:
- Oral temperature over 100.0 F (See “Fever” p.36).
- 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.

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

YES

See “Allergic Reaction” (p.12) and “Communicable Disease” (Resource Section) for more information.

NO
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.

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.

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?

Contact responsible school authority & parent or legal guardian.

CALL EMS 9-1-1.
SHOCK

If injury is suspected, see “Neck & Back Pain” (p.45) and treat as a possible neck injury.

Do NOT move student unless he/she is endangered.

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

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

Is student:
- Not breathing? See “CPR” (pp.21-24) and/or “Choking” (p. 25).
- Unconscious? See “Unconsciousness” (p.62).
- Bleeding profusely? See “Bleeding” (p.17).

CALL EMS 9-1-1.

Contact responsible school authority & parent or legal guardian.

URGE MEDICAL CARE if EMS not called.

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

- 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.
SPLINTERS OR IMBEDDED PENCIL TIP

- Wear disposable gloves when exposed to blood or other body fluids.
- Check student’s immunization record for tetanus. See “Tetanus Immunization” (p.60).
- Gently wash area with clean water and soap.

Is splinter or pencil tip:
- Protruding above the surface of the skin?
- Small?
- Shallow?

NO

- Leave in place.
- Do NOT probe under skin.
- Contact responsible school authority & parent or legal guardian.
- Encourage medical care.

YES

- Remove with tweezers unless this causes student pain.
- Do NOT probe under skin.
- Were you successful in removing the entire splinter/pencil tip?

NO

- Wash again.
- Apply clean dressing.

YES
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.

**Check student’s airway.**
- **IF student stops breathing start CPR.** See “CPR” (p.21-24).

YES

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

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” (p.60).

Contact responsible school authority & parent or legal guardian.
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?

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.

Refer to student’s Allergy Action plan.

Administer medications as directed in action plan.

CALL EMS 9-1-1.

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

Contact responsible school authority & parent or legal guardian.

Contact responsible school authority & parent or legal guardian.

Contact responsible school authority & parent or legal guardian.
STOMACHACHES/PAIN

Stomachaches/pain may have many causes including:
- Illness.
- Hunger.
- Overeating.
- Diarrhea.
- Food poisoning.
- Injury.
- Menstrual difficulties.
- Psychological issues.
- Stress.
- Constipation.
- Gas pain.
- Pregnancy.

Suspect neck injury. See “Neck and Back Pain” (p.45).

Contact responsible school authority & parent/legal guardian.

URGE PROMPT MEDICAL CARE.

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?

Take the student’s temperature. Note temperature over 100.0 F as fever. See “Fever” (p.36).

Does student have:
- Fever?
- Severe stomach pains?
- Vomiting?

Allow student to rest 20-30 minutes in a room that affords privacy.

If stomachache persists or becomes worse, contact responsible school authority & parent or legal guardian.

Does student feel better?

Allow student to return to class.
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**

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.

See "Mouth & Jaw" (p. 44) for tongue, cheek, lip, jaw or other mouth injury not involving the teeth.
**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.

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

**Contact responsible school authority & parent or legal guardian.**

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

Apply a cold compress to face to minimize swelling.
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.
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.
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?

Is unconsciousness due to injury?
- See “Neck & Back Pain” (p.45) and treat as a possible neck injury.
- Do NOT move student.
- Open airway with head tilt/chin lift.

CALL EMS 9-1-1.

Is student breathing?
- 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.

CALL EMS 9-1-1.

Contact responsible school authority & parent/legal guardian.
If a number of students or staff become ill with the same symptoms, suspect food poisoning.

CALL POISON CONTROL 1-800-222-1222. and ask for instructions. See “Poisoning” (p.48) and notify local health department.

Vomiting may have many causes including:
- Illness.
- Bulimia.
- Anxiety.
- Pregnancy.
- Injury/head injury.
- Heat exhaustion.
- Overexertion.
- Food Poisoning.

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

Take student’s temperature. Note oral temperature over 100.0 F as fever. See “Fever” (p.36).

- 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?

Contact responsible school authority & parent/legal guardian.

URGE MEDICAL CARE.

Contact responsible school authority & parent/legal guardian.
**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 water are not available.

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

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Develop a pandemic flu plan for your school using the CDC School Pandemic Flu Planning Checklist available at <a href="https://www.cdc.gov/h1n1flu/schools">https://www.cdc.gov/h1n1flu/schools</a>.</td>
</tr>
<tr>
<td>2.</td>
<td>Build a strong relationship with your local health department and include them in the planning process.</td>
</tr>
<tr>
<td>3.</td>
<td>Train school staff to recognize symptoms of influenza.</td>
</tr>
<tr>
<td>4.</td>
<td>Follow your school policies to decide to what extent you will encourage or require students and staff to stay home when they are ill.</td>
</tr>
<tr>
<td>5.</td>
<td>Have a method of disease recognition (disease surveillance) in place. Report increased absenteeism or new disease trends to the local health department.</td>
</tr>
<tr>
<td>6.</td>
<td>Make sure the school is stocked with supplies for frequent hand hygiene including soap, water, alcohol-based hand sanitizers and paper towels.</td>
</tr>
<tr>
<td>7.</td>
<td>Encourage good hand hygiene and respiratory etiquette in all staff and students.</td>
</tr>
<tr>
<td>8.</td>
<td>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.</td>
</tr>
<tr>
<td>9.</td>
<td>Develop alternative learning strategies to continue education in the event of an influenza pandemic.</td>
</tr>
</tbody>
</table>

#### RESPONSE – DURING AN OUTBREAK

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Heighten disease surveillance and reporting to the local health department.</td>
</tr>
<tr>
<td>2.</td>
<td>Communicate regularly with parents informing them of the community and school status and expectations during periods of increased disease.</td>
</tr>
<tr>
<td>3.</td>
<td>Work with local education representatives and the local health department to determine if the school should cancel non-academic events or close the school.</td>
</tr>
<tr>
<td>5.</td>
<td>Continue to educate students, staff and families on the importance of hand hygiene and respiratory etiquette.</td>
</tr>
</tbody>
</table>

#### RECOVERY – FOLLOWING AN OUTBREAK

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Continue to communicate with the local health department regarding the status of disease in the community and the school.</td>
</tr>
<tr>
<td>2.</td>
<td>Communicate with parents regarding the status of the education process.</td>
</tr>
<tr>
<td>3.</td>
<td>Continue to monitor disease surveillance and report disease trends to the health department.</td>
</tr>
<tr>
<td>4.</td>
<td>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.</td>
</tr>
</tbody>
</table>
RECOMMENDED 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.


5. Bandage scissors & tweezers.


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.

Nebraska Emergency Guidelines for Schools 2015 Edition
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.
# Nebraska Emergency Guidelines for Schools 2015 Edition

## CRISIS TEAM MEMBERS

<table>
<thead>
<tr>
<th>Position</th>
<th>Name</th>
<th>Work #</th>
<th>Home #</th>
<th>Cell/Pager</th>
<th>Room #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrator</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Designee</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychologist</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Counselor</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secretary</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## CPR/FIRST AID CERTIFIED STAFF

<table>
<thead>
<tr>
<th>Name</th>
<th>Room</th>
<th>CPR – Yes/No</th>
<th>First Aid – Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## CRISIS CONTACTS

<table>
<thead>
<tr>
<th>Name</th>
<th>Emergency Contact Information</th>
<th>Alternate Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local Critical Incident Management Team</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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):

Complete this page as soon as possible and update as needed.
3-001 SCOPE AND AUTHORITY: These regulations are intended to implement Neb. Rev. Stat. §§ 79-217 to 79-223.

3-002 DEFINITIONS: For purposes of these regulations:

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

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

**Department** means the Department of Health and Human Services.

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

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

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

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

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

Fever, flushed face, headache, aches in muscles or joints, unexplained tiredness or listlessness, loss of appetite, stomach ache, nausea or vomiting, diarrhea, convulsions, sore throat, nasal congestion or discharge, unexplained skin eruption, sore or inflamed eyes.
3-004 REPORTING

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

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

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

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

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

3-007 (RESERVED)

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

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

3-008.01 For the purposes of complying with the requirement of immunization against the diseases listed above:
3-008.01A Students 2-5 years of age enrolled in a school-based program not licensed as a child care provider are considered to be immunized if they have received:

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

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

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

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

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

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

3-009 REQUIRED EVIDENCE OF IMMUNIZATION

3-009.01 For purposes of compliance with the immunization requirement, the board of education or school board or other governing authority, must require the presentation of
an immunization history which includes the name of the vaccine and the month, day, and year of administration.

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

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

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

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

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

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

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

3-010.01B A notarized affidavit signed by the student or, if he or she is a minor, by a legally authorized representative of the student, stating that the immunization conflicts with the tenets and practice of a recognized religious denomination of which the student is an adherent or member or that immunization conflicts with the personally and sincerely followed religious beliefs of the student.
3-010.02 A student may be provisionally enrolled in a school in Nebraska if he or she has begun the immunizations against the specified diseases prior to enrollment and continues the necessary immunizations as rapidly as is medically feasible. For purposes of complying with these requirements:

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

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

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

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

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

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

3-012 REPORTING REQUIREMENTS: A report to the Department summarizing immunization status is required by November 15 of each year from the board of education or school board of each school district, or other governing authority of the school. The report must include the following information regarding those entering school for the first time (kindergarten or 1st grade), those entering the 7th grade, and all transfer students from outside the state (excluding the entering and 7th grades):
3-012.01 For children in the entering grade (kindergarten or 1st grade depending on the school district’s entering grade):

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

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

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

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

<table>
<thead>
<tr>
<th>DISEASE / CONDITION</th>
<th>INCUBATION PERIOD *</th>
<th>SYMPTOMS OF ILLNESS</th>
<th>INFECTION PERIOD</th>
<th>MINIMUM ISOLATION PERIODS AND CONTROL MEASURES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chickenpox</td>
<td>2-3 weeks</td>
<td>Fever, skin eruption begins as red spots that become small blisters (vesicles) and then scab over.</td>
<td>For up to 5 days before eruption until all lesions are crusted.</td>
<td>Exclude until all lesions are crusted; avoid contact with susceptibles. No exclusion of contacts. Alert parents of immune-suppressed child(ren) of possible exposure.</td>
</tr>
<tr>
<td>Conjunctivitis (Pink Eye)</td>
<td>24-72 hours</td>
<td>Redness of white of eye, tearing, discharge of pus.</td>
<td>During active phase of illness characterized by tearing and discharge.</td>
<td>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.</td>
</tr>
<tr>
<td>Coryza (Common Cold)</td>
<td>12-72 hours</td>
<td>Nasal discharge, soreness of throat.</td>
<td>One day before symptoms and usually continuing for about 5 days.</td>
<td>Exclusion unnecessary. No exclusion of contacts.</td>
</tr>
<tr>
<td>Diphtheria</td>
<td>2-5 days</td>
<td>Fever, sore throat, often gray membrane in nose or throat.</td>
<td>Usually 2 weeks or less. Seldom more than 4 weeks.</td>
<td>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. <em>Report immediately by telephone</em> all cases to local and/or state health departments.</td>
</tr>
</tbody>
</table>

* **Note:** Incubation period refers to the time between exposure and the onset of symptoms. Exclusion periods vary based on the nature of the disease and the stage of illness.
<table>
<thead>
<tr>
<th>DISEASE / CONDITION</th>
<th>INCUBATION PERIOD *</th>
<th>SYMPTOMS OF ILLNESS</th>
<th>INFECTION PERIOD</th>
<th>MINIMUM ISOLATION PERIODS AND CONTROL MEASURES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enterobiasis (Pinworm, Thread-worm, Seatworm)</td>
<td>Life cycle about 3-6 weeks</td>
<td>Irritation around anal region. Visible in stool.</td>
<td>As long as eggs are being laid; usually 2 weeks.</td>
<td>Exclude until treated as documented by physician. No exclusion of contacts. Careful handwashing essential.</td>
</tr>
<tr>
<td>Fifth Disease</td>
<td>Estimated at 6-14 days</td>
<td>Minimal symptoms with intense red &quot;slapped cheek&quot; Appearing rash; lace-like rash on body.</td>
<td>Unknown.</td>
<td>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.</td>
</tr>
<tr>
<td>Hand, Foot and Mouth</td>
<td>3-5 days</td>
<td>Fever, sore throat, elevated blisters occurring on hands, feet or in the mouth.</td>
<td>During acute illness, usually one week. Spread through direct contact with nose and throat discharge and aerosol droplets.</td>
<td>Exclude cases during acute phase and until fever-free for 24 hours without the use of fever-reducing medication.</td>
</tr>
<tr>
<td>Hepatitis A</td>
<td>15-50 days, average 28-30 days</td>
<td>Fever, nausea, loss of appetite, abdominal discomfort and jaundice.</td>
<td>Two weeks before jaundice until about 7 days after onset of jaundice.</td>
<td>Exclude for no less than 7 days after onset of jaundice. Return with documented physician approval. No exclusion of contacts. Immune globulin (IG) or hepatitis A vaccine prevents disease if given within two weeks of exposure. IG to family contacts only. Careful handwashing essential.</td>
</tr>
<tr>
<td>DISEASE / CONDITION</td>
<td>INCUBATION PERIOD *</td>
<td>SYMPTOMS OF ILLNESS</td>
<td>INFECTION PERIOD</td>
<td>MINIMUM ISOLATION PERIODS AND CONTROL MEASURES</td>
</tr>
<tr>
<td>----------------------</td>
<td>---------------------</td>
<td>---------------------</td>
<td>-----------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>Herpes Simplex (Type 1)</td>
<td>2-12 days</td>
<td>Onset as clear vesicle, later purulent. Following rupture, scabs and in 1-2 weeks, heals. Commonly about lips and in mouth.</td>
<td>For a few weeks after appearance of vesicle.</td>
<td>Exclusion unnecessary. No exclusion of contacts. Avoid contact with immunosuppressed or eczematous persons. Good personal hygiene, avoid sharing toilet articles.</td>
</tr>
<tr>
<td>Impetigo</td>
<td>4-10 days</td>
<td>Running, open sores with slight marginal redness.</td>
<td>As long as lesions draining and case hasn't been treated.</td>
<td>Exclude until brought under treatment and acute symptoms resolved. No exclusion of contacts. Good personal hygiene is essential. Avoid common use of toilet articles.</td>
</tr>
<tr>
<td>Influenza</td>
<td>24-72 hours</td>
<td>Fever and chills, often back or leg aches, sore throat, nasal discharge and cough; prostration.</td>
<td>A brief period before symptoms until about a week thereafter.</td>
<td>Exclude for duration of illness. No exclusion of contacts.</td>
</tr>
<tr>
<td>Measles (Rubeola)</td>
<td>10-14 days</td>
<td>Begins like a cold; fever, blotchy rash, red eyes, hacking frequent cough.</td>
<td>5 days before rash until 4 days after rash.</td>
<td>Exclude for duration of illness and for no less than 4 days after onset of rash. Exclude unimmunized students on same campus from date of diagnosis of first case until 14 days after rash onset of last known case or until measles immunization received or laboratory proof of immunity is presented or until history of previous measles infection is verified as per records or the Nebraska Department of Health and Human Services. <em>Report immediately by telephone</em> all cases to local and/or state health departments.</td>
</tr>
<tr>
<td>DISEASE / CONDITION</td>
<td>INCUBATION PERIOD *</td>
<td>SYMPTOMS OF ILLNESS</td>
<td>INFECTION PERIOD</td>
<td>MINIMUM ISOLATION PERIODS AND CONTROL MEASURES</td>
</tr>
<tr>
<td>---------------------------</td>
<td>---------------------</td>
<td>-------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Meningitis (bacterial)</td>
<td>3-4 days with a range of 2-10 days</td>
<td>Sudden onset of fever, headache, stiff neck, nausea, vomiting, sensitivity to light, and altered mental status</td>
<td>Infectious until 24 hours into antibiotic course</td>
<td>Local or state health authorities will determine appropriate follow-up and investigation on a case-by-case basis. Student should be excluded from school until antibiotic course has been initiated and symptoms have fully resolved, and may return with medical clearance.</td>
</tr>
<tr>
<td>Meningitis (viral)</td>
<td>3-7 days</td>
<td>Sudden onset of fever, headache, stiff neck, nausea, vomiting, sensitivity to light, sleepiness, altered mental status; rubella-like rash may be present.</td>
<td>Infectious until symptoms have fully resolved.</td>
<td>Active illness seldom exceeds 10 days. Student should be excluded from onset of symptoms until full resolution, and may return with medical clearance.</td>
</tr>
<tr>
<td>MRSA (staph bacterial infection)</td>
<td>Variable and indefinite.</td>
<td>Skin lesion; can take on different forms.</td>
<td>As long as purulent lesions drain or the carrier state persists.</td>
<td>Exclusion unnecessary unless directed by physician. Keep lesions covered at school. Good handwashing and sanitation practices; no sharing of personal items.</td>
</tr>
<tr>
<td>Mumps (Epidemic Parotitis)</td>
<td>2-3 weeks</td>
<td>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.</td>
<td>About 7 days before gland swelling until 9 days after onset of swelling or until swelling has subsided.</td>
<td>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.</td>
</tr>
<tr>
<td>Pediculosis (Infestation with head or body lice)</td>
<td>Eggs of lice hatch in about a week; maturity in about 2-3 weeks</td>
<td>Itching; infestation of hair and/or clothing with insects and nits (lice eggs).</td>
<td>While lice remain alive and until eggs in hair and clothing have been destroyed. Direct and indirect contact with infested person</td>
<td>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.</td>
</tr>
<tr>
<td>DISEASE / CONDITION</td>
<td>INCUBATION PERIOD *</td>
<td>SYMPTOMS OF ILLNESS</td>
<td>INFECTION PERIOD</td>
<td>MINIMUM ISOLATION PERIODS AND CONTROL MEASURES</td>
</tr>
<tr>
<td>---------------------</td>
<td>---------------------</td>
<td>---------------------</td>
<td>-----------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>Pertussis (Whooping Cough)</td>
<td>7 days – usually within 10 days</td>
<td>Irritating cough – symptoms of common cold usually followed by typical whoop in cough in 2-3 weeks.</td>
<td>About 7 days after exposure to 3 weeks after typical cough. When treated with erythromycin, 5-7 days after onset of therapy.</td>
<td>Exclude until physician approves return per written documentation. Exclude inadequately immunized close contacts as deemed appropriate by school officials following investigation by the local and/or state Department of Health and Human Services. Chemoprophylaxis may be considered for family and close contacts. Report immediately by telephone.</td>
</tr>
<tr>
<td>Poliomyelitis (Infantile Paralysis)</td>
<td>3-35 days; 7-14 days for paralytic cases</td>
<td>Fever, sore throat, malaise, headache, stiffness of neck or back, muscle soreness.</td>
<td>Not accurately known. Maybe as early as 36 hours after infection; most infectious during first few days after onset of symptoms.</td>
<td>Exclude until physician approves return. Report immediately by telephone.</td>
</tr>
<tr>
<td>Ringworm (Tinea Infections)</td>
<td>10-14 days</td>
<td>Scaly oval patches of baldness of scalp; brittle and falling hair, scaly oval lesions of skin.</td>
<td>As long as infectious lesions are present, especially when untreated.</td>
<td>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.</td>
</tr>
<tr>
<td>Rubella (German Measles)</td>
<td>14-21 days</td>
<td>Low-grade fever, slight general malaise; scattered Measles-like rash; duration of approximately 3 days.</td>
<td>About one week before rash until 7 days after onset of rash.</td>
<td>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.</td>
</tr>
<tr>
<td>DISEASE / CONDITION</td>
<td>INCUBATION PERIOD *</td>
<td>SYMPTOMS OF ILLNESS</td>
<td>INFECTION PERIOD</td>
<td>MINIMUM ISOLATION PERIODS AND CONTROL MEASURES</td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>---------------------</td>
<td>---------------------</td>
<td>------------------</td>
<td>------------------------------------------------</td>
</tr>
<tr>
<td>Scabies</td>
<td>Infection caused by almost invisible mite. Lesions symptomatic after 4-6 weeks.</td>
<td>Severe itching; lesions around loose fleshy tissue (e.g., finger webs, elbows, crotch, etc.)</td>
<td>Until mites and eggs destroyed.</td>
<td>Exclude until the day after treatment is started. No exclusion of contacts.</td>
</tr>
<tr>
<td>Shingles / Herpes Zoster</td>
<td>Latent form after primary infection with chickenpox.</td>
<td>Grouped small blisters (vesicles) often accompanied by pain localized to area</td>
<td>Physical contact with vesicles until they become dry.</td>
<td>Exclude children with shingles / zoster if the vesicles cannot be covered until after the vesicles have dried. Individuals with shingles /zoster should be instructed to wash their hands if they touch the potentially infectious vesicles.</td>
</tr>
<tr>
<td>Streptococcal Infection; (Scarlet Fever, Scarletina, Strep Throat)</td>
<td>1-3 days</td>
<td>Sore throat, fever, headache. Rough rash 12-48 hours later.</td>
<td>Until 24-48 hours after treatment begun.</td>
<td>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.</td>
</tr>
</tbody>
</table>

* 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).