

**SECTION III:
Screening, Assessment, and Special Education
Protocols and Guidelines**

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SCREENING/ASSESSMENT GUIDELINES

GUIDELINES

One of the important functions of a school health program is to promote student health through early identification and detection of health problems that may result in disability and/or interfere with learning. When performed in a context of individual health assessments and continuing care, carefully planned and implemented screening programs are appropriate components of the school health program. Screening results help complete the total health assessment of the individual student.

When developing and implementing screening programs, the following guidelines should be carefully considered.

- A significant incidence of a disease or condition should be present to justify the cost and/or the time spent in the screening effort.
- The disease/condition should have a significant effect on the quality of life and/or the learning process.
- Acceptable methods of treatment should be available and accessible.
- Early identification and intervention prior to the onset of symptoms results in beneficial outcomes for the student.

TEACHER OBSERVATION

Teachers play an important role in noticing changes in appearance and behavior that may be related to a student's health status. Their day-to-day contact with their students gives them an opportunity to detect differences in the health of individual students which might go unnoticed by others, even the student's family members

As a guide to the teacher and other school personnel, the following conditions may indicate a need for referral to the NM Public Education Department (PED) licensed school nurse.

- Frequent absences
- Persistent fatigue
- Attention deficit
- Fidgeting (noted as new behavior)
- Skin eruptions
- Frequent nosebleeds
- Deficiency in motor skills
- Emotional disturbances
- Obvious abnormal weight/height changes
- Shortness of breath

SCHOOL HEALTH SCREENING

VISION SCREENING

A **general** vision screening program is a process that allows designated trained persons to screen large numbers of students in a short period of time for the purpose of identifying vision problems. **Screening is not diagnostic.** PED-licensed school nurses should train or verify training and supervise those persons conducting vision screening in the school setting. Screening will not identify every student who needs eye care, nor will every student who is referred require treatment. Students who fail a screening should be referred to an eye care specialist for a comprehensive diagnostic examination.

An **individual** vision screening program is a process whereby specific students are referred by teachers, Student Assistance Teams, Special Education, Child Find, parents or others for screening as part of an extended evaluation. These may be symptomatic students or students who are being evaluated for Special Education. Except for correctable vision defects, glasses have no value in the specific treatment of learning disabilities, dyslexia or reading disabilities or visual processing problems.

NM School Vision Screening Program

Legislation was passed in New Mexico in 2007 requiring vision screening to be administered to students enrolled in identified grades. That same legislation created a fund to provide assistance for students without insurance and referred by school nurses to obtain a comprehensive eye exam and/or eye wear as appropriate.

Standards for Vision Screening at School

As a consequence of this legislation, *Standards for Vision Screening in New Mexico Schools* (www.nmschoolhealthmanual.org/resources/forms.htm, Section III) were developed to standardize and provide direction for vision screening in NM schools.

Target populations for required screening in New Mexico schools include the following grades and all new and transfer students who do not have a record of vision screening on file with the school.

- Pre-kindergarten
- Kindergarten
- First Grade
- Third Grade

The standards for vision screening at schools endorse photoscreening as well as traditional screening and an alternative screening method for those students who cannot adhere to instructions for the other screening methods. The standards require the following tests to be administered as a minimum for general school vision screening.

- Distance Visual Acuity
- Ocular Alignment (once in any target grade)
- Color Vision (once in any target grade)

In addition, near vision acuity is recommended as part of routine vision screening of students with a special education referral.

Pre-screening observation for both eye appearance and visual behaviors should be ongoing for all students in all grades. All school staff should, likewise, be familiar with these pre-screening guidelines.

Referral criteria are listed in the NM vision standards for all levels of pre-screening observation as well as for each required screening test. To standardize the referral process and assist with the follow-up process go to www.nmschoolhealthmanual.org/resources/forms.htm, Section III for the vision referral form developed for school nurses use.

Save Our Children’s Sight Fund

In addition to requiring a school vision screening program, the 2007 legislature created a mechanism through which New Mexico automobile owners may contribute either \$1.00 or \$5.00 to the Save Our Children’s Sight Fund at the time of vehicle registration by checking a box on the registration form. The Office of School and Adolescent Health of the New Mexico Department of Health (NM DOH) is the financial agent for distribution of these funds.

Access to the funds requires a referral from the school nurse who provided oversight for vision screening at school and made the referral for additional follow-up. The NM DOH contact for school nurses to access the funding on behalf of students is through the Office of School and Adolescent Health and the Regional School Health Advocate RNs.

For students without health insurance coverage for eye care, money in this fund can be used to pay for comprehensive eye examinations as well as lenses and frames for eye glasses through the New Mexico Lions Operation KidSight, Inc. (NMLOK), the administering agency of the program, and must meet the criteria established by NM DOH Office of School and Adolescent Health and the New Mexico Lions Operation KidSight, Inc.. The voucher form and additional information about the program can be accessed through the New Mexico School Health Manual Resource Page in Section III. www.nmschoolhealthmanual.org/resources/forms.htm.

Vision Screening Procedures

Distance Visual Acuity

Preparation

Identify a quiet, well-lighted area free of glare and distractions. There must be adequate linear feet to accommodate wall charts (10 or 20 feet as specified by chart instructions). The wall chart should be placed at approximate eye level of the student being screened and on a wall free of other visual stimuli. Identify students to be screened and provide any classroom pre-screening education that is needed.

Materials

- Traditional Testing Tools: Snellen Letter, HOTV, or Lea Symbol Charts
Alternative Testing Tools: Bailey Hall Cereal Test, Colenbrander Lea Symbols Low Vision Chart, Teller Acuity Cards or McDowell Kit
- Pointer to indicate symbols
- Occluding device (card, plastic occluder, paper cup)*
- Non-stretchable tape measure or yardstick
- Masking tape or laminated paper feet
- Pencil/pen and forms for recording results

*Non-disposable equipment should be disinfected between student use.

Screening Procedures

- 1) Measure 10 or 20 feet (according to chart instructions) from the wall and place masking tape or laminated feet on the floor at the appropriate distance.
- 2) Place chart on wall at eye level of students being tested.
- 3) Students who wear glasses should wear glasses for **general** screening. Students being tested in **individual** screening should be tested with **and** without glasses.
- 4) Instruct student to place **HEELS** on marker or be seated with the back of the chair directly over the marker.
- 5) Instruct student to keep both eyes open when being tested.
- 6) Instruct student to cover left eye with occluder first to help screener remember sequence.
- 7) Begin with the line which is normal vision for the student being screened. Point to symbol and ask student to identify symbol indicated. Move up or down on chart as necessary until student can identify majority (one more than half) of symbols on any horizontal line.
- 8) Repeat Steps 5-7 with right eye occluded.
- 9) Record findings.

Results/Referral Criteria

For the results/referral criteria when testing for distance visual acuity use the NM vision screening standards at <http://www.nmschoolhealthmanual.org/resources/forms.htm>, Section III. Students with results of more than one line difference between eyes should be referred to an eye care specialist. Those with normal acuity in one eye and abnormal vision in the other eye should be referred. Follow-up on referrals is the responsibility of the school nurse.

Recording Results

Visual acuity is usually expressed in terms of a 20-foot testing distance. Charts or cards that are designed for use at 10 feet or other testing distance have been adapted to be equivalent to the 20 foot testing distance. Visual acuity is recorded as a fraction (20/20). The top number (numerator) represents the 20-foot distance measured from the chart to the floor marker. The bottom number (denominator) represents the line on the chart the student is able to see. A result of 20/20 means that a student can see at 20 feet what should normally be seen at 20 feet. When visual acuity is abnormal, the bottom number will be higher, i.e. 20/50. Results are recorded for each eye separately. Always record data for right eye first. Record date of the screening test.

Ocular Alignment

Preparation

Identify a quiet, well-lighted area free of glare and distractions. Identify students to be screened and provide classroom pre-screening education as needed. **This test is required only once in any of the target population grades.**

Materials

- Testing Tool: Random Dot E (preferred), Stereo Fly, Butterfly, or Randot Preschool Stereoacuity
- Non-stretchable tape measure
- Pencil/pen and forms for recording results

Screening Procedures

For the correct use of the selected testing tool and screening procedures the screener should refer to instructions for that particular tool.

Results/Referral Criteria

Any student who fails to identify the test tool object should be referred for a comprehensive eye examination.

Reporting Results

Results are recorded as pass or fail.

Color Vision

Preparation

Identify a quiet, well-lighted area free of glare and distractions. Identify students to be screened and provide classroom pre-screening education as needed. **This test is required only once in any of the target population grades.**

Materials

- Standard color discrimination testing tool
- Pencil/pen and forms for recording results
- Any other materials recommended by testing tool instructions, i.e. pointer, Q-tip, paint brush

Screening Procedures

- 1) The screener should refer to instructions for the selected testing tool for the correct use of the tool and screener procedures.
- 2) Both eyes should remain open.

Results/Referral Criteria

Criteria for passing the screening will be dependent on the testing tool used. Parents should be notified if the student fails to pass color vision screening. In consultation with the parent, referral to an eye care provider might be considered for anticipatory guidance and development of coping strategies for this abnormality.

Reporting Results

Results are recorded as positive or negative for color vision.

Near Vision Acuity (Recommended for Special Education screening only.)

Preparation

Identify a quiet, well-lighted area free of glare and distractions. Identify students to be screened and provide classroom pre-screening education as needed. **This test is not required for general screening but is recommended for special education referrals.**

Materials

- Near vision cards of line letters, HOTV, tumbling E or numbers
- Pointer to indicate symbols
- Non-stretchable tape measure

- Pencil/pen and forms for recording results

Screening Procedure

- Students who wear glasses should be tested with and without glasses.
- Display testing cards at 14 inches (or recommended distance indicated for testing cards) from student's eyes. Place card on table top or hold at test distance.
- Instruct student to identify symbol(s) to which the screener points. Begin with symbol line which is normal acuity for age of student being tested.
- Test with both eyes open.

Results/Referral Criteria

Refer to testing device criteria information. Near vision acuity testing is done with both eyes open. Students must identify 80% of letters/symbols on the critical line of 20/30.

Near vision tests are not completely accurate for use in testing children under age 10 because of the accommodative power of the eye in this age group. Near vision cards may identify students with astigmatism because symbols will be blurred.

Recording Results

Results for near vision are recorded as pass/fail in reading the critical line of 20/30 binocular visual acuity or written as 20/_____.

Vision Related Definitions

O.D. Right eye, oculus dexter

O.S. Left eye, oculus sinister

O.U. Each eye, oculus uniterque or both eyes - oculi unitas

Blind No useable or functional vision

Legally Blind Usually acuity of 20/200 or worse with best possible correction

Federal guidelines indicating eligibility for services available for persons with severe, non-correctable vision defects and visual acuity.

Cortically Blind Neurologically-based vision defect

The visual system is intact but the individual has sustained brain damage that prevents the brain from properly processing and interpreting the visual image and information taken in by the eye. The individual may have some useable or functional vision, including light perception and blink reflex.

Amblyopia Lazy eye

Amblyopia is identified by stereopsis testing and distance vision tests. It is a condition that if not discovered and treated before the age of six or seven usually leads to permanent reduction of vision in the affected eye. An eye with amblyopia has dimness of vision without any apparent disease of the eye. It is often caused when one eye turns in or out while the other sees straight (strabismus) so that a double image is sent to the brain. It may also be associated with a marked difference in the refractive error of each eye (anisometropia) resulting in two images. The brain solves this confusion by ignoring the message from one eye that gradually weakens through disuse. The usual treatment

is patching the good eye in order to force the use of the weaker one. Sometimes this is combined with glasses, surgery (for strabismus), medication, or eye exercises.

Anisometropia Unequal refraction of the two eyes

With anisometropia eyes may have myopia or hyperopia but of different degrees, or one may be myopic and the other hyperopic. Marked anisometropia is a common cause of amblyopia because the eye with the greater refractive error is ignored.

Astigmatism Eye refractive error problem

Astigmatism results in blurred vision because of the irregular or defective curvature of the cornea or the lens causing a distorted image because light rays cannot focus on a single point of the retina. If the astigmatic person looks at a figure consisting of straight lines radiating out from a center, the lines pointing in only one direction may be seen clearly while the lines radiating out in another direction are blurred. Astigmatism affects the vision at all distances. It may be associated with myopia or hyperopia. Most cases of astigmatism can be corrected with glasses or contact lenses.

Color Deficiency Inherited vision defect

Color deficiency is not a disease; it is characterized by the inability to recognize certain colors--primarily red or green, but rarely blue or yellow. Deficiency in this visual function is not correctable. It is important for students, parents, and teachers to be aware of this condition to help the student develop appropriate coping mechanisms. An estimated 5% of the population has defective color vision; 8% males and 0.5% of the females.

Hyperopia Farsightedness

Identified by near vision tests, hyperopia is a refractive error in which the light rays focus behind the retina, either because the eyeball is too short or the lens is too thin and flat and does not bend the light rays enough. The result is that students who are farsighted see better at a distance than close-up. This condition can be corrected with glasses or contact lenses.

Myopia Nearsightedness

Identified by distance vision tests, myopia is a refractive error in which the light rays are bent and focused in the front of the retina, either because the eyeball is too long or because the lens is too thick and curved so that it bends the rays too much. As a result, students who are nearsighted see better close-up than at distances. Myopia is usually first seen in children 6-8 years of age. It can be corrected with glasses or contact lenses.

Strabismus Squinting

Identified by ocular alignment and stereopsis testing, strabismus is the term used to describe eyes that are not straight or properly aligned due to a muscle imbalance. One eye, or sometimes both, may turn in or turn out. The various forms of strabismus are spoken of as tropias. Their direction is indicated by the appropriate prefix cyclotropia, desotropia, exotropia, hypertropia, hypotropia. Sometimes more than one of these conditions is present. The deviation may be constant or it may come and go. It may be present at birth or it may become apparent at a later age spontaneously. It might occur after an illness or accident. Strabismus may be due to birth injuries, heredity, faulty muscle attachments, excessive farsightedness, and illness with fever. It cannot be outgrown nor will it improve by itself. An eye deviation that persists without treatment may result in permanent visual impairment because the vision in one eye is suppressed causing amblyopia. Treatment directed toward straightening the eyes can involve glasses, patches, eye drops, surgery, eye exercise.

HEARING SCREENING

There are no requirements for hearing screening in New Mexico schools. The following guidelines are based on recommendations from the American Speech, Language and Hearing Association (<http://www.asha.org/aud/occupational.htm>) and the National Association of School Nurses (<http://www.nasn.org/Default.aspx?tabid=232>).

Oversight of hearing screening and follow-up in the schools should be provided by the PED-licensed school nurse. The purpose of hearing screening is to identify students who have hearing impairments that interfere with or have the potential for interfering with communication and learning processes. Authorities generally agree that early detection of medically remediable hearing loss helps to prevent related problems in speech, social and educational development.

The identification of hearing problems is accomplished by using individual pure-tone air-conduction testing. Acoustic immittance screening might also be considered if trained staff are available. A well-balanced program will include screening and rescreening threshold audiometry as well as referrals for audiological or medical evaluations. Students identified with hearing abnormalities should be followed on a regular basis to ensure that their communication, educational and medical needs are met. Education and habilitation planning and counseling for parents and teachers should be implemented.

Hearing Screening Procedures

Pure Tone Conduction Testing

Equipment

A pure tone audiometer, calibrated to published audiometric standards is required for reliable pure tone conduction testing. Audiometers are delicate electronic devices and can easily be damaged. The audiometer needs routine maintenance and accuracy checks by qualified technicians. All audiometers should be electroacoustically checked and serviced (returned to the factory if necessary) at least once a year and more often if a malfunction is suspected. Pure tones are described in terms of pitch or frequency. **Hertz (Hz) equals units that define frequency. Loudness is measured in decibels (dB).**

Target Population for Testing

Pre-school, kindergarten, first, third and eighth graders are the recommended target grades for pure tone conduction hearing screening as well as all other students referred for testing by teachers, parents, medical providers or other school personnel. In addition, all high risk students and new students with no documented evidence of prior hearing testing at the designated grade levels should be included. All students being referred for special education evaluation should be tested according to guidelines developed by the New Mexico Public Education Department.

TEST	Grades To Be Screened for Hearing												Special Education Evaluation	New Students	Symptoms/ History of Hearing Problem			
	Pk	K	1	2	3	4	5	6	7	8	9	10				11	12	

Pure-Tone Audiometry	X	X	X	O	X	O	O	O	O	X	O	O	O	O	X	X	X
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X = Screen

O = Screen if no previous records available

Screening Test

The **Sweep Test** is the preferred pure tone conduction hearing screening test. It is a screening measure whereby preselected frequencies are presented at predetermined levels, and the student is asked to give a response each time the tone is heard. The series of frequencies is presented first in the right ear and then in the left. Each student is tested individually. Time intervals between the presentation of each tone must vary for the screening results to be reliable.

The audiometric equipment should be checked before testing to verify that it is working properly. The test environment should be as quiet as possible. The recommended frequencies for sweep testing include **1000, 2000 and 4000 Hz presented at 20 dB**, using the following steps as procedural guidelines.

- 1) Set (intensity) hearing level dial at 20 dB.
- 2) Set audiometer on "reverse" or "tone off" so that the sound goes through the earphone only when the tester pushes the "tone switch".
- 3) Student should be positioned so that the tester's hand and eye movements cannot be observed.
- 4) Instruct student to raise hand when tone is heard; lower hand when tone disappears. Keep instructions simple. The student unable to raise a hand can respond by dropping a small object, such as a block, into a container. An oral response, "yes", is also acceptable.
- 5) Earphones should be placed on the student by the tester to assure proper fitting so that the earphone is centered over the ear canal. Care should be taken to prevent obstructing the ear canal or folding the ear.
- 6) Provide a sample tone of loud intensity, such as 200 Hz at 40 dB, to ensure that student understands what is meant by the word "tone".
- 7) Provide student opportunity to ask questions.
- 8) The suggested order of presenting tones is: 1000, 2000 and 4000 Hz.

The student fails the sweep test if one of the tested frequencies cannot be heard in one ear at the recommended decibel level. At this point an otoscopic exam should be performed. Signs of abnormalities, such as otitis media, tympanic perforation or cerumen impaction, warrant a medical referral. However, the student without any abnormalities on otoscopic exam should be scheduled for a repeat test at a later time; allow three weeks between screening tests. A second failure at pure tone conduction hearing screening warrants a medical referral.

Immittance Testing

Impedance audiometry (tympanometry and acoustic immittance) provides information about the middle ear. It is a valuable diagnostic tool but not usually included in hearing screening. This measure is optional in school screening programs, but should not be substituted for the pure tone audiometric testing. It may be used for the very young and difficult to screen students.

Rescreening and Referral Criteria

Audiometry screening results should be properly documented as pass/fail for each ear separately. Observational factors such as frequent earaches, draining ears, excessive cerumen, mouth breathing and decreased responsiveness in the classroom should all be considered when making a medical referral. The referral process should be initiated by discussing with the parents any observations of school personnel in addition to test results.

A referral form can be found at www.nmschoolhealthmanual.org/resources/forms.htm, Section III. The form should be accompanied by at least one audiogram showing abnormality, along with observations, history and explanation for referral. Any referral should be accompanied with a request that the school nurse receive a follow-up report to enhance anticipatory guidance efforts with parents and school staff that might be appropriate.

Ability to Hear Speech

How well an individual can hear the frequencies will reveal how well speech is heard. The overall speech range is 250-4000 Hz. In the spoken word, vowels are composed of frequencies from primarily 250 to 1000/1500 Hz. Consonants are composed of frequencies from primarily 1000/1500 to 4000 Hz, in addition to a few higher and lower frequencies. For example, if the student's audiogram shows good hearing in the low tones but not in the high tones, vowels will be heard but consonants will be missed.

Audiological Assessment

The evaluation report on a student who has been referred by the school nurse and tested by the audiologist will contain valuable information about the individual's ability to hear speech. Under controlled conditions, the student is tested on the ability to hear spoken words that are repeated to the audiologist. The evaluation report should contain results on speech reception threshold and a discrimination score.

Speech reception threshold (SRT) is stated in terms of decibels. It indicates the level of intensity (loudness) required to be able to hear and repeat correctly a certain quantity of specified words.

Discrimination score (articulation score) is stated in terms of percentage. It is the percentage of certain words heard correctly when speech is made louder. It is of special value in the selection of hearing aids. It can be helpful for the school nurse in estimating how clearly and distinctly speech is heard by the student when wearing a hearing aid.

Go to www.nmschoolhealthmanual.org/resources/forms.htm, Section III for the "*Familiar Sounds Audiogram*." This tool depicts the kinds of sounds heard at which decibels and hertz and is useful when explaining hearing results to parents and the student.

Signs and Symptoms of Hearing Problems

The classroom teacher plays an important role in recognizing and reporting students who show symptoms of possible hearing loss. The student who presents the following may experience difficulty in hearing and should be referred to the school nurse for further evaluation.

- **Physical Conditions**
 - Draining ears
 - Ears filled dried wax or crust from draining ears

Inflammation in or around the ear
Mouth breathing
Upper respiratory allergies
Cleft palate

- **Health History**

- Chronic colds
 - Chronic ear infections
 - Mastoiditis and meningitis
 - Neonatal history (low birth weight, prematurity, perinatal infections)

- **Complaints**

- Pain in or around ear
 - Ears “stopped up”
 - Ringing or buzzing in ears

- **Behaviors**

- Asks speaker to repeat
 - Turns head to side when listening
 - Leans forward when listening
 - Stares intently at speaker
 - Appears confused or bewildered when listening to speaker
 - Hears better when directly in front of speaker
 - Interrupts conversation (not aware that others are talking)
 - Has trouble with oral directions
 - Performs better on written work than oral work
 - Has poor diction and/or articulation
 - Withdraws from group activities when hearing is required
 - Doesn't pay attention - Some students may develop a habit of inattention even when hearing is normal; however, presence of inattention should not be dismissed, and the student should be given a hearing test.

Classroom Considerations for the Hearing Impaired Students

It is essential that the teacher understand a student's hearing problem and important to establish a feeling of acceptance for the hearing impaired student. It is also important that the teacher be alert for signs of improvement or deterioration in hearing and be willing to discuss these observations with the school nurse and/or parents.

Significance of Loss

The degree of difficulty the student experiences will depend upon the amount and type of hearing loss. Students who have trouble hearing speech sounds may be unable to follow directions. It is likely that they will make mistakes in spelling and will have difficulty producing some of the speech sounds correctly.

Students with severe hearing loss often experience difficulty listening. If the student has a hearing loss in only high tones, some of the sounds may be heard well and others poorly. Often high tone loss results in failure to hear the following speech sounds: Sh, Ch, Th, S, F, V and J.

Unilateral Hearing Loss

Hearing loss in one ear will create difficulty locating the direction from which the sound originated, particularly when there is loud background noise. Classroom noise may keep the student from hearing directions correctly. It is also important that the student with unilateral

hearing loss be reminded to take care when walking or playing in traffic areas or on the playground.

Hearing Aid Users

Hearing aid wearers may be distracted by environmental noise creating difficulty in following conversations in a group. In a classroom with a student wearing a hearing aid the teacher should understand the mechanics of the hearing device to ensure it is being effectively utilized and assist in trouble shooting with any problems.

Seating Considerations

- Bilateral hearing loss: Seat the student directly in front of the teacher.
- Unilateral hearing loss: Seat the student close to the instructor with the normal ear toward the source of instruction.

Speaker Awareness

- Patiently restate and rephrase when the student does not understand.
- Do not stand in a glare, such as a window.
- Face the student when speaking.
- When using a writing board, face the class when providing explanations.
- Speak slowly and distinctly.
- Speak naturally; do not exaggerate lip movements.
- Speaking too loudly may be especially disturbing to the hearing aid wearer.
- Use FM voice projection equipment if available.
- Use lapel microphones as appropriate if available.

Tips on Giving Directions

- Acquaint the student with any new vocabulary when a new topic is introduced.
- Get the student's attention before giving directions.
- Ensure that the student understands the directions.
- Encourage the student to request that directions be repeated if necessary.
- Provide opportunity for student to repeat directions.
- Use written directions if student has continued difficulty understanding.

Special Considerations

- Fatigue may be a factor because hearing impairment requires extra concentration to receive information.
- Language development may be challenging because many words and ideas have no meaning if the student is unable to hear the words. Encouraging the hearing impaired to do extra reading, spelling, creative writing, etc. may help compensate, but it is not uncommon for these students to exhibit delays in language development.

HEIGHT/WEIGHT/BMI MEASUREMENT

New Mexico has no requirements for height/weight/BMI **screening** of students enrolled in school in any grades. In addition, the NM Department of Health (DOH) Medical Oversight

Committee (MOC) **does not endorse** school-based BMI screening. However, it does state in a position paper that **surveillance** might be appropriate if done well, safeguards are in place, and if costs are considered. See www.nmschoolhealthmanual.org/resources/forms.htm, Section III for the entire MOC position statement released in January, 2010.

Body Mass Index (BMI)

Body mass index (BMI) is the ratio of weight to height squared and is often used to assess weight status because it is relatively easy to measure and it correlates with body fat. It can be calculated using the Centers for Disease Control and Prevention (CDC) Child and Teen BMI Calculator at <http://apps.nccd.cdc.gov/dnpabmi/> or by using the following formula.

$$\text{BMI} = \frac{\text{Weight (kg)}}{[\text{Height (m)}]^2}$$

After BMI is calculated it is plotted by age on a gender-specific growth chart to obtain an age and sex specific BMI percentile. See www.cdc.gov/growthcharts for the CDC's BMI-for-age growth charts for girls and boys aged 2-20 years.

Toolkit: Collecting Student BMI was developed by Alliance for a Healthier Generation and approved by the CDC as a toolkit for use in assessing student BMI for the purpose of surveillance or program evaluation. It does not include resources to implement a BMI screening program where BMI is recorded on individual students and reports sent to parents. See http://www.healthiergeneration.org/uploadedFiles/For_Schools/New_Builder_Pages/Toolkits/Policy/BMIToolkit.pdf for the complete toolkit.

BMI Surveillance

BMI surveillance programs assess the weight status of a specific population (e.g., students in an individual school, school district, or state) to identify the percentage of students potentially at risk for weight-related health problems. Data collected from surveillance are typically anonymous and may be used to identify population trends as well as monitor outcomes of interventions.

BMI Screening

BMI screening programs assess the weight status of individual students to identify those at risk and provide those students and their parents with information to help them take appropriate action. School-based BMI screening programs, like height-weight screening programs, have not been proven to be effective nor have they been proven to be cost-effective.

Safeguards for BMI Measurement

To reduce the risk of harming students, the CDC has identified a set of safeguards and recommends they be in place for any BMI measurement program.

- Introduce the program to school staff and community members and obtain parental consent.
- Train qualified staff, usually the school nurse, in administering the program.
- Protect student privacy.
- Obtain and use accurate measurement equipment.
- Accurately calculate and interpret data.
- Develop efficient data collection procedures.

- Avoid BMI results to evaluate student or teacher performance.
- Regularly evaluate the program and its intended outcomes and unintended consequences.

Evidence-based Strategies to Address Obesity in Children and Adolescents

Ten school-based policies and practices have been identified by the CDC to promote physical activity and healthy eating and are endorsed by the NM MOC. These have been identified as the school-based strategies most likely to improve obesity-related health behaviors of young people.

- 1) Address physical activity and nutrition through a Coordinated School Health Program (CSHP).
- 2) Designate a school health coordinator and maintain an active school health council.
- 3) Assess the school's health policies and programs and develop a plan for improvements.
- 4) Strengthen the school's nutrition and physical activity policies.
- 5) Implement a high-quality health promotion program for school staff.
- 6) Implement a high-quality course of study in health education.
- 7) Implement a high-quality course of study in physical education.
- 8) Increase opportunities for students to engage in physical activity.
- 9) Implement a quality school meals program.
- 10) Ensure that students have appealing, health choices in foods and beverages offered outside of the school meals program.

SCOLIOSIS SCREENING

As a result of literature review on recommendations for scoliosis screening and assessing priorities for the evolving role of school nurses, the following recommendations were issued by memorandum by the DOH Chief Medical Officer in 1995.

- Mass scoliosis screening should not be done in schools.
- Visual inspection of the back should always be performed by a medical provider when examination for other reasons takes place.
- Nurses who choose to do scoliosis screening based on special concerns of parents, school and community, should be properly trained and should establish a follow-up referral system for students with positive and/or suspicious findings.

STUDENT HEALTH ASSESSMENT

HEALTH HISTORY

The student health history provided by the parent/guardian of each student should include the following information.

- Medical diagnosis and medications
- Allergies
- History of hospitalization, surgeries, or accidents
- History of chronic middle ear infections and/or colds (more than 4 a year)
- Current immunization status
- Current medical and dental care providers
- With whom student actually lives

HEALTH RECORD

The school health record should contain the health history and any additional health information to assist with a nursing assessment of the health of each student. It is important that school personnel understand the confidential nature of this school health record. Written policies should govern who may have access to the records and where and how they should be stored. Information from the health record should not be released to outside agencies or individuals without written consent of the student's parents, with the exception of immunization records.

The administrator responsible for health services should determine with the health staff how records are to be used and who is responsible for recording data and keeping records up to date. The school nurse is usually responsible for maintaining the health records. Sample health record forms can be found at www.nmschoolhealthmanual.org/resources/forms.htm, Section III.

BLOOD PRESSURE PERCENTILES

There is no recommendation for blood pressure (BP) screening. Current BP tables show percentiles for systolic blood pressure and diastolic blood pressure according to height, sex and age. The 50th percentile provides the BP level at the midpoint of the normal range. The 95th percentile provides a BP level that defines hypertension; any student who consistently has BP that falls in this range should be referred for medical evaluation. Go to www.nhlbi.nih.gov/guidelines/hypertension/child_tbl.pdf for detailed BP tables for children.

Hypertensive emergencies occur rarely in children. Proper management of childhood hypertension depends on prompt recognition and treatment. Inadequate awareness of pediatric blood pressure (BP) norms, poor technique resulting in inaccurate measurements, or failure to obtain blood pressure measurements can prevent or delay recognition of this clinical condition.

BP Measurement Technique

It is important for the healthcare provider to measure blood pressure accurately, using the correct equipment and technique.

- BP should be measured after the child has been sitting in a quiet environment for a few minutes.

- Child should be seated with back and feet in a supported position. It may be necessary to measure the BP a few times (several minutes apart) to get the most accurate reading.
- BP should not be measured if the child is crying or unable to cooperate.
- An appropriate size cuff should be used.
- BP should be measured in the right arm.
- Stimulants such as cigarettes and caffeine should be avoided for several hours before BP is measured.

Defining Hypertension in Children

The following table provides some general guidelines for the school nurse when interpreting BP levels on students. This guide is provided only for a generalized interpretation of a BP reading in children and adolescents and should not be used as a definitive evaluation of BP status.

Guidelines for BP Interpretation in Youth		
Normal	89 th percentile or lower	Youth's BP is normal.
Pre-hypertension	90 th to 94 th percentile	Youth's BP is slightly elevated and may benefit from lifestyle changes that can lower BP.
Stage 1 Hypertension	95 th percentile up to 5 millimeters of mercury (mmHg) above the BP 99 th percentile	Youth has high BP. Treatment with lifestyle changes is recommended. Medication may be recommended if no positive results from lifestyle changes in 4-6 months.
Stage 2 Hypertension	5 mmHg or more above 99 th percentile	Youth has severe high BP. Medications will likely be recommended along with lifestyle changes.

SPECIAL EDUCATION ASSESSMENT

(Note: These guidelines for Special Education referrals are adapted from Albuquerque Public Schools.)

SPECIAL EDUCATION REFERRALS

The school nurse is responsible for health screenings for any referrals on students being evaluated or re-evaluated for Special Education. Developing a process for managing these referrals with Special Education staff will allow the evaluation to flow in a timely fashion for all parties involved. Using the referenced forms, the following guidelines are intended to assist the school nurse in organizing her/his role in the process to facilitate this happening.

General Guidelines

- The school nurse should be notified in a timely fashion of **ALL** students who are being referred to nursing services for initial evaluation or reevaluation for Special Education services.
- The school nurse should obtain parental consent to perform screenings and complete an assessment and Initial Student Health History interview on each individual referral.
- The school nurse should then complete an Initial Student Health History form and a Student Health Assessment form <http://www.nmschoolhealthmanual.org/resources/forms.htm>, Section III which includes vision and hearing screening results and a general health assessment. The screenings, assessment and health history should be completed within 10 school days after receiving the referral.
- When completing the Student Health Assessment form it is appropriate to utilize vision and hearing screening results that have been completed within the current school year rather than repeating them.
- At the discretion of the school nurse and based on student complaints or symptoms, a physical assessment may be performed and/or referral made to a medical provider for the assessment. Any school nurse concerns should be shared with parent/guardian with a request for follow up with a medical provider if appropriate. These concerns can be documented using the Sample Referral Form <http://www.nmschoolhealthmanual.org/resources/forms.htm>, Section III.
- **Health Assistants should not be authorized to complete health assessments** for Special Education referrals or reevaluations. However, they may **assist** the school nurse complete components of the assessments when appropriately trained and when requested to participate.

Initial Referral

- To obtain a complete medical history of the student, it is recommended that the Initial Student Health History be obtained from parent/guardian by the school nurse by telephone or in-person interview. If this is not possible, the Initial Student Health History form may be sent home with instructions to complete and return it so that screening may proceed.
- If attempts to obtain health history information are unsuccessful, documentation of this fact and any known health information may be entered on the Nurse Screening Assessment Summary form and returned to designated staff in the Special Education program.

- **While health history information is important, the inability to obtain it should not prevent educational testing from taking place in a timely manner.**
- All findings, recommendations and comments can be documented on the Nurse Screening Assessment Summary form and submitted to designated staff in the Special Education program with a copy to the student health file.
- Student Health Assessment forms and Initial Health History forms should always be a part of the student health file.

Re-evaluation Referral

- The school nurse should complete a Health History Review as indicated on page two of the Initial Student Health History form for all students referred for the routine 3-year re-evaluation.
- All findings, recommendations and comments can be documented on the Nurse Screening Assessment Summary form and submitted to designated staff in the Special Education program with a copy to the student health file.
- Student Health Assessment forms and Health History forms should always be a part of the student health file.

Gifted Program Referral

- For Gifted students the school nurse should complete health assessment and vision and hearing screening at his/her discretion on review of student's health records and previous screening results.
- Referrals on Gifted students identified with a disability are processed as routine Special Education referrals.

Speech and Language Pathology Referrals (SLP)

- For SLP referrals the school nurse should review the student health record and complete hearing screening if results on record are from screening in a prior school year.
- Any school nurse action on the SLP referral should be documented in the student health file and reported to the speech and language pathologist.

COMMUNICATION AND REFERRAL PROCESS

- Communication between the school nurse and appropriate special education staff and diagnosticians is the responsibility of all parties. At the beginning of each school year, the school nurse should discuss referral processing procedures with the special education staff in charge who will be providing the initial referrals for nursing assessment which should be at least 10 school days prior to diagnostic evaluation.
- At the beginning of each school year the school nurse should review all students who are scheduled for reevaluation during the school year and the date each reevaluation is due. This list is usually obtained from designated Special Education staff.
- Creating a plan to complete all referrals in a timely manner and creating good communication with Special Education staff should help streamline the referral process so that referrals come to the school nurse and are processed in a timely manner within the

school year. A school year starts at the beginning of the school year and runs to the beginning of the next school year, inclusive of summer months.

- Using a tracking form will help keep the referral process organized and on time in addition to having teachers and diagnosticians log in requests and submit referral forms appropriately to prevent confusion.

INDIVIDUAL EDUCATION PLANS (IEP)

Adding Services

- An IEP meeting is not necessary to request an evaluation for related services for a student already in Special Education.
- If the student qualifies for related services and an IEP meeting is scheduled, the school nurse need not attend if it is not an annual IEP and the related service is not nursing services.
- When a student is referred for evaluation by PT, OT, APE, Assistive Technology or any related service other than nursing services or speech and language pathology (SLP), the school nurse need not be involved and no additional assessments or health history information need be provided by the nurse.
- When a student is referred for an evaluation by SLP, the school nurse should review the student's health record and perform a hearing screening if one has not been done within the current school year. Failure to pass the hearing screening should result in a referral for Audiology evaluation with results being documented in the student health record and shared with the school speech and language pathologist.

Changing Existing Services

- To change or delete health services on an IEP an addendum may be added to the existing IEP and does not require a full formal IEP meeting with all staff.
- It is acceptable for the school nurse, Special Education representative and the parent to meet, discuss and make changes to the IEP regarding school health services.

Exiting Special Education Services

The school nurse is responsible for reviewing the student's health record and documenting any significant information on the Student Assessment Summary Sheet.

SCHOOL NURSE SCREENING PACKET CONTENT

Initial Evaluation Referral

- Student Health Assessment Form
- Initial Student Health History Form
- Special Education Nurse Screening Assessment Summary Form

3-year Re-evaluation Referral

- Student Health Assessment Form
- Health History Review Form
- Special Education Nurse Screening Assessment Summary Form

Gifted Re-evaluation Referral

- Student Health Assessment Form (if warranted)
- Health History Review
- Special Education Nurse Screening Assessment Summary

Speech & Language Referral

- Related Student Health History
- Hearing Screening Results for Current School Year
- Audiology Report (if applicable)

CHILD ABUSE AND NEGLECT

SCHOOL STAFF RESPONSIBILITIES

Child abuse and neglect are serious and widespread problems, but it can be interrupted and prevented. School personnel can play a key role in the identification and reporting of suspected child abuse.

The New Mexico Children's Code (32A-4-1 NMSA through 32A-4-34 NMSA) sometimes cited as the Abuse and Neglect Act, states that physicians, law enforcement officers, nurses, school personnel and others acting in official capacities who SUSPECT abuse must report it immediately to the local offices of the Children, Youth and Family Department (CYFD), Social Services Division in their respective communities or appropriate tribal social services offices. All certified school personnel, including school nurses, are required to complete training in the detection and reporting of child abuse and neglect during the person's first year of employment by a school district in New Mexico (22A-10-32 NMSA).

When a child discloses indicators discussed in the following pages, it does not prove conclusively that a child is abused or neglected. He/she may tell a story that seems difficult to believe, but the story should be taken seriously and the child's concerns explored. The presence of more than one indicator combined with other information warrants further assessment by CYFD. School employees do not need to substantiate abuse before reporting it to CYFD. They only need to **SUSPECT** it. In New Mexico the CYFD or appropriate tribal social service office investigates all reports of suspected child abuse or neglect.

REPORTING CHILD ABUSE/NEGLECT

CYFD maintains the NM Statewide Central Intake (SCI) system which is housed in Albuquerque for reporting suspected or known child abuse/neglect. It can be accessed state-wide through a hotline at 1-800-797-3260. Detailed information on reporting suspect abuse/neglect is available at <http://cyfd.org/node/26>.

Reports are more likely to result in appropriate action and/or investigation if the following information is available at the time the report is being made.

- Name of child, parent and legal guardian, address where child resides
- Age, sex, SS# of child
- Family composition, language spoken in home
- Location of the child at time of reporting
- Location where suspected abuse occurred
- Name and address of person alleged to be responsible for abuse/neglect
- Nature and extent of suspected abuse or neglect
- Names of other professionals in contact with child
- Past history of child/family
- Child's affect
- Any disability the victim may have
- History of domestic violence, substance abuse/mental illness, or criminal activity

PHYSICAL INDICATORS OF ABUSE

The following information is presented for reference for school health providers when concerns arise of child abuse (physical and sexual) and neglect. Keep in mind that some of the indicators and behaviors presented here are seen in children who are experiencing stress within their families. Family problems such as domestic violence, alcoholism, or parental absence may affect a child's physical and mental health. A key element in assessing the possibility of child abuse is checking to see if the child can offer a reasonable explanation for his/her behavior and/or physical findings. A history that is not consistent with injuries or observed behaviors is a key factor in deciding whether or not abuse has occurred.

Physical Abuse

When physical abuse occurs the signs are often visually evident but may go unnoticed and/or be considered normal for an active child. Here are some signs that may trigger suspected abuse for a health care provider.

- Bruises in various stages of healing
 - on the face, lips, mouth, torso, back, buttocks, thighs
 - forming a pattern/imprint reflecting the shape of the article that was used to inflict the mark on the body
 - on different skin surfaces of the body inconsistent with the history of the injury
 - regularly appearing bruises after absence, weekend, or vacation
- Burns for which the child has no explanation
 - classic cigar or cigarette burns on the soles, palms, back or buttocks
 - sock-like or glove-like intentional immersion burns on the extremities that may be doughnut shaped on buttocks or genitalia and spare creases of the body
 - intentional burns leaving a characteristic imprint pattern on the skin surface such as curling iron, electric burner, iron or heated objects
 - infected burns as result of delay in seeking treatment
- Deformities with accompanying swelling/pain suspicious of fractures/dislocations
 - commonly of extremities, skull, nose or facial structure
 - multiple fractures in various stages of healing revealed on medical evaluation
- Lacerations, abrasions, injuries or hair loss/bald patches on a child with no reasonable or consistent explanation offered
 - seen most often on the child's face, eyes, internal and external oral area, genitalia, buttocks, and anus
 - injuries in various stages of healing
 - circumferential ligature marks may be seen as the result of "rope burns" around the ankles, wrists and neck
 - hair loss usually in patches and potentially the result of forceful pulling

Sexual Abuse

Indicators of sexual abuse are more likely to be subtle and behavioral in nature; however, physical indicators of sexual abuse may include the following signs.

- New onset of difficulty walking or sitting

Bloody, stained, or inappropriately soiled underwear (leaves and dirt inside underwear but not present on outer clothing)

- Swelling, bruising, lacerations or bleeding in genital or anal area
- Pregnancy
- Pain or bleeding on urination
- Vaginal/penile discharge and/or odor
- Sexually transmitted infections (STIs)
- Poor sphincter tone (poor bowel or bladder control)

Neglect and Emotional Abuse

The effects on children of neglect and emotional abuse are long term and are more likely to manifest by chronic physical and mental ill health. The health care provider may observe any or all of the following neglect and emotional abuse signs and symptoms.

- Unattended physical problems and unmet medical needs of the child
- Underweight child or small stature for age with no known medical diagnosis to explain condition (failure to thrive)
- Normal intelligence but showing deficiencies in areas of intellectual and motor development
- Inappropriate care consistent with hunger, poor hygiene and unsuitable clothes for climate

BEHAVIORAL INDICATORS OF ABUSE

Behavioral indicators of abuse are nonspecific; the child who is experiencing sexual abuse may demonstrate the same behavior as a child who is experiencing emotional abuse. For example, sexual or emotional abuse of a five-year-old child may result in a behavior change such as “wetting his/her pants”.

The observer should keep in mind that a sudden change in behavior is more concerning than observation of a behavior which has always been present in that child. The observer should be aware that many factors can influence a child’s behavior. Family difficulties such as domestic violence, drug addiction, parental loss will also result in behavioral changes in a child.

Behavior indicators seen in children who may be abused or neglected might include emotional changes, school problems, inappropriate sexual behavior, signs of neglect.

Emotional Changes

- Withdrawal, depression or expression of suicidal thoughts (e.g., I want to die, I should just go away, I feel like killing myself)
- Child demonstrates anger by violent or self-abuse acts
- Child demonstrates unreasonable fearful reactions to normal circumstances (e.g., a child who is afraid to be alone in a room)
- Younger child demonstrates new clingy or irritable behavior (e.g., always wants to sit in the teacher’s lap or cries, becomes angry, lashes out with little provocation)

School Problems

- New onset of poor concentration or decreased attention span
- Consistently demonstrates fatigue or listlessness (e.g., falling asleep in class)

- Delinquent or anti-social behaviors (e.g., stealing, violence or threatened violence towards classmates)
- Truancy or frequent absences from class
- Dramatic change in academic achievement
- Unwillingness to change for or participate in physical education class
- Poor peer relationships/friendless (e.g., a child no one wants to play with)
- Demonstration of low self-esteem by behavior or statements
- Demonstration of regressive behavior (e.g., a 6 year old who now sucks her thumb, refuses to eat unless fed, and talks “baby talk”)
- Demonstration of fear of a specific person or situation or new onset of withdrawal (e.g. a child who previously went gladly with a caretaker now resists vigorously)
- Extension of stay at school with early arrival and late departure (e.g. abuse occurs at home and child is fearful to return)

Inappropriate Sexual Behavior

- Inappropriate displays or seeking of “affection” (e.g., attempts french kissing with teacher, sexually provocative dress or manner for developmental level)
- Demonstration of sophisticated, precocious knowledge of sex acts by engaging others in sexual acts (e.g. attempts oral sex on other children or inserts objects in another child’s anus or vagina)
- Inappropriate compulsive masturbation to the exclusion of other enjoyable activities
- Masturbation in a manner that could cause injury (e.g. inserts objects in vagina or anus)

Evidence of Neglect

- Begging for or stealing food at school
- Lack of appropriate supervision outside of school
 - child is alone for extended periods of time inappropriate to developmental level
 - child makes statements indicating no caretaker in the home
- Untreated medical condition (e.g. untreated seizures, asthma, ADD, ADHD, or diabetes)

FOLLOW-UP ON REPORTING

Any verbal statement from a child that he/she has been sexually or physically assaulted in any way constitutes suspicion of abuse and must be reported.

Collaboration between the schools and social services is strongly encouraged to maintain reliability and continuity of care. The school nurse can establish a working relationship with the local social service agency by contact and follow up with the assigned social worker/case manager. Consideration should be given to regular meetings with school nurses, other school staff and social services staff to establish and maintain an ongoing rapport.

SCHOOL SPORTS PHYSICAL

INTRODUCTION

Identifying local health care professionals who can legally perform sports physicals that are acceptable under the various regulating bodies is an issue for some school districts because of the limited availability of providers. The following information is offered to assist school staff in identifying the categories of health care professionals who have appropriate credentials to perform sports physicals for students.

GUIDELINES*

- For participation outside of the school day, a student must be physically fit and have a current certificate of examination on file with the school for any participation in organized sports outside of the school day. This requirement also applies to cheer/drill participants.
- The New Mexico Activities Association (NMAA) eligibility bylaws state that a student's fitness to participate in sports must be based on a physical examination and verified in writing, to the extent authorized by his/her practice act and licensing authority, by a practitioner from one of the following categories of medical professionals.
 - Medical Doctor, (MD)
 - Doctor of Osteopathy (DO)
 - Nurse Practitioner (NP)
 - Physician's Assistant (PA)
- By State Education Agency regulations, a student's fitness may also be verified in writing by a licensed chiropractic physician to the extent authorized by his/her practice act and licensing authority.
- Based on review of best practices for screening students for participation in athletic activities, the Medical Examination for Participation in Interscholastic Athletics form is recommended by NMAA. This form was developed by a committee of providers representing a wide variety of healthcare interests and national health organizations. It can be accessed at <http://www.nmschoolhealthmanual.org/resources/forms.htm>, Section III.

* Adapted from the NMAA Handbook eligibility bylaws Section 6.12.