Conducting Health Assessments

Overview

Process. Health assessment consists of day-to-day health encounters, planned and unplanned, that school health personnel have with students and staff; population-based screening programs; and routine physical examinations. A comprehensive health assessment process involves:

- School health personnel collecting subjective and objective data related to the student's health and illness behaviors.
- Analyzing the data for accuracy and completeness.
- Collecting more data as needed.
- Analyzing the information for identification of student health risks, problems, and potential stressors.

Student Health Encounters. Students present a range of complaints, from potentially life-threatening situations to more common problems, such as colds and coughs. Students also seek advice, support, or just time out from stress in both the classroom and at home. Although most students go to the health room, informal encounters may occur in any number of locations in the school; for example, a student interacts with a school nurse in the hallway, cafeteria, or playground; a teacher stops the school nurse in the hallway to refer a student; or a school nurse conducts a follow-up visit with a student in the hallway or some other place in the school (following the student's visit to the health room).

School nurses are frequently assigned to cover more than one school, and as such, they are not always readily accessible to students. Often a teacher, health aide, or school secretary is the initial person to see the student, so it is important for them to understand the parameters of a school health encounter and what types of questions should be asked to assist licensed health personnel in making an assessment. Making a health assessment remains the responsibility of the school nurse or other fully qualified and licensed health care professional.

History of the Complaint. When assessing a student, the school nurse needs to obtain subjective data about the complaint or the history of the complaint. The initial person seeing the student must skillfully explore the presenting symptom by analyzing the complaint. Information on the location, frequency, duration and severity, quality, quantity, setting, associated symptoms, and factors that make the symptom better or worse will guide the action taken, including referral to a health care provider, observation in the health office, and/or notifying parents.

Health History. The health history provides additional subjective data as part of the assessment process. School health personnel should ask open-ended questions that encourage a student to describe the problem. It is important to encourage discussion around different areas of the student's life (e.g., home, work, and school), especially if the problem seems to be chronic. For today's student, especially the adolescent, a psychosocial review of systems is as important as the physical examination. A brief psychosocial assessment, including asking questions about any risk behaviors the student may be engaged in, may include the following questions.

- "Tell me about it."
- "When did it start?"
- "Has it ever happened before?"
- "What did you do?"
- "Did you tell your parents?"
- "What did they do?"
- "Are you taking any medication?"
- "Are you having problems in your classes?"
- "What class do you have now?"

Questions may focus on the following categories: home life, food, activities, shelter, supervision, health care, and support systems. (Note: Chronic reoccurring symptoms may be associated with psychosocial problems, such as abuse.) The school nurse should be aware of different cultural, ethnic, or socioeconomic backgrounds of students. (Note: The web site School Health * Culture Zone provides cultural resources for school nurses. The address is http://courses.international.edu/bc680/nmcgahn/)

Physical Assessment. Assessment also includes objective data or a physical assessment. The person assessing the student obtains information about signs of an illness (e.g., vital signs) and takes appropriate measures, such as having the student rest in the health room and either returning to class or calling parents if the student is to be sent home, suggesting any follow-up with the student's health care provider, or calling emergency services.

Resources

American Academy of Pediatrics (1991). Policy Statement. School Health Assessments (RE9221). *Pediatrics, 88* (3), pp. 649-651.

Subsection

The following subsections identify and explain traditional individual student health assessments that are encountered by health care providers in the school environment.

- Four Common Encounters in the School Health Office
- Health Information Form Requirements
- School Entrance Physical Examination Requirements
- Immunization Requirements
- Athletic Pre-Participation Physical Examination Requirements
- Vocational/Technical Medical Assessment

Four Common Health Conditions Encountered in the School Health Office

The four most frequent conditions encountered in the school health office are (1) headaches, (2) sore throat, (3) abdominal pain, and (4) general malaise. The focus of this subsection is on the initial stage of assessment and does not include medical management. The following four examples of encounters were contributed by Simmons College Graduate Program in Primary Health Care Nursing and represent some suggested processes in assessing students. These guidelines are based on current practice and the clinical experience of contributors. If any of these symptoms are brought to the attention of an untrained school staff member, that staff member should refer the student to the appropriate licensed health professional (i.e., registered nurse, school physician, or licensed nurse practitioner).

Headaches

Headaches can be classified as acute, chronic, and recurrent. Acute headaches are of recent onset and frequently are associated with infectious illnesses, such as colds and influenza. Chronic and recurrent headaches may be associated with stress and tension, migraines, or potentially serious medical problems, such as sinusitis, dental problems, concussion, or brain lesion. Up to 20 percent of all school-age children experience frequent, recurrent headaches.

The following list of key questions and key physical examination components are commonly used to obtain subjective and objective information when assessing the student who complains of a headache.

Headache: Questions (Subjective Data)

Question	Action
1. Name and age of student?	Obtain health record.
2. Has there been any recent head injury?	Examine the student's head for evidence of lacerations, bleeding, bumps, or bruises.
3. Where is the location of the headache? What is the severity? How long has the headache persisted?	Any headaches that are characterized as severe, unilateral, or have persisted beyond 12 hours should be evaluated by a licensed health professional immediately.
4. Are there any associated symptoms: vomiting, stiff neck, difficulty with vision, drowsiness, recent behavior, or personality changes?	If positive, the student should be seen by a licensed health professional immediately. These symptoms can be associated with a life-threatening infection, such as meningitis.

Headache: Questions (Subjective Data)

Question	Action
5. Does the student have any other serious chronic medical disorders?	If positive, there may be an association. The student should be evaluated by a licensed health professional that same day.
6. How often does the student get headaches? What has made them feel worse or better?	There may be certain measures the student can take to treat the headache: lie down and rest, take acetaminophen, and apply a cool washcloth to forehead. Medication may require an authorized prescriber's order and parental consent depending on state laws and school policy.
7. Is the student feeling ill in any other way: sore throat, stomachache, chills?	Headaches can be associated with common infectious illnesses, such as colds, strep, pharyngitis, or flu. The student should be seen by a licensed health professional that same day for appropriate testing, diagnosis, and treatment.
8. Has the student eaten recently?	Headaches may be associated with hypoglycemia.

Headache: Physical Examination Components (Objective Data)

Action	Plan
1. Check the temperature. 2. Neck: Is there tenderness or pain on motion? 3. Eyes: Are the pupils equal in size? 4. Head: Are there any lacerations, bleeding, bumps, or bruises?	If temperature is elevated or if there is tenderness or pain on motion of neck, inequality of pupils, or evidence of head trauma, the student needs to be evaluated by a licensed health professional immediately.

Headaches: Potential Causes

Assessment	Plan
1. Acute onset headache.	This may be associated with infectious illnesses, such as strep throat, colds, or influenza.
2. Acute recurrent headache.	This may be migrainous. A student who presents with a severe headache should be sent home to be evaluated by their health care provider.

Headaches: Potential Causes

Assessment	Plan
3. Chronic non-progressive headache (as a result of tension or stress).	This may cause dull, constant pain, commonly located around the forehead and temporal area. The student can often alleviate the pain with rest, dim lighting, a cool washcloth, and non-aspirin pain reliever. Medication may require an authorized prescriber's order and parental consent depending on state law and school policy.

Sore Throat (Pharyngitis)

Infections of the throat may be caused by either viruses or bacteria, but the vast majority of infections are viral. Because it is not possible to know whether the infection is viral or bacterial by inspection, a referral for a throat culture may be necessary in order to identify an infection caused by bacteria, such as *Streptococcus*. An untreated streptococcal sore throat can lead to serious complications, such as rheumatic fever or nephritis. About 10 to 20 percent of children who present with sore throat have a *Streptococcus* infection (strep throat) as the cause of their pharyngitis. The typical incubation period for strep throat is one to three days. Viral infections of the throat usually last three to four days as part of a cold or upper respiratory infection.

The following list of key questions and key physical examination components are commonly used to obtain subjective and objective information when assessing the student who complains of a sore throat.

Sore Throat: Questions (Subjective Data)

Question	Action
1. Name and age of student?	Obtain health record.
2. How long has the sore throat been present? How severe is the discomfort?	Any sore throat that is characterized as very painful or has been present beyond 24 hours should be evaluated by a licensed health professional that same day.
3. Are there any associated symptoms, such as cold, cough?	Sore throat associated with upper respiratory symptoms is likely to be caused by a virus.
4. Does the student have the following symptoms: headache, rash, chills, or abdominal pain?	Sore throat associated with these symptoms is more likely to be caused by bacteria.

Sore Throat: Questions (Subjective Data)

Question	Action
5. Has the student had many sore throats or strep infections in the past?	If positive, the student should have a throat culture in order to rule out strep throat, a potentially serious infection.
6. Does the student have any serious chronic medical disorder, such as kidney disease, diabetes, or congenital heart disease?	If positive, the student should be evaluated by a licensed health professional that same day.
7. Has the student had recent contact with anyone who has had strep throat or impetigo (i.e., skin infection caused by *Streptococcus)*?	Sore throat following a recent contact with someone who had strep throat or impetigo warrants a throat culture in order to rule out *Streptococcus* as a cause of the pharyngitis.

Sore Throat: Physical Examination Components (Objective Data)

Action	Plan
1. Check the temperature. 2. Neck: Are the glands in the neck swollen and/or tender? 3. Mouth: Does the throat appear red? Are the tonsils enlarged? Is pus or exudate present on the throat or tonsils?	If positive for elevated temperature and enlarged and tender glands with a red and pus-like throat, the student needs to be evaluated by a licensed health professional.

Sore Throat: Potential Causes

Assessment	Plan
1. Viral infections.	If there is no rash, fever, difficulty swallowing, swollen or tender glands, abdominal pain, or headache, the student most likely has a viral infection. The symptoms may be alleviated by taking a non-aspirin pain reliever, gargling with weak, warm salt water, and drinking some fluids. Medication may require an authorized prescriber's order and parental consent depending on state law and school policy.
2. Bacterial infections.	Sore throat associated with such symptoms as fever, difficulty swallowing, swollen and tender glands, abdominal pain, rash, or headache is more likely to be caused by bacterial infections. The student needs to have a throat culture performed. Usually the results are available within 24 to 48 hours. If positive, the student should be placed on antibiotics by the student's primary care provider. Students are considered not contagious after 24 hours of antibiotic therapy.

Abdominal Pain

Abdominal pain, usually classified as acute or recurrent, is a difficult complaint to assess. It can indicate a condition, such as appendicitis, that may require surgery. Other non-abdominal conditions (such as urinary tract infections or pneumonia) can also mimic acute or serious abdominal problems, such as appendicitis.

Recurrent abdominal pain is also a challenge to diagnose since the student usually appears healthy but is complaining of severe pain. Chronic abdominal pain is classified as three or more episodes severe enough to interfere with activity occurring over a three-month period or longer. The etiology is usually unknown but may be psychosomatic in origin and associated with stress at home or in the classroom.

The true incidence of an acute abdominal pain caused by appendicitis is estimated at between 7 and 12 percent; 10 to 12 percent of school-age children are affected by recurrent or chronic abdominal pain.

The following list of key questions and key physical examination components are commonly used to obtain subjective and objective information when assessing the student who complains of abdominal pain.

Abdominal Pain: Questions (Subjective Data)

Question	Action
1. Name and age of student?	Obtain school health record.
2. Analyze the symptom. Ask the student to describe the pain, frequency, location, duration, if it radiates, and what makes it better or worse.	Inspect the area for any obvious recent injury. If pain appears severe and is interfering with activities, the student should be referred to a licensed health professional immediately.
3. Is this a new complaint? If not, how many times has the student complained of this?	If this is a common complaint for this student, it may be indicative of stress-related illness and the student could stay in school.
4. Does the student have associated symptoms, such as nausea, vomiting, diarrhea, constipation, decreased appetite?	If positive, these symptoms may indicate a viral infection but also may be indicative of an acute abdominal condition. Consult a licensed health professional immediately.
5. For girls: Is it associated with frequency or burning on urination? Is it associated with menses?	Urinary tract or vaginal infections need to be diagnosed and treated by a licensed health professional. If positive for the onset of menstrual period, rest, over-the-counter pain reliever (per school protocol or licensed prescriber's order, both with parental consent), and heat may be used to decrease pain and discomfort.

Abdominal Pain: Physical Examination Components (Objective Data)

Action	Plan
1. Check temperature and blood pressure. 2. Abdomen: Is pain localized? Does it radiate? Any signs of injury? 3. Is student pale? Sweaty? 4. Is mobility or activity severely restricted?	If positive for temperature and other signs of severe pain, the student needs to be referred immediately to a licensed health professional to rule out appendicitis or other emergency condition.

Abdominal Pain: Potential Causes

Assessment	Plan
1. Acute abdominal pain.	Appendicitis is the most common cause of acute abdominal pain.
2. Recurrent abdominal pain.	Recurrent pain is associated with urinary tract infection, constipation, gastrointestinal viral infections, stress, and gynecological problems.

General Malaise: "I Don't Feel Well"

This complaint, frequently heard in school health offices, is vague and nonspecific and can indicate a wide variety of problems, from specific physical problems to psychosomatic or stress-related problems.

School personnel need to obtain accurate information, since this complaint may not be the real reason the student is in the health office. The student may be using this complaint as a means of communicating an underlying problem to the school nurse or other school personnel. This assessment demands a thorough, skillful, and sensitive interview.

The following list of key questions and key physical examination components are commonly used to obtain subjective and objective information when assessing the student who complains of a general malaise.

General Malaise: Questions (Subjective Data)

Question	Action
1. The most efficient way to collect information of a physical nature is to review the body systems. This includes a review of past and present illnesses and usually proceeds head to toe.	Differentiate between physical and psychological etiology.
2. Ask general questions: "Are you having any pain anywhere? Have you been sleeping? Any nausea, vomiting, diarrhea?"	If positive, follow up with more complete information on specific area.
3. Questions concerning family, home, school, and peers need to be open-ended and sensitive. "Has anything changed at home? How is school going?"	If positive, student might just need some "time out" in health office. Assess for further referral for counseling.

General Malaise: Physical Examination Components (Objective Data)

Action	Plan
1. Check temperature.	If positive, this may indicate nonspecific viral or bacterial disease. Refine assessment and refer for further evaluation.

General Malaise: Potential Causes

Assessment	Plan
1. Organic cause.	Vague, nonspecific complaints can still be indicative of physical injuries and illnesses. These need to be ruled out by careful history and data collection before the assumption is made that the complaint is stress related.
2. Psychosomatic or stress related.	Stress-related illness and chronic complaints warrant follow up and counseling by school guidance counselors, or referral to community services.

Note: See sample school health encounter forms in Appendix E.

Health Information Form Requirements

Authorization

***Code of Virginia*, Section 22.1-270, Preschool Physical Examinations, I.** The *Code of Virginia* requires that parents or guardians of entering students shall complete a health information form, which is developed by the Departments of Education and Health or which is developed by school divisions and approved by the Superintendent of Public Instruction.

Excerpt: See Appendix A for *Code of Virginia*, § 22.1-270, I.

SUPTS. MEMO. SUPTS. MEMO. No. 22, February 5, 1999, Subject: School Health Form HPE-h12. (See Appendix A for a copy of SUPTS. MEMO.)

Excerpt:

The following form has been deleted: Form HPE-h12, THE SCHOOL ENTRANCE HEALTH INFORMATION FORM (DATED DECEMBER 1983). The information on that form is provided on the School Entrance Physical Examination and Immunization Certification, (MCH 213C) dated October 1991.

Recommendation

Referral and Follow-Up Process. Any issues noted on the health information form may require referral or follow-up activities. The school nurse who is responsible should:

- Review the completed health information form.
- Identify health issues.
- Provide appropriate referrals and follow up.
- Collaborate with parents and appropriate health care providers to ensure linkages between the school, home, and community.

Documentation

Health Information Form. The following "health information forms" are approved by the Superintendent of Public Instruction (school divisions can develop their own form, but it must be approved by the Superintendent of Public Instruction). (See *Code of Virginia*, § 22.1-270, I.)

- School Entrance Physical Examination and Immunization Certification: Part I – Health Information Section (MCH-213 C, Rev. 10/91).

  - School Entrance Health Form: Part I – Health Information Form (MCH-213 D, Rev. 1/99).

    Note: The School Entrance Health Form (MCH-213 D, Rev. 1/99) should be used beginning with school year 1999-2000, as the form becomes available.

New Form: School Entrance Health Form (MCH-213 D). At the time of development of this manual, the School Entrance Physical Examination and Immunization Certification form (MCH-213 C, Rev. 10/91) was being revised. The revised form, entitled School Entrance Health Form (MCH-213 D, Rev. 1/99), is to be used for school year 1999-2000—when form becomes available—for health information, comprehensive physical examination, and immunization reporting requirements as required by the *Code of Virginia*. The following is a summary of the revised form (MCH-213 D, Rev. 1/99).

- **Part I - Health Information Form**

  Replaces Health Information Form (HPE-h12 12/83), as required by the *Code of Virginia* § 22.1-270, I, Preschool physical examinations.

- ***Part II – Comprehensive Physical Examination Report***

  Replaces School Entrance Physical Examination and Immunization Certification—Part I and Part II (MCH-213 C, Rev. 10/91), as required by the Code of Virginia *§ 22.1-270, A – H, Preschool physical examinations.*

- ***Part III – Certification of Immunization***

  Replaces the School Entrance Physical Examination and Immunization Certification—Part III (MCH-213 C, Rev. 10/91), as required by the Code of Virginia *§ 22.1-271.2, Immunization requirements.*

Copy of Forms. *See Appendix D for a copy of the following forms:*

- *School Entrance Physical Examination and Immunization Certification (MCH-213 C, Rev. 10/91).*
- School Entrance Health Form: *Health Information Form / Comprehensive Physical Examination Report / Certification of Immunization* (MCH-213 D, Rev. 1/99).

School Entrance Physical Examination Requirements

Authorization

***Code of Virginia*, Section 22.1-270, Preschool Physical Examinations, A. - H.** The *Code of Virginia* requires that no pupil shall be admitted for the first time to any public kindergarten or elementary school in a school division unless such pupil shall furnish, prior to admission, (i) a report from a qualified licensed physician of a comprehensive physical examination of a scope prescribed by the State Health Commissioner performed no earlier than 12 months prior to the date such pupil first enters such public kindergarten or elementary school or (ii) records establishing that such pupil furnished such report upon prior admission to another school or school division and providing the information contained in such report. Such physical examination shall not be required of any child whose parent or guardian shall object on religious grounds and who shows no visual evidence of sickness, provided that such parent or guardian shall state in writing that, to the best of his knowledge, such child is in good health and free from any communicable or contagious disease.

Excerpt: See Appendix A for *Code of Virginia* § 22.1-270. A. -H.

Notes: The term "elementary school" is not defined by the *Code of Virginia*, § 22.1-270, for the purpose of the school entrance physical examination. However, *Regulations Establishing Standards for Accrediting Public Schools in Virginia*, (8VAC 20-131-10 et.seq.), Virginia Department of Education, (adopted by the Board of Education, September 1997) refers to schools with grades K-5 as elementary schools, grades 6 to 8 as middle schools, and grades 9 to 12 as secondary schools.

SUPT. MEMO. SUPTS. MEMO. No. 21, January 29, 1993, Subject: Legally Permissible Activities of Licensed Nurse Practitioners. (See Appendix A for copy of SUPTS. MEMO.)

Excerpt:

> *The attached letter from the Virginia Commissioner of Health contains information about* [December 10, 1992] *legally permissible activities of licensed nurse practitioners under the regulations of the state Boards of Medicine and Nursing.*
>
> *For example, LNPs may substitute for licensed physicians in such matters as the routine physical examinations required for school entrance, participation in sports, and eligibility for other services such as homebound instruction for pregnant students.*

HEALTH COMMISSIONER LETTER. Letter from State Health Commission to Superintendent of Public Instruction, December 10, 1992: Licensed Nurse Practitioners. (See Appendix A for copy of State Health Commissioner's Letter.)

Excerpt:

> *The Virginia Department of Health interprets the code section 22.1-270 that requires the report of a preschool physical examination signed by a "qualified licensed physician" allows the report to be signed by a LNP* [licensed nurse practitioner].

Overview

A periodic physical examination is critically important for all children and adolescents and especially for those children who do not have primary care providers and ongoing monitoring of their growth and development. The physical examination is crucial for preventive, diagnostic, or corrective purposes. The objectives of a physical examination are to understand and follow up on health conditions that may adversely affect the student's well-being and ability to learn. While it is understood that the primary responsibility for a student's health care rests with the family, the school is responsible for the safety and well-being of students while they are in the school setting. Therefore, the family and the schools are in a partnership when it comes to the physical well-being of a child entrusted to the school division. Adequate and appropriate follow-up intervention is necessary to ensure that all school children have a periodic physical examination.

Recommendation

Procedure and Personnel. In some cases the physical examination may be performed at school. Physical examinations completed in school should be done in the presence of a third person (usually the school nurse), in a private setting, and with sufficient time allotted for an appraisal of both physical and mental health. Line-up examinations are inappropriate because they are insensitive to the individual's right to privacy and confidentiality.

Parents should be present, if possible. If the parent is present at the time of the physical examination, they should be apprised of all findings concerning the child's growth and development and the findings of the health appraisal. When the parent is not present written notification of the health care provider's findings is necessary.

Referral and Follow-Up Process. Any issues noted during the physical examination may require referral or follow-up activities. The school nurse should:

- Review the completed school entrance physical examination report.
- Identify health issues.
- Provide appropriate referrals and follow-up interventions.

- Collaborate with parents and appropriate health care providers to ensure linkages between the school home and community.

Documentation.

School Entrance Physical Examination Form. The following forms constitute the "scope" of a comprehensive physical examination prescribed by the State Health Commission. (See *Code of Virginia*, § 22.1-270, A. -H.)

- School Entrance Physical Examination and Immunization Certification: Part II – Certification of School Health Examination (MCH-213 C, Rev. 10/91).

- School Entrance Health Form: Part II – Comprehensive Physical Examination Report (MCH-213 D, Rev. 1/99).

  Note: The School Entrance Health Form (MCH-213 D, Rev. 1/99) should be used beginning with school year 1999-2000, as the form becomes available.

New Form: School Entrance Health Form (MCH-213 D). At the time of development of this manual, the School Entrance Physical Examination and Immunization Certification form (MCH-213 C, Rev. 10/91) was being revised. The revised form, entitled School Entrance Health Form (MCH-213 D, Rev. 1/99), is to be for school year 1999-2000—when the form becomes available—for health information, comprehensive physical examination, and immunization reporting requirements as required by the *Code of Virginia*. The following is a summary of the revised form (MCH-213 D, Rev. 1/99).

- **Part I - Health Information Form**

  Replaces Health Information Form (HPE-h12 12/83), as required by the *Code of Virginia* § 22.1-270, I, Preschool physical examinations.

- ***Part II – Comprehensive Physical Examination Report***

  *Replaces School Entrance Physical Examination and Immunization Certification—Part I and Part II (MCH-213 C, Rev. 10/91), as required by th*e Code of Virginia *§ 22.1-270, A – H, Preschool physical examinations.*

- ***Part III – Certification of Immunization***

  Replaces the School Entrance Physical Examination and Immunization Certification—Part III (MCH-213 C, Rev. 10/91), as required by the Code of Virginia *§ 22.1-271.2, Immunization requirements.*

Copy of Forms. *See Appendix D for a copy of the following forms:*

- *School Entrance Physical Examination and Immunization Certification (MCH-213 C, Rev. 10/91).*

- *School Entrance Health Form:* Health Information Form / Comprehensive Physical Examination Report / Certification of Immunization *(MCH-213 D, Rev. 1/99).*

Immunization Requirements

Authorization

***Code of Virginia*, Section 22.1-271.2, Immunization Requirements.** The *Code of Virginia* requires that no student shall be admitted by a school unless at the time of admission the student or his parent or guardian submits documentary proof of immunization to the admitting official of the school or unless the student is exempted from immunization pursuant to subsection C.

Excerpt: See Appendix A for *Code of Virginia*, § 22.1-271.2, A. - G.

***Code of Virginia*, Section 22.1-271.1, Definitions (for Immunization Requirements).** The *Code of Virginia*, for the purpose of § 22.1-271.2, defines the following terms: "admit" or "admission," "admitting official," "documentary proof," "student," "immunized" or "immunization," and "school."

Excerpt: See Appendix A for *Code of Virginia* § 22.1-271.1.

***Code of Virginia*, Section 32.1-46, Immunization of Children Against Certain Diseases; Authority to Share Immunization Records.**

Excerpt: See Appendix A for *Code of Virginia* § 32.1-46.

***Code of Virginia*, Section 32.1-47, Exclusion From School of Children Not Immunized.**

Excerpt: See Appendix A for *Code of Virginia* § 32.1-47.

Minimum Requirements

Commonwealth of Virginia, State Board of Health: Regulations for the Immunization of School Children, Virginia Department of Health, Bureau of Immunization, August 1, 1995, defines immunization requirements for students attending school.

The *Code of Virginia,* §22.1-271.2, mandates the immunization requirements for all children attending school and licensed day care in Virginia. Section 3.00 of the Rules and Regulations for the Immunization of School Children [75] details the minimum immunization requirements outlined by the State Board of Health for school attendance. (See the Appendix A for copy of this schedule)

[75] Virginia Department of Health, Bureau of Immunizations. (1995). *Commonwealth of Virginia, State Board of Health: Regulations for Immunizations of School Children.* Richmond, Va.: Author.

The *Code of Virginia,* § 32.1-46, currently requires students to be vaccinated against polio, diphtheria, tetanus, pertussis, measles, mumps, rubella, hepatitis B (for children born on or after January 1, 1994), and Haemophilus influenzae type B (for children through 30 months of age). Immunization requirements are revised periodically to reflect the most recent recommendations of the Advisory Committee on Immunization Practices (ACIP) and the American Academy of Pediatrics (AAP). The regulations for Virginia are revised as needed in accordance with these recommendations. The Virginia Department of Health, Division of Immunization, can provide the most current recommendations. (See Appendix A for the Recommended Childhood Immunization Schedule, United States, January-December 1998 approved by the Advisory Committee of Immunization Practices [ACIP], the American Academy of Pediatrics [AAP], and the American Academy of Family Physicians [AAFP].)

Note. New legislation effective July 1, 1999:

- **Varicella.** Students born on or after January 1, 1997 are required to receive immunization against varicella zoster (chicken pox), not earlier than 12 months of age. Students who have evidence of immunity as demonstrated by laboratory confirmation of immunity or a reliable medical history of the disease are exempt from the requirement.

- **Hepatitis B for sixth graders.** Beginning July 1, 2001, all children who have not received three doses of hepatitis B vaccine will be required to receive such immunization prior to entering the 6th grade.

Exceptions

The *Code of Virginia*, §22.1-271.2, provides for exemptions from immunization requirements for religious and medical reasons, responsibilities of admitting officials to insure the immunization status of students, for the exclusion of students who are not in compliance with the immunization requirements, and responsibilities related to documentation of immunizations.

Medical Exemptions. Medical exemptions are issued for a child with a medical contraindication to one or more vaccines. The parent or guardian must present a statement on the MCH-213 form from a licensed health professional or local health department official that the physical condition of the child is such that the administration of one or more of the required immunizing agents is contraindicated and whether the condition is permanent or temporary.

Religious Exemptions. Religious exemptions are issued to a child's parent/guardian by signing the Certificate of Religious Exemption form (Form CRE-1), an affidavit which must be notarized. If the parent maintains the need to continue the religious exemption during a documented school health emergency, the student will be excluded from school for his or her protection until the emergency is concluded.

Recommendation

Procedure and Personnel. To assure immunization compliance in assigned school(s), the school nurse should:

- Establish a system of documenting immunization compliance on the School Health Record.

- Issue special exemptions as the principal's designated official. To accomplish this, the school nurse should:

    1. Issue special exemption certificates.
    2. Maintain tickler file on all special exemption certificates issued.
    3. Monitor status to assure legal compliance with the immunization law.
    4. Document status on receipt of valid Certificate of Immunization.
    5. Report to principal any students who fail to provide required documentation and must be suspended from school until this requirement is met.

- Maintain liaison with state health department immunization representative.

Referral and Follow-Up Process. Representatives of the Virginia Department of Health are authorized to audit school records to insure compliance with the regulation. (A minimum of 10 percent of the state's public schools are selected from a random sample for annual audit.) However, local health department staff will be conducting record reviews for a statistically valid local immunization audit.

Recommended Childhood Immunization Schedule. Please see Appendix A for a copy of the following publication, which has been approved by the Advisory Committee of Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP).

- *Recommended Childhood Immunization Schedule*, United States, January-December 1998, approved by ACIP, AAP, and AAFP.

Consultation and Technical Assistance. Although these guidelines are designed to cover most situations, school personnel need to refer to the most recent edition of *Commonwealth of Virginia, State Board of Health: Regulations for the Immunization of School Children*, Virginia Department of Health, Division of Immunization, to ensure that all students attending any public, private, or parochial school and all attendees of licensed child care centers in the Commonwealth are adequately immunized and protected against diphtheria, pertussis, tetanus, poliomyelitis, rubeola, rubella, mumps, haemophilus influenzae type B, hepatitis B disease, and varicella (all students born on or after 1/1/97), as appropriate for the age of the student. In addition, school personnel may contact either their local health department or the Virginia Department of Health, Division of Immunization, (804) 786-6246, for further consultation or technical assistance.

Documentation

Recording Requirement. Every school must record each student's immunizations on the school immunization record, which is provided by the Virginia Department of Health and which must be made part of the mandatory permanent student record. (See *Code of Virginia*, § 22.1-272.2, E.)

Proof of Immunization. "Documentary proof" of immunization includes any of the following appropriately completed forms. (See *Commonwealth of Virginia, State Board of Health: Regulations for the Immunization of School Children*, Virginia Department of Health, Bureau of Immunization, August 1, 1995.)

- Form MCH-213C (Part III—Certificate of Immunization) or a computer-generated facsimile of Form MCH-213C signed by a physician or his designee or an official of a local health department.
- The MCH-213C SUPPLEMENT indicating the dates of administration of the required vaccine is acceptable in lieu of recording these dates on Form MCH-213C (Part III—Certificate of Immunization) signed by a physician or his designee or an official of a local health department, as long as the supplement is attached to Form MCH-213C and the remainder of Form MCH-213C (Parts I-II) has been appropriately completed.
- For a new student transferring from an out-of-state school, any immunization record, which contains the exact date (month/day/year) of administration of each of the required does of vaccine when indicated and complies fully with the requirements prescribed under Section 3.1 of the *Regulations for the Immunization of School Children* are acceptable. Questions regarding records should be directed to the local health department.
- School Entrance Health Form: Part III – Certification of Immunization (MCH-213 D, Rev. 1/99).

  Note: The School Entrance Health Form (MCH-213 D, Rev. 1/99) should be used beginning with school year 1999-2000, as the form becomes available.

New Form: School Entrance Health Form (MCH-213 D). At the time of development of this manual, the School Entrance Physical Examination and Immunization Certification form (MCH-213 C, Rev. 10/91) was being revised. The revised form, entitled School Entrance Health Form (MCH-213 D, Rev. 1/99), is to be for school year 1999-2000—when the form becomes available—for health information, comprehensive physical examination, and immunization reporting requirements as required by the *Code of Virginia*. The following is a summary of the revised form (MCH-213 D, Rev. 1/99).

- **Part I – Health Information Form**

  Replaces Health Information Form (HPE-h12 12/83), as required by the *Code of Virginia* § 22.1-270, I, Preschool physical examinations.

- ***Part II – Comprehensive Physical Examination Report***

  Replaces School Entrance Physical Examination and Immunization Certification—Part I and Part II (MCH-213 C, Rev. 10/91), as required by the Code of Virginia *§ 22.1-270, A – H, Preschool physical examinations.*

- ***Part III – Certification of Immunization***

  Replaces the School Entrance Physical Examination and Immunization Certification—Part III (MCH-213 C, Rev. 10/91), as required by the Code of Virginia *§ 22.1-271.2, Immunization requirements.*

Reporting Requirement. Within 30 calendar days after the beginning of each school year or entrance of a student, each school admitting official must file an immunization summary report with the local health department, using the most recent edition of the Student Immunization Status Report form (Form SIS-1). (See *Code of Virginia*, § 22.1-272.2 E.)

Compliance. Officials from the Virginia Department of Health and local health departments are authorized to inspect school immunization records. (A minimum of 10 percent of the state's public schools is selected from a random sample for annual audit.) (See *Code of Virginia* § 22.1-272.2 E.) However, local health department staff will be conducting record reviews for a statistically valid local immunization audit.

Copy of Forms. See Appendix D for a copy of the following forms:

- School Entrance Physical Examination and Immunization Certification form (MCH-213C).
- School Entrance Health Form: *Health Information Form/Comprehensive Physical Examination Report/Certification of Immunization* (MCH-213 D, Rev. 1/99).
- Immunization Record, Virginia Department of Health (MCH-213C-Supplement).
- Certificate of Religious Exemption, Commonwealth of Virginia (CRE-1).
- Student Immunization Status Report (Form SIS-1).

Athletic Pre-Participation Physical Examination Requirements

Authorization

Virginia High School League, Inc. (VHSL). The VHSL requires that all high school students complete a pre-participation physical examination in order to be eligible to compete in a varsity sport. The purpose of this examination is to identify a student at risk for injury while participating in competitive sports and to update the medical information in the student's record previously provided by the parent/guardian.

A separate examination and certification are required for each high school year and are valid from May 1 of the current year through June 30 of the succeeding year. The completed form must be on file in the Office of the Principal. The Medical Advisory Board of VHSL, Inc. is responsible for updating the Athletic Participation/Parental Consent/Physical Examination Form as needed in order to remain consistent with the most recent recommendations and guidelines pertaining to the health and well-being of adolescents.

Separate jurisdictions may choose to require middle school athletes participating in competitive sports, other than intra-mural sports, to submit a pre-participation physical. However, this is not a state requirement and is left up to the discretion of the particular locality. Middle schools that choose to require physical examinations may use this form or provide another form developed by the health care providers of their choice.

Recommendation

Procedure and Personnel. The athletic physical assessment is best performed by the student's primary health care provider. Studies indicate that about 80 percent of high school athletes undergoing sports pre-participation assessments had no other health assessments during the school year. Therefore, students should be encouraged to have this evaluation performed by their health care provider where the assessment can be integrated with other age-appropriate anticipatory guidance and screening. The pre-participation assessment should best occur four weeks before the beginning of the athletic season so that previous injuries can be identified in time so they can be treated with a rehabilitation program to prevent injury.

Referral and Follow-Up Process. The completed forms should be reviewed by the school nurse or other health professional to clarify questionable health information. The school nurse should track such referrals and collaborate with parents.

Documentation

Athletic Pre-Participation Physical Examination.

- Completed Athletic Participation Parental Consent Physical Examination Form.

Copy of Form. See Appendix D for a copy of the most recent Athletic Participation Parental Consent Physical Examination Form.

Resources

Virginia Department of Health and Virginia Department of Education. (1992). *Virginia School Health Guidelines*. Richmond, Va.: Author.

Massachusetts Department of Public Health. (1995). *Comprehensive School Health Manual*. Boston, Mass.: Author.

American Academy of Pediatrics (1994). Policy Statement. Medical Conditions Affecting Sports Participation (RE9432). *Pediatrics, 94* (5), pp. 757-760.

Merenstein, G.B. (1997). *Handbook of Pediatrics, 18th ed.* (pp. 685-707). Stanford, Conn.: Appleton & Lange.

Virginia High School League, Inc. (1995-96.) *Virginia High School League Inc., Handbook*. Charlottesville, Va.: Author.

Vocational/Technical Medical Assessment

Authorization

Vocational Program Health Requirements. Certain vocational training programs may have health requirements that were established to minimize transmission of communicable disease in the work setting.

The following list provides examples of what might be required for some vocational programs.

Vocational Program Health Requirements

Program	Health Requirements	Resources
Cosmetology	Annual tuberculin skin test	Health Department Private Physician
Licensed Practical Nursing Emergency Medical Technical	Annual tuberculin skin test Hepatitis B vaccine Tetanus vaccine	Health Department Private Physician
Horticulture	Tetanus vaccine	Health Department Private Physician
Dental Assistant	Annual tuberculin skin test Hepatitis B vaccine Tetanus vaccine	Health Department Private Physician

Recommendation

Procedure and Personnel. Each school division should ascertain the requirements for its own vocational programs; students should be counseled about these requirements and available community resources for meeting them.

Referral and Follow-Up Process. The completed forms should be reviewed by the school nurse or other health professional to clarify questionable health information. The school nurse should track such referrals and collaborate with parents.

Record Keeping and Documentation. It is recommended that documentation of counseling be maintained in the student's file.

Population-Based Screening Programs

Introduction. Population-based screening for health problems, an important component of a school health program, is designed to detect previously unrecognized conditions or pre-clinical illnesses as early as possible in order to provide early intervention and remediation and limit potential disability and negative impact on scholastic performance. The following guidelines are applicable to any screening program in either the school or community.

Assessment. The scope and nature of a screening program should be based on the documented health needs of the population served. These needs may have been identified by a state agency and may be mandated by statute or regulation, or they may be identified by local school or community health personnel, parents, students, or educators. Decisions should be based on the definition of the target population that is at risk for developing an illness or condition that is not likely to be detected unless the screening program is offered.

Planning. Careful planning is the key to an effective screening program. The time invested at the planning stage will make implementation easier and more accurate. The school nurse should play a major role in the planning phase and will need to spend the required time to develop a successful program. The following activities and/or decisions should be addressed during the planning phase:

- Determine the purpose of the screening program.
- Define the population to be screened.
- Decide which screening procedure or test to use.
- Ensure that adequate resources are available for equipment and supplies; staff training; and staff time to conduct tests and retests, record results, interpret them to students and families, and conduct follow-up interventions.
- Determine referral criteria.
- Collaborate with members of the school health team, including community health providers, regarding the following issues: criteria used for referral for diagnosis and treatment, decisions regarding who will be treated, and what resources are available for follow-up interventions, especially for those who are uninsured.
- Plan the mechanics of the actual screening program, including determination of time required for screening, and designating screening personnel role responsibilities.
- Decide how to include content regarding the disease or condition and screening procedure into the health education curriculum

- Determine how to evaluate and report the results of the screening program.

Implementation. Implementation begins with the training of the screening personnel or arranging for training of staff (school nurses, health aides, physical education teachers, volunteers, and so forth). It encompasses the following steps as well:

- Order supplies.
- Ensure that the equipment is in good working order (e.g., audiometer, sphygmomanometer, or reflotron calibrated recently).
- Notify parents of screening.
- Recruit, orient, and train personnel and/or volunteers, if used.
- Arrange for space that is appropriate, quiet, and private.
- Perform the actual screening as planned. Document all test results on student health records.
- Re-screen students with borderline or questionable results (school nurse usually does this).
- Refer for follow-up care all those who fail to meet the criteria.
- Notify parent or guardian by letter and telephone call if appropriate.
- Notify medical provider by letter, usually via parent or guardian.
- Obtain reports from the medical provider or other related professionals, such as audiologists or optometrists regarding diagnosis, treatment, and follow-up care.
- Continue contact with parents or guardians, including home visits or telephone calls, until follow-up care is achieved.
- Communicate as needed with educational staff. Ensure confidential data handling.
- Attach follow-up medical reports to the health record.

Evaluation. Use evaluative outcome criteria that focus on the results of the program, measure behaviors, and give dates by which behaviors occur. Tally test data by grade; compare results to expected results based on national or state data. Finally, compare completed referrals to a set goal (e.g., “95% of referrals will be completed”). Work toward increasing the percentage of completed referrals.

Effective screening programs are likely to identify health problems that otherwise would not be identified until a later date, when treatment is less effective or more costly.

Screening does not substitute for a diagnostic evaluation. In addition, screening is useless if appropriate referral and follow-up care are not carried out effectively. Following up is a critical step at which early diagnosis and prompt treatment can effect remediation of the problem before it becomes a disability and/or more costly to treat. Screening and follow-up interventions are essential roles of the school health program.

Waiver Procedure. Waivers for some types of screening are available in order to make local school health programs more relevant to the community. Contact local school division for procedures and waiver requests.

Subsections

The following subsections identify and explain traditional student population health assessments that are typically used by health care providers in the school environment.

- Blood Pressure Screening
- Dental Screening and Oral Health
- Early Periodic Screening and Diagnosis and Treatment (EPSDT) Program and Medicaid/CMSIP
- Fine/Gross Motor Screening
- Hearing Screening
- Height and Weight Screening
- Scoliosis Screening
- Speech and Language Screening
- Vision Screening

Blood Pressure Screening

Authorization

No Specific Legal Mandate. There is no specific legal mandate to provide blood pressure screening. Blood pressure measurement should be included in the physical examination as part of the continuing care of the child, not as an isolated screening procedure. The school entry physical examination and the yearly athletic physical for high school athletes require documentation of a student's blood pressure.

Overview

Blood pressure assessment provides a physiological indicator of cardiovascular status. Hypertension (higher than normal blood pressure) in children is defined as persistent blood pressure elevation that is at or above the blood pressure of 95 percent of children at the same age and sex on initial screening. The detection of high blood pressure during childhood is of potential value in identifying those children who are at increased risk of primary hypertension (hypertension that develops without apparent cause) as adults and who might benefit from earlier intervention and follow-up care. For many children less than 10 years of age, there is an identifiable cause (secondary hypertension) that can be successfully treated. Older children and adolescents are more like to have primary hypertension. Early identification of children with elevated blood pressures may make it possible to halt the hypertensive process and the development of complications. Proper diet, regular exercise, and avoidance of smoking are important in helping to maintain normal blood pressure.

The American Academy of Pediatrics (AAP) recommends blood pressure measurements annually in children between 3 and 6 years of age and every 2 years thereafter. The American Medical Association (AMA) recommends blood pressure measurements annually during adolescence.

Recommendation

Procedure and Personnel. Trained health care personnel should follow standard practices for procedures for measuring blood pressure. To obtain an accurate measurement the cuff must cover two-thirds of the child's arm. Interpretation of the measurement is made by consulting a table of normative pressures for the child's age. Elevated readings should be confirmed on at least two separate occasions and the average computed.

National High Blood Pressure Education Program Working Group on Hypertension Control in Children and Adolescents published percentiles [76] and suggested the following classification of hypertension by age group, gender, and percentile of height.

Blood Pressure Levels for the 90th and 95th Percentiles of Blood Pressure for Boys Aged 1 to 17 Years by Percentiles of Height

Age *Y*	Blood Pressure Percentile*	Systolic Blood Pressure by Percentile of Height and mm Hg †							Diastolic Blood Pressure by Percentile of Height and mm Hg †						
		5%	10%	25%	50%	75%	90%	95%	5%	10%	25%	50%	75%	90%	95%
1	90th	94	95	97	98	100	102	102	50	51	52	53	54	54	55
	95th	98	99	101	102	**104**	106	106	55	55	56	57	58	59	59
2	90th	98	99	100	102	104	105	106	55	55	56	57	58	59	59
	95th	101	102	104	106	108	109	110	59	59	60	61	62	63	63
3	90th	100	101	103	105	107	108	109	59	59	60	61	62	63	63
	95th	104	105	107	109	111	112	113	63	63	64	65	66	67	67
4	90th	102	103	105	107	109	110	111	62	62	63	64	65	66	66
	95th	106	107	109	111	113	114	115	66	67	67	68	69	70	71
5	90th	104	105	106	108	110	112	112	65	65	66	67	68	69	69
	95th	108	109	110	112	114	115	116	69	70	70	71	72	73	74
6	90th	105	106	108	110	111	113	114	67	68	69	70	70	71	72
	95th	109	110	112	114	115	117	117	72	72	73	74	75	76	76
7	90th	106	107	109	111	113	114	115	69	70	71	72	72	73	74
	95th	110	111	113	115	116	118	119	74	74	75	76	77	78	78
8	90th	107	108	110	112	114	115	116	71	71	72	73	74	75	75
	95th	111	112	114	116	118	119	120	75	76	76	77	78	79	80
9	90th	109	110	112	113	115	117	117	72	73	73	74	75	76	77
	95th	113	114	116	117	119	121	121	76	77	78	79	80	80	81
10	90th	110	112	113	115	117	118	119	73	74	74	75	76	77	78
	95th	114	115	117	119	121	122	123	77	78	79	80	80	81	82
11	90th	112	113	115	117	119	120	121	74	74	75	76	77	78	78
	95th	116	117	119	121	123	124	125	78	79	79	80	81	82	83
12	90th	115	116	117	119	121	123	123	75	75	76	77	78	78	79
	95th	119	120	121	123	125	126	127	79	79	80	81	82	83	83
13	90th	117	118	120	122	124	125	126	75	76	76	77	78	79	80
	95th	121	122	124	126	128	129	130	79	80	81	82	83	83	84
14	90th	120	121	123	125	126	128	128	76	76	77	78	79	80	80
	95th	124	125	127	128	130	132	132	80	81	81	82	83	84	85
15	90th	123	124	125	127	129	131	131	77	77	78	79	80	81	81
	95th	127	128	129	131	133	134	135	81	82	83	83	84	85	86
16	90th	125	126	128	130	132	133	134	79	79	80	81	82	82	83
	95th	129	130	132	134	136	137	138	83	83	84	85	86	87	87
17	90th	128	129	131	133	134	136	136	81	81	82	83	84	85	85
	95th	132	133	135	136	138	140	140	85	85	86	87	88	89	89

* Blood pressure percentile determined by a single measurement.
† Height percentile determined by standard growth curves.

[76] National High Blood Pressure Education Program Working Group on Hypertension Control in Children and Adolescents. (1996). Update on the 1987 Task Force Report on High Blood Pressure in Children and Adolescents: A Working Group Report from the National High Blood Pressure Education Program. *Pediatrics, 98*(4), pp. 649-658.

Blood Pressure Levels for the 90th and 95th Percentiles of Blood Pressure for Girls Aged 1 to 17 Years by Percentiles of Height

Age *Y*	Blood Pressure Percentile*	Systolic Blood Pressure by Percentile of Height and mm Hg †							Diastolic Blood Pressure by Percentile of Height and mm Hg †						
		5%	10%	25%	50%	75%	90%	95%	5%	10%	25%	50%	75%	90%	95%
1	90th	97	98	99	100	102	103	104	53	53	53	54	55	56	56
	95th	101	102	103	104	**105**	107	107	57	57	57	58	59	60	60
2	90th	99	99	100	102	103	104	105	57	57	58	58	59	60	61
	95th	102	103	104	105	107	108	109	61	61	62	62	63	64	65
3	90th	100	100	102	103	104	105	106	61	61	61	62	63	63	64
	95th	104	104	105	107	108	109	110	65	65	65	66	67	67	68
4	90th	101	102	103	104	106	107	108	63	63	64	65	65	66	67
	95th	105	106	107	108	109	111	111	67	67	68	69	69	70	71
5	90th	103	103	104	106	107	108	109	65	66	66	67	68	68	69
	95th	107	107	108	110	111	112	113	69	70	70	71	72	72	73
6	90th	104	105	106	107	109	110	111	67	67	68	69	69	70	71
	95th	108	109	110	111	112	114	114	71	71	72	73	73	74	75
7	90th	106	107	108	109	110	112	112	69	69	69	70	71	72	72
	95th	110	110	112	113	114	115	116	73	73	73	74	75	76	76
8	90th	108	109	110	111	112	113	114	70	70	71	71	72	73	74
	95th	112	112	113	115	116	117	118	74	74	75	75	76	77	78
9	90th	110	110	112	113	114	115	116	71	72	72	73	74	74	75
	95th	114	114	115	117	118	119	120	75	76	76	77	78	78	79
10	90th	112	112	114	115	116	117	118	73	73	73	74	75	76	76
	95th	116	116	117	119	120	121	122	77	77	77	78	79	80	80
11	90th	114	114	116	117	118	119	120	74	74	75	75	76	77	77
	95th	118	118	119	121	122	123	124	78	78	79	79	80	81	81
12	90th	116	116	118	119	120	121	122	75	75	76	76	77	78	78
	95th	120	120	121	123	124	125	126	79	79	80	80	81	82	82
13	90th	118	118	119	121	122	123	124	76	76	77	78	78	79	80
	95th	121	122	123	125	126	127	128	80	80	81	82	82	83	84
14	90th	119	120	121	122	124	125	126	77	77	78	79	79	80	81
	95th	123	124	125	126	128	129	130	81	81	82	83	83	84	85
15	90th	121	121	122	124	125	126	127	78	78	79	79	80	81	82
	95th	124	125	126	128	129	130	131	82	82	83	83	84	85	86
16	90th	122	122	123	125	126	127	128	79	79	79	80	81	82	82
	95th	125	126	127	128	130	131	132	83	83	83	84	85	86	86
17	90th	122	123	124	125	126	128	128	79	79	79	80	81	82	82
	95th	126	126	127	129	130	131	132	83	83	83	84	85	86	86

* Blood pressure percentile determined by a single measurement.
† Height percentile determined by standard growth curves.

Referral and Follow-Up Process. All children with blood pressure readings inconsistent with norms for their age, weight, sex, and height should be referred to their health care provider for follow-up care. Every attempt should be made by school health personnel to work with parents, encouraging follow-up care with their health care provider and getting feedback on any changes that the health care provider recommends, in order that school personnel can make the appropriate educational adjustments.

If a student has been identified as having blood pressure measurements that are of concern to their health care provider, the school nurse should work closely with the

student's teachers in order to ensure any necessary adjustments are made in the classroom to provide the child with an optimum learning experience.

Documentation

Recording Recommendation. A record of the blood pressure screening of each student can be kept by recording the results on the following form:

- Cumulative Health Record (Form LF.009).

Copy of Forms. See Appendix D for a copy of the following form:

- Cumulative Health Record (Form LF.009).

Dental Screening and Oral Health

Authorization

No Specific Mandate. There is not a specific mandate for dental screening in Virginia.

Overview

Dental screening is an opportunity to detect early dental or oral health problems in children. Screening is not a replacement for a complete examination in a dentist's office. However, dental screening can be an important component of an oral health program and an important element of a school health program.

Oral health is a critical aspect of an individual's overall health, contributing to their general wellness and affecting their quality of life. General physical health, appearance, speech, and interpersonal relations are all impacted by an individual's oral health. Addressing such issues as oral hygiene, the quality of dental care, community water fluoridation, and good nutrition and safety habits at a young age will help determine the quality of a person's oral health throughout their life.

The American Academy of Family Physicians (AAFP) and the American Academy of Pediatrics (AAP) recommend that a child's first dental visit should occur at the age of 3, with frequency of subsequent visits determined by the dentist. The American Academy of Pediatric Dentistry, the American Society of Dentistry for Children, and the American Dental Association recommend that a child's first dental visit should occur at 6 months of age or when the first tooth erupts, whichever comes later, but no later than 1 year of age, with the frequency of subsequent visits determined by the dentist.

Schools have a unique opportunity to effect the oral/dental health of the community by providing:

- Dental screening to all students.
- Dental health education, in an effort to create an awareness of the importance of good dental health and well-balanced nutritious meals as part of the school food service.

In addition, by collaborating with the Virginia Department of Health, Division of Dental Health, and local health departments, schools can help to ensure:

- Dental care for children who might otherwise not receive treatment, such as fluoride and sealants as determined by dental experts.
- Fluoridation of the public water supply.

- Access to services, such as consultation and in-service training for teachers, school nurses, and interested community groups.

Children suffering with oral disease often are unable to concentrate on their school work. They may be experiencing pain related to dental caries or infection and/or be unable to chew, resulting in decreased nutrition. Both of these conditions can severely limit the ability of a child to focus on school work. Additionally, poor oral health can result in a speech defect, poor appearance, and permanent loss of teeth. Consequently, this impairment of a child's overall physical and emotional health can result in an inability to achieve their academic and social potential.

Recommendation

A school health program should attempt to include:

- Dental screening.
- Dental health education.
- Referrals and follow-up care.

Dental Screening. If children are to maintain optimum oral health, they should have a dental examination on a routine basis. Ideally, the examination should be done in the dentist's office. If this is not possible, then less comprehensive inspections or screenings can be done in the school setting. The screening should look for the presence of dental caries (tooth decay), periodontal disease (inflammation of the gums and supporting structures), malocclusion (irregularity of the teeth or jaw), and trauma from oral injuries.

School nurses, using a tongue blade and adequate illumination (e.g., penlight) can detect tooth decay and gum problems (e.g., mild gingivitis). However, x-rays are necessary to detect interproximal caries in the early stages. (Please see Appendix E for a copy of a sample dental referral form.)

Referral and Follow-Up Process. All children with obvious dental caries, mild gum disease, or complaint of oral pain related to possible infection or injury should be referred to their dentist for a more complete examination. Every attempt should be made by school health personnel to work with parents, encouraging follow-up care with the dentist and getting feedback on any changes that the dentist recommends, in order that school personnel can make the appropriate educational adjustments.

Teachers can play an important role in promoting good dental care and oral health. They can identify children in the classroom who are in pain related to dental problems or a child with a speech defect that may be related to a dental problem and possibly expedite a referral. In addition, reinforcement of dental health education issues by teachers, including good daily oral hygiene and good nutritional and safety habits, may contribute to a decrease in the incidence of children with oral health problems.

Dental Education. The schools can promote good oral health and prevent oral problems by educating students and parents. Oral health education should focus on:

- Prevention of decay through proper methods of oral hygiene (e.g., brushing, flossing).
- Use of fluoride or fluoridated water.
- Good nutrition by restricting candy and soft drinks.
- Prohibiting the possession of tobacco products and providing information on the dangers of all tobacco products, including chewing tobacco.
- The importance of using mouth-guards in organized high body contact sports. (The National Collegiate Athletic Association has mandated use of mouth-guards for football, hockey, men's lacrosse, and women's field hockey. Mouth-guards are recommended for basketball and baseball because many orofacial injuries occur in these sports.)
- Cautioning children about running, pushing, and shoving other children. (Fractures of teeth frequently occur at drinking fountains as a result of these activities.)
- The dangers of poorly designed school play equipment. (Schools and the community should work closely to provide safe play equipment for all children.)

Resources. An effective dental screening and oral health education program require the availability and use of resources in the community. Local health departments, the Virginia Department of Medical Assistance Services, and the Virginia Department of Health, Division of Dental Health, provide resources for the children in Virginia. The following chart provides a summary of resources available from the health department and other local and state agencies.

Dental Screening and Oral Health Education Programs

Program	Resources Available
Health Departments	♦ Many local health departments provide dental care for pre-school and school-age children. Charges are on a sliding fee schedule based on family income. Children on free lunch are not charged. ♦ Dental personnel of the local health departments are an excellent resource for consultation, in-service education, screenings, and dental education in the schools.
Department of Medical Assistance Services	♦ Dental care is available through private practitioners and the many local health departments for children eligible for Medicaid. Eligibility is based on income and other factors determined by the local department of social services. Not all dentists accept Medicaid. Check with the dentist before referring children for care.
Virginia	♦ Fluoridation of Public Water Supply—This is the best method

Dental Screening and Oral Health Education Programs

Program	Resources Available
Department of Health, Division of Dental Health.	available to prevent dental decay in a community. The Division will provide funds for any community with a population of more than 800 people to fluoridate the public water supply. ♦ School Based Fluoride Mouthrinse Programs—This practice, for use in rural areas without fluoridated water, is another excellent method of reducing dental decay. Children rinse for 1 minute once a week with a diluted fluoride solution. The division will provide training and supplies for the first year and fluoride rinse for subsequent years. Targeted grades are K-6 for this prevention dental program. Approximately 45 counties have schools participating in their programs. ♦ The division will provide consultation on oral health topics and will provide in-service training for teachers and school nurses. Upon request, educational materials are also available on a limited basis. ♦ Dental Surveys and Screenings—The division will conduct dental screenings and perform epidemiological surveys to determine the dental needs of a school division in selected areas of the state. ♦ For further information on any of these services or programs, please contact the Virginia Department of Health, Division of Dental Health, P.O. Box 2448, 1500 East Main Street, Room 136, Richmond, VA, 23218-2448, or call (804) 786-3556.
Local and State Dental and Dental Hygiene Societies	♦ Assistance may be obtained from local dental or dental hygiene societies or the Virginia Dental Association. Please contact one of the local dentist or hygienists in your community for assistance.

Documentation

Recording Recommendation. A record of the dental screening of each student can be kept by recording the results on the following form:

♦ Cumulative Health Record (Form LF.009).

Copy of Forms. See Appendix D for a copy of the following form:

♦ Cumulative Health Record (Form LF.009).

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) and Medicaid/CMSIP

Overview

This subsection presents a brief summary of Medicaid and school health services, including Early and Periodic Screening, Diagnostic and Treatment (EPSDT) and the Virginia Children's Medical Security Insurance Plan (CMSIP). The information is from *Medicaid and School Health: A Technical Assistance Guide*, August 1997, Health Care Financing Administration (HCFA)—the federal agency that administers the Medicare, Medicaid, and Child Health Insurance Programs. Additional information is included throughout this subsection following the word "note."

The purpose of the *Technical Assistance Guide* is to provide information and technical assistance regarding the specific Federal Medicaid requirements associated with implementing a school health services program and seeking Medicaid funding for school health services. Because of the numerous types of school-based arrangements in existence throughout the country, in the guide, "school health and school-based services" refers to any type of Medicaid-covered school-based health services provided by or within a school system, whether in the school, through a school-based or school-linked clinic or through the Individuals with Disabilities Education Act (IDEA).

For additional information and technical assistance regarding the specific federal Medicaid requirements associated with implementing a school health services program and seeking Medicaid funding for school health services, please refer to:

Medicaid and School Health: A Technical Assistance Guide*, August 1997*
U.S. Department of Health and Human Services
Health Care Financing Administration
7400 Security Boulevard
Baltimore, MD 21244-1850
Web site: http://www.hcfa.gov/medicaid/scbintro.htm

Medicaid

***Overview**. Medicaid is a jointly-funded, federal-state health insurance program for certain low-income and needy people. It covers approximately 36 million individuals including children, the aged, blind, and/or disabled, and people who are eligible to receive federally assisted income maintenance payments.*

According to Medicaid and School Health: A Technical Assistance Guide*, August 1997, HCFA, the Medicaid Program was authorized by Congress as part of the Social Security Act Amendments of 1965 and became Title XIX of the Act. Medicaid is a health insurance program for certain low-income families with children; aged, blind or disabled*

people on Supplemental Security Income; certain low-income pregnant women and children; and people who have very high medical bills.

Medicaid is funded and administered through a state-federal partnership. Although there are broad federal requirements for Medicaid, each state designs and administers its own program, which creates substantial variation among state programs in terms of persons covered, types and scope of benefits offered, and the amount of payments for services. States have authority to:

- *Establish eligibility standards.*
- *Determine what benefits and services to cover.*
- *Set payment rates.*

Each state operates its Medicaid program in accordance with its State Plan for Medical Assistance, a document that describes the state's basic eligibility, coverage, reimbursement and administrative policies. The State Plan must be approved by the Health Care Financing Administration (HCFA), the federal agency that administers the Medicaid program. HCFA administers the Medicaid program though 10 Regional Offices located throughout the country. Each state's State Plan is periodically updated to reflect changes in state policy or to conform to new federal requirements.

Because states have flexibility in structuring their Medicaid programs, there are variations from state to state. All states, however, must cover these basic services: inpatient and outpatient hospital services; laboratory and X-ray services; skilled nursing and home health services; doctors' services; family planning; and periodic health checkups, diagnosis and treatment for children.

***Medicaid and School Health Services**. According to* Medicaid and School Health: A Technical Assistance Guide*, August 1997, HCFA, school health services play an important role in the health care of adolescents and children. Whether implemented for children with special needs under the Individuals with Disabilities Education Act (IDEA), or for routine preventive care, on-going primary care and treatment in the form of a school-based or linked health clinic, school-centered programs are often able to provide medical care efficiently and easily without extended absences from school. Recognizing the important role school health services can play, the Medicaid program has been supportive of school-centered health care as an effective method of providing access to essential medical care to eligible children.*

There are, however, challenges in the collaboration between the Medicaid program and the schools. Federal Medicaid requirements are complex and the implementation of Medicaid varies by state. Because many schools are unaccustomed to these requirements and the complexity of operating in the "medical services world," understanding and negotiating Medicaid in order to receive reimbursement often has the effect of placing a considerable administrative burden on schools.

In order for Medicaid to reimburse for health services provided in the schools, the services must be included among those listed in the Medicaid statute (section 1905(a) of the Act) and included in the state's Medicaid plan or be available under the Early and Periodic Screening, Diagnostic and Treatment benefit (EPSDT, described below). There

is no benefit category in the Medicaid statute titled "school health services" or "early intervention services." Consequently, a state must describe its school health services in terms of the specific section 1905(a) services that will be provided. Except for services furnished under EPSDT, a service must be specifically identified in the state's Medicaid plan to make Medicaid payment available for it.

Issues for School Health Services Providers and Medicaid Managed Care. According to *Medicaid and School Health: A Technical Assistance Guide,* August 1997, HCFA, the pursuit of Medicaid reimbursement for school health services is complicated by the recent growth in Medicaid managed care. A school provider who becomes accustomed to the Medicaid rules under the "traditional" Medicaid fee-for-service practice may find the system and accompanying requirements completely changed if a state decides to move its beneficiaries into Medicaid managed care. Because a state that mandatorily moves Medicaid beneficiaries into managed care does so under a waiver, there are no specific statutory requirements for states to establish relationships between school-based providers and managed care entities. HCFA policy is to strongly encourage states, upon submission and negotiation of their waivers, to promote relationships between the managed care entities and school-based providers. HCFA also encourages schools and school districts to get involved with the state and/or managed care entities during the formation of the waivers in order to establish relationships and ensure a place in the new health delivery system. In this manner, provision of medical services can be coordinated by the school-based providers and the managed care entities in order to ensure children receive necessary services and care is not duplicated.

There are many types of arrangements that states put in place under their waivers to promote and assure the coordination of care between managed care entities and school-based providers. Some states have instituted state laws that require coordination between managed care organizations and school-based health providers. In addition, some school-based health providers have developed formal arrangements, including legal contracts; protocols for referral and treatment; authorization for school based providers to provide services to managed care enrollees and bill Medicaid directly; and commitments to expedite the treatment of patients referred by school-based health providers. Some states, in their waivers, "carve out" school-health services and reimburse those services under the "traditional" Medicaid fee-for-service program. However, most states carve out Medicaid-covered IDEA services in their waivers, and place the responsibility of primary and preventive services with the managed care entity. While formulating such arrangements with managed care entities often entails an administrative burden and can be a cumbersome process, schools and school-based health centers that serve Medicaid beneficiaries in states that move their beneficiaries into managed care must secure a role in the managed care system if they are to be reimbursed for the services provided to children.

***Virginia**. In Virginia, the Virginia Department of Medical Assistance Services (DMAS) is the organization that is directly responsible for the administration of the Medicaid program. Eligibility determinations and enrollment of eligible children are handled by local Department of Social Services offices.*

For more information, please contact:

Virginia Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219
Telephone (804) 786-7933
Web site: http://dit1.state.va.us/~dmas/

Children's Medical Security Insurance Program (CMSIP)

***Overview**. The federal Children's Health Insurance Program matches federal funds to help states expand health care coverage to the nation's estimated 10 million uninsured children. The Children's Health Insurance Program is designed to give states maximum flexibility while ensuring meaningful coverage. States may set eligibility at up to 200 percent of the federal poverty level, or at 50 percent above their current Medicaid eligibility level, whichever is higher. Coverage would include inpatient and outpatient hospital services, physicians' surgical and medical services, laboratory and X-ray services, and well baby/child care including immunizations.*

Virginia CMSIP. Virginia's child health insurance program, called the Children's Medical Security Insurance Plan (CMSIP), is designed to provide comprehensive health benefits for uninsured children (under 19 years) of working families with household incomes below 185 percent of the federal poverty level (FPL) who do not qualify for Medicaid. Depending upon the age of the child, the maximum household income for Medicaid eligibility is 100 percent to 133 percent of FPL. Children enrolled in CMSIP receive all the health services provided to Medicaid recipients (inpatient and outpatient hospital care, physician's and surgical services, psychiatric or psychological services, laboratory and radiological health services, and EPSDT) plus additional benefits for substance abuse treatment.

The Virginia Department of Medical Assistance Services administers CMSIP. Eligibility determinations and enrollment of eligible children are handled by the local Department of Social Services offices.

For more information, contact:

Virginia Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219
Telephone: (804) 786-7933
Web site: http://www.state.va.us/~dmas/

Virginia Children's Medical Security Insurance Plan Information Line:
1-877-VA-CMSIP [1-877-822-6747] (toll free)

Early Periodic Screening, Diagnostic and Treatment (EPSDT)

Overview. According to *Medicaid and School Health: A Technical Assistance Guide, Health Care Financing Administration*, August 1997, HCFA, Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is a mandatory Medicaid benefit for children under the age of 21 which, at a minimum, must include screening services, vision services, dental services, hearing services, and other necessary diagnostic and treatment services within the Medicaid statute whether or not the services are generally included under the state's Medicaid plan.

EPSDT is Medicaid's comprehensive and preventive children's health care program geared toward early assessment of children's health care needs through periodic examinations. The goal is to assure that health problems are diagnosed and treated as early as possible, before the problems become complex and treatment more costly. States must develop periodicity schedules for each service after consultations with organizations involved in child health care.

The following are required EPSDT services (under Section 1905[r] of the Act):

- **Screening services,** which must contain the following five elements:

    1. Comprehensive health and developmental history, including assessment of both physical and mental health development.

        Note: A comprehensive developmental assessment should be obtained by history and observation of the child, by a developmental screening test. Developmental assessment is part of every routine initial and periodic examination, including gross motor development, fine motor development, communication skills or language development, social and emotional development, and cognitive skills.

    2. Comprehensive unclothed physical exam.

        Note: An unclothed physical exam is performed by physician or licensed nurse practitioner.

        Note: State law requires that any suspicion or evidence of physical abuse or neglect be reported the Department of Social Services. (See the section on "Referring Child to Protective Services" within this Chapter).

    3. Appropriate immunizations according to the ACIP (Advisory Committee on Immunization Practice) schedule.

        Note: All immunizations are covered by EPSDT. Reimbursement of immunizations is for administration only. All vaccines must be obtained through the Virginia Department of Health's Virginia Vaccines for Children (VVFC) program, which is a federally mandated program. For further information about

VVFC, please contact the Virginia Department of Health, Division of Immunization, at (804) 786-6246.

4. Laboratory tests, including blood lead level assessment.

   Note: The following laboratory tests are required components of the EPSDT screening program. (See periodicity chart at the end of this section.)

- Hematocrit/hemoglobin
- Sickle cell
- Tuberculin
- Lead toxicity screen
- Urinalysis (if age appropriate)

Note: The provider who is performing the services is the one who bills for the services. Therefore, if laboratory work were being sent out to a lab to be processed, the school would only bill for shipping and handling.

Note: Physical and laboratory determination will be useful in assessing nutritional status or consideration for WIC (Women, Infants, and Children's Supplemental Food Program) eligibility. This is only available to children under 5 years old.

5. Health education, including anticipatory guidance.

   Note: According to *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, [77] anticipatory guidance provides the family with information on what to expect in the child's current and next developmental phases. The wide range of anticipatory topics to be considered for each health supervision visit (e.g., EPSDT visit) include:

   - Benefits of a healthy lifestyle and practices
   - Prevention of illness and injury
   - Nutrition
   - Oral health
   - Sexuality
   - Social development
   - Family relationships
   - Parental health

[77] Green M. (Ed.). 1994 *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*. Arlington, Va.: National Center for Education in Maternal and Child Health.

- Community interactions
- Self-responsibility
- Social/vocational achievement

♦ **Vision services**, which at a minimum must include diagnosis and treatment for defects in vision, including eyeglasses.

Note: Vision screening does not require machine testing but should include at a minimum the Snellen or other standard vision chart.

♦ **Dental services**, which at a minimum must include relief of pain and infection, restoration of teeth, and maintenance of dental health.

A semi-annual direct referral to a dentist for dental screening is required beginning at age three. Oral screening is not a substitute for examination through direct referral to a dentist.

♦ **Hearing services**, which at a minimum must include diagnosis and treatment for defects in hearing, including hearing aids.

Note: Hearing screening should use standard testing methods. If an abnormality is found, schedule a second screening with a physician or audiologist.

Note: Children diagnosed as hearing impaired should be referred to Children Specialty Services via the local health department for evaluation and authorization of hearing devices. If the student is being evaluated for special education, the Director of Special Education should be involved.

♦ **Other necessary health care, diagnostic services and treatment services**. As with all Medicaid services, any limitation that the state imposes on EPSDT services must be reasonable and the benefit provided must be sufficient to achieve its purpose. In addition, states must provide other necessary health care, diagnostic services, treatment and other measures described that are listed under the Medicaid statute, to correct and ameliorate defects and physical and mental illnesses and conditions discovered by screening services, whether or not covered in a particular state Medicaid plan.

This means that if the state does not cover an optional service under its state plan, such as occupational therapy, the state would have to make medical assistance available for the service when furnished to a child eligible for EPSDT if occupational therapy is medically necessary. As such, EPSDT constitutes an exception to the comparability requirements in that the state does not have to make comparable services to all Medicaid beneficiaries. This is an important point because this means that <u>if medically necessary, a Medicaid eligible child is entitled to any Medicaid-coverable service, regardless of whether the state covers it in the state plan or not.</u> However, a state may still subject these services to prior authorization for purposes of utilization control.

- **Provision of medically necessary interperiodic screening**. Interperiodic screenings, outside of the state's established periodicity schedule, must be made available to EPSDT beneficiaries when an illness or condition is suspected that was not present during the regular scheduled periodic screening. Referrals for interperiodic screens may be made by a physician, school nurse, and parent, or by self-referral. The provider performs the necessary screening components, which need not include all five elements of the required periodic screening, and provides or refers for any additional diagnostic or treatment services.

  The referral for interperiodic screening can be made by any health or developmental education personnel who comes in contact with the child, within or outside of the health care system**.** The purpose of the interperiodic screening is to assure that children are assessed as soon as a problem is suspected even if they are not scheduled for a complete screening for many months. For example, a teacher might suspect a speech delay in a child based on the child's performance in the classroom. The child could have already received his or her periodic screen. The teacher can refer the child to a speech pathologist (either through or outside the school system) for an interperiodic exam to determine if the child does indeed have a speech delay needing treatment. State Medicaid agencies cannot require prior authorization for either periodic or interperiodic screens as this would be an inappropriate limitation on the very service which is needed to determine that a medical or mental health problem exists.

Because of the proximity of schools to the target population, HCFA has always encouraged the participation of schools in the Medicaid program as they can play a particularly useful role in providing EPSDT services. School-based health services can represent an effective tool that can be used to bring more Medicaid-eligible children into preventive and appropriate follow-up care.

In addition, schools present a wonderful opportunity for Medicaid outreach. That is, because schools are by definition "in the business of serving children," they can be a catalyst for encouraging otherwise eligible Medicaid children to obtain primary and preventive services, as well as other necessary treatment services.

Resources and Publications

The following lists some resources and publications that provide further information and insight into the relationship of schools to Medicaid managed care. In addition, specific information regarding Medicaid managed care enrollment can be accessed via the Internet at http:www.hcfa.gov.

Publications

- *A Partnership for Quality and Access: School-Based Health Centers and Health Plans.* The School Health Policy Initiative

Division of Adolescent Medicine
Department of Pediatrics
Montefiore Medical Center
111 East 210th Street
Bronx, NY 10456-2490
(718) 654-4190

- Hacker K. Integrating School-Based Health Centers into Managed Care in Massachusetts, *Journal School Health*, *66*(9) November 1996, 317-321.

Resources

- National Assembly on School-Based Health Care
  666 11th Street, NW, Suite 735
  Washington, D.C. 20005
  Telephone: (202) 638-5872 or (888) 286-8727 (toll free)
  Web site: http://www.nasbhc.org/
  Note: NASBHC is a nonprofit private association representing school-based health care providers and supporters.

- *Making the Grade*
  (State and Local Partnerships to Establish School-Based Health Centers)
  1350 Connecticut Ave., NW, Suite 505
  Washington, DC 20036
  Telephone: (202) 466-3396
  Web site: http://www.gwu.edu/~mtg/
  Note: MTG is a national program of the Robert Wood Johnson Foundation located in the School of Public Health and Health Services at The George Washington University

Virginia

- *Virginia Medicaid Toll-Free Lines (updated October 16, 1998).*

  1-800-552-8627--Medicaid Provider Helpline
  1-800-358-5050--Transportation Helpline
  1-800-643-2273--Medallion/Health Maintenance Organization (HMO) Helpline
  1-800-421-7376--Maternal & Child Health Helpline
  1-800-884-9730--Eligibility Helpline
  1-877-822-6764--Virginia Children's Medical Security Insurance Plan

Virginia EPSDT Periodicity Schedule: Recommendation for Preventive Health Care

	INFANCY						EARLY CHILDHOOD					LATE CHILDHOOD					ADOLESCENCE			
AGE (m-months, y-years)	By 1 m	2 m	4 m	6 m	9 m	12 m	15 m	18 m	2 y	3 y	4 y	5 y	6 y	8 y	10 y	12 y	14 y	16 y	18 y	20 y
HISTORY Initial/Interval	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
MEASUREMENTS																				
Height and Weight	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Head Circumference	x	x	x	x	x	x	x	x	x											
Blood Pressure										x	x	x	x	x	x	x	x	x	x	x
SENSORY SCREENING																				
Vision	x	x	x	x	x	x	x	x	x	x	x_t	x_t	x_t	x_t	x_t	x_t	x_t	x_t	x_t	x_t
Hearing	x	x	x	x	x	x	x	x	x	x	x_t	x_t	x_t	x_t	x_t	x_t	x_t	x_t	x_t	x_t
DEVELOPMENT/ BEHAVIOR ASSESSMENT	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
PHYSICAL EXAM	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
ANTICIPATORY GUIDANCE	x	x			x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
PROCEDURES																				
Hereditary/Metabolic Screening	x																			
Immunization		x	x	x			x	x	x			x						x		
Tuberculin Test	<----------				x	->	<--------		x	------->		<-------		x	------->		<-------		x	->
Anemia Testing	<----------				x	->	<--------		x	------->		<-------		x	------->		<-------		x	->
Urinalysis	<----------			x	-------->		<--------		x	------->		<-------		x	------->		<-------		x	->
Lead High Risk				(x)		x	(x)		x	x	x	x								
Lead Low Risk				x		x	(x)		x	(x)										
DENTAL REFERRAL										(x) <---		Semi-Annual Referral					Required --------->			

x To be performed

(x) Required if not done when previously scheduled.

x_t Required at this age. Standardized screening method.

1 For high risk groups. Annual TB skin testing is recommended.

2 Present medical evidence suggests the need for reevaluation of the frequency and timing of hemoglobin, EP or hematocrit tests. One determination is therefore suggested during each time period. Performance of additional tests is left to the individual practice experience.

3 Present medical evidence suggests the need for reevaluation of the frequency and timing of urinalyses. One determination is therefore suggested during each time period. Performance of additional tests is left to the individual practice experience.

4 Testing is based upon risk. High-risk children with elevated blood tests may require more frequent testing based upon recent medical evidence and according to individual experience.