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MANUAL OF PROCEDURES

FOR THE SCHOOL HEALTH SERVICES

OF NEW YORK CITY



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FOREWORD

It is not an easy task to establish the procedures of work for doctors, nurses and teachers, which will bring to the school children of New York City the best health protection and guidance services which our combined efforts can give. Nevertheless, such procedures are necessary for orderly administration where almost a million children are concerned and two great systems are involved.

In the following pages are found the statements of policies and practices which have been found useful in carrying out the school health program. Recent experimental studies have indicated that these are effective procedures. The direction of school health efforts will always change with the changing world. Even before these pages reach the reader, the war may have necessitated other changes, but in order to run as effective a service as possible, it seems wise to record accurately those practices which have been found most effective. This manual is therefore presented to the doctors, nurses and teachers who are responsible for the school program.

The Department of Health, the Board of Education and the Catholic School Boards wish to take this opportunity to thank the many workers who have contributed their experience to the making of this manual.

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INTRODUCTION

THIS MANUAL is issued in order to bring up to date the extensive changes that have been made in the past few years in the health procedures of the elementary public and parochial schools and the public junior high schools of New York City. It is intended to serve as a guide to the large group of doctors, nurses, teachers, and others through whose cooperation the benefits of modern preventive medicine and a progressive educational program reach each child in every classroom.

The procedures described have been based upon painstaking observation of the program in operation¹ and upon other pertinent research findings in the fields of medicine and public health. Changes in procedures in school health work are inevitable and desirable so long as medicine and education are free to experiment with ways of improving their services to society. A final pattern of health services would be disastrous. Behind us are the days of emphasizing great numbers of routine inspections and examinations which supposedly gave the administrator a cross section of the health status of the whole school population but which, without doubt, revealed little about the well-being or progress of the individual child. Today the individual child and his specific needs are our chief concern.

Behind us are many outmoded methods of controlling communicable disease, but ahead of us are such unsolved problems as the prevention of rheumatic fever and dental caries, problems that must remain unsolved until medical science reveals their causes. Behind us also are overspecialized, independent, uncoordinated efforts in caring for such problems as defective vision and hearing and emotional disorders. Before us is the need to fit these activities into their proper relationships through a com-

¹ Nyswander, Dorothy B., Ph. D. *Solving School Health Problems; The Astoria Demonstration Study*. New York: The Commonwealth Fund, 1942. 364 pp.

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prehensive, overall administrative program so planned as to conserve our resources and at the same time serve the individual in the best possible manner.

Discarded is the concept that school children owe their favorable health status solely to medical examinations and the ministrations of school teachers and nurses. Today we see so much more clearly than we did a generation ago that the prenatal instruction given mothers, better professional attention at birth, training in infant nutrition and care, early immunizations, improvements in housing, advances in sanitary conditions of neighborhoods, protection of milk and other foods, introduction of playgrounds, planned community attacks on tuberculosis and other communicable diseases—all can make their contribution. We have learned that without the cooperative functioning of each of these services, today's children cannot achieve well-being.

Today's program of school health attempts to carry out the following services:

1. To insure adequate health supervision for all children in the school, through the cooperative efforts of parents, teachers, principals, nurses, physicians, dentists, and welfare, medical, and social agencies.
2. To make wider use of what the teacher knows about the physical status, mental and emotional development, and behavior of each child in her class in order to develop more effective methods of selecting those children in need of medical care.
3. To bring to the teacher greater understanding of the role which the health status of the child may play in his growth, development, and behavior.
4. To make the medical examination of a school child more effective and to use it as an educational experience for the child and his parents.
5. To emphasize the value of cumulative health and medical records for each child.

Introduction

6. To recognize the fact that the private physician, dentist, or clinic can give the child effective medical and dental care and that closer working relationships between the school, private practitioners, and private agencies are badly needed.
7. To help physically handicapped children to establish normal contacts and relationships with nonhandicapped children as completely and rapidly as possible.

In the foregoing statements no mention is made of the importance of a healthful school environment and the need for continued emphasis on health instruction by the classroom teacher, as these have been discussed in other publications by the specific groups directly responsible for them.

The services outlined in this handbook have been conceived, tested, and found effective by personnel now working in the New York City schools. They form a program which the staff has participated in developing through painstaking and conscientious effort, but only as that staff—educational, medical, and nursing—continues to work as a unit cooperatively, constructively, enthusiastically, and yet critically, will the child profit by these efforts. It is believed that as the staff learns to follow the policies and procedures herein outlined and grows in understanding the philosophy underlying the work, an increasingly effective service will develop for all elementary school children.

This manual has been made possible only by the cooperative efforts of teachers, nurses, doctors, and administrators, all of whom have contributed to the materials. Special credit is given certain committees of district health officers and supervising school physicians who reviewed in detail all materials, and to Dr. Abraham Kantrow and Miss Agnes Fuller, upon whose initial collection of materials this manual is based.

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Director, Bureau of Child Hygiene

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SCHOOL HEALTH RECORDS

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1. THE CUMULATIVE HEALTH RECORDS

EFFECTIVE SCHOOL health service depends to a large extent upon record keeping. Especially has this been found true in large cities where the population is not stationary. If the records of a child do not tell a complete story of his health status he is apt to be seriously handicapped at some time during his school career. Teachers, nurses, and doctors who know neither the child nor his family are dependent on the health story that the records tell. In the completeness and clarity of the records kept, and in the appropriateness of the follow-up procedures and *guidance* that is planned are found the measures of the efficiency of the school health service.

In New York City two health records are kept for every pupil in the public elementary and junior high schools—the School Medical Record and the pupil's Health Card. Under certain circumstances additional records of a confidential nature are kept.

The records are designed to bring together three sources of information about a child, namely, the medical judgment of the doctor, the observations and technical measurements made by the teacher, and the plan of follow-up care to be given by the nurse. When the two records are used together, an integrated *plan* for the care of the child can be developed. A record which contains only indices of a child's physical defects is of little value for purposes of follow-up care.

THE SCHOOL MEDICAL RECORD

The School Medical Record (Form 103S) which has been used since 1939 is designed to provide a comprehensive and cumulative health picture of the school child. See Figure 1. A card is used for each child on which is written his medical his-

Procedures for the School Health Services

tory, physical findings, and the decisions for follow-up work made by the doctor and nurse. These cards are kept on file in the medical office of the school where the child is enrolled.

Use to be Made of the School Medical Record

The face of the School Medical Record is divided into three sections. The upper section contains data identifying the child, and affords space for recording the dates of any immunizations and common communicable diseases; and also if he has had a tonsillectomy. The data to be recorded under HISTORY LEADS in the upper section are intended to guide the school physician in his interview with the parent (see page 39). At the examination a check should be placed in each small box under HISTORY LEADS, if that item in the history has been found significant. The Roman numerals I, II, and III which head the boxes stand for the three complete medical examinations (see page 40), which may be given if found necessary.

In the middle and largest section of the card, which is divided into three parts, should be recorded the history, the physical findings, and the recommendations obtained as the result of the three school medical examinations.

The information requested in the spaces under HISTORY should furnish subsequent readers of the School Medical Record a concise statement of the circumstances of the medical examination, including the date, the child's grade, the presence at the examination of a responsible adult, and the reason for the examination. To indicate which adult furnished the data that were written under HISTORY (*Par. Pres.*) the letters M, F, S, GM should be used for mother, father, sister, and grandmother. If the reason for giving the examination is that the child has been newly admitted to the school system, this fact should be indicated with the letters NA under *Reason for Exam.* If children are referred to the school physician for examination because of a specific health problem,

the outstanding reason for this referral should also be written briefly on the card. Examples of such reasons are: frequent absence for illness, behavior problem, principal requests advice, etc.

The health history of a child is absolutely necessary if his health needs are to be evaluated correctly, for the school physician and nurse can give practical and useful guidance to parents and teachers only when they possess a comprehensive picture of the child and his environment. The facts recorded on the School Medical Record will include positive statements of significance in the child's health history. Facts out of his past history having no bearing on the child's present or future health status should be omitted. Whenever facts seem to have an immediate or future significance, they should be noted. For example, a child may have been hospitalized because of rheumatic fever, but the heart was not affected. Such a fact in the child's history should by all means be recorded for it can make an important contribution to understanding the child's present and potential health status.

In the middle section under EXAM. the physician will check (✓) the physical findings of the case in the boxes provided for this purpose. The three columns of boxes headed by Roman numerals relate, as we have said, to the three medical examinations. Any other physical findings not related to the eleven findings should be recorded in the blank spaces numbered 12 through 15.

Before checking (✓) a physical finding, thus committing the school health service to follow up that defect, the school physician may wish to see the child again at a later date. In this event the abbreviation Ob for observation and the date when such observation is to be made should be written in the box opposite the defect under consideration.

Should the physician observe a physical defect for which no medical supervision is necessary, for example, an old healed burn, instead of placing a check after the physical finding, he will write Nfn (no follow-up necessary).

FIGURE 1

SCHOOL MEDICAL RECORD

LAST NAME		FIRST NAME		FLOOR		CLASS														
Arnold		Polly		FLOOR		K														
NO.	ST.	BORO	Q. NO.	P. S.				CLASS												
1	12-26	31 st Ave	Queens 2 nd	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
2	IMMUNIZATIONS				PAST HISTORY				HISTORY LEADS				CLASS							
3	Date 5/10/32				Date				Date				Date							
4	Small Pox 1934				Measles 1930				A. Development				1 A							
5	Diphtheria 1934				Whooping Cgh.				B. Illnesses				1 B							
6	Supplementarily 1937				Scarlet Fever				C. Family Diseases				2 A							
7	Additional Information on file at:				Diphtheria				D. Health Habits				2 B							
8					Tonsillectomy				E. Living Conditions				3 A							
Exam. I		Grade 2 A		Par. Pres. Mother		HISTORY		PHYSICIAN'S FINDINGS		EXAM.		OPINION-RECOMMENDATIONS		CLASS						
Date: 6/2/39		Reason for Exam.: New Admission		"Sore Throats"		B. repeated sore throats swollen glands and fever - 2 years. Slow gain in weight		1 Skin		I		① Hypertrophied tonsils; pus expressed; cervical glands ++		1 A						
D. appetite poor; eats sweets all day; bed at 10-11 P.M		E. one bed for two children in family		gain in weight		4 Eye Disease		2 Ear Disease		II		② Slender build, subcutaneous fat., poor posture		2 A						
				D. one bed for two children in family		5 Vision		3 Hearing		III		Rx mother to visit Mon E and E tomorrow re ②.		2 B						
						6 Nose		4 Eye Disease				③ Advised against sweets before meals; bed at 8 P.M. Nurse to contact agency re another bed.		3 A						
						7 Throat		5 Vision												
						8 Teeth		6 Nose												
						9 Heart		7 Throat												
						10 Orthopedic		8 Teeth												
						Physical Appearance		9 Heart												
						A. B.		10 Orthopedic												
								11 Physical Appearance												
								12												
								13												
								14												
								15												

CODE: <input checked="" type="checkbox"/> = Abnormal, Ob. = Observe, G = Good, A = Average, B = Below Par, N.P. = No Follow-Up.		S. M. Smith M.D.	
INTERVAL HISTORY Exam. II		OPINION—RECOMMENDATIONS	
Date:	Reason for Exam.:	Par. Pres.:	M.D.
INTERVAL HISTORY Exam. III		OPINION—RECOMMENDATIONS	
Date:	Reason for Exam.:	Par. Pres.:	M.D.
ADDITIONAL NOTES AND EXAMINATIONS		ADDITIONAL NOTES AND EXAMINATIONS	
Date:	Physical appearance good Gained 8 lbs. since T-A 12/20/58	Date:	M.D.

FIGURE 1 (BACK)

SCHOOL MEDICAL RECORD	
Parent's Request For Examination: I request examination by school physician when necessary.	Parent's Request For Diphtheria Immunization: I request diphtheria immunization by school physician.
Date: <i>10/13/59</i> Signature: <i>Mrs. Fred Arnold</i>	Date: Signature:
RETURN APPOINTMENTS	RETURN APPOINTMENTS
Date	Date
NOTES BY SCHOOL NURSE	
School or Home	Nurse
Date	
<i>10/19/59</i> S	<i>Mother returned 12K from Mon. Ev-E. Appt for T and A during Xmas. vacation. Discussed restriction of sweets and planning of meals & bedtime. Note to C.S.S. about needs of family.</i>
	<i>M.C.R.</i>
<i>11/10</i> S	<i>Polly had T.A. on 12/28/59; C.S.S. reports providing bed, advice on budget, etc</i>
	<i>M.C.R.</i>
<i>3/2/60</i> S	<i>T-N-conference Polly looks improved</i>
	<i>M.C.R.</i>

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In connection with item 11, *Physical Appearance*, the school physician will write *G*, *A*, or *B* to indicate good, average, or below par. (See section 14.)

In the upper section of the space entitled *OPINION-RECOMMENDATIONS* descriptions of the positive physical findings should be written, each to be preceded by the number that precedes the physical findings that were checked, or by *B*, for a child with below-par appearance. The lower section of this space is to be used for the physician's written recommendations, and, if further observations are recommended, the physician's reasons for wishing to observe the child should be stated here in writing. The box number of each physical finding that has been checked, or *B* for below par, or *H* for history will precede each recommendation. The symbol \mathbb{R} should indicate the heading of the recommendations.

When the physician gives a child either a screening or a follow-up examination (see page 43), his findings and recommendations will be recorded in the third section of the card under *ADDITIONAL NOTES AND EXAMINATIONS* which is reserved for medical opinions. This is the place where the nurse will also record the medical findings and recommendations made by the physician who treats the child.

On the back of the School Medical Record spaces are provided for the signature of the parent requesting that a medical examination and diphtheria immunization be given by the school medical staff, dates for return appointments for medical care, and the nurse's notes about follow-up activities. The nurse's notes should be concise, yet present all pertinent information on the child's health problems. (See p. 18.)

The *GROWTH RECORD* located in the lower right-hand corner should be filled in for special cases only, when the school physician recommends that height and weight measurements be taken at certain intervals during a school term. Otherwise teachers

The Cumulative Health Records

will record height and weight measurements only once each school term on the pupil's Health Card. (See Figure 2.)

It is often desirable that no one but the nurse write on the School Medical Record. In recording the physician's findings and the plan of action which the physician, parent, and nurse work out together at the time of the medical examination, the nurse acquires first-hand knowledge of the health status of the child. At this time she has the opportunity to use her special knowledge of the child and of his family in supplementing the school physician's findings and helping to develop an intelligent plan for follow-up care.

In making entries on the School Medical Record, the following abbreviations are used:

M—Mother	G—Good
F—Father	A—Average
GM—Grandmother	B—Below par
S—Sister	R—Recommendations
NA—New Admission	H—History
Ob—Observe	F—Follow-up
Nfn—No follow-up necessary	TNC—Teacher-nurse conference
TNC-MD—Teacher-nurse conference with doctor	

THE CONFIDENTIAL RECORD

Because the School Medical Record is accessible to many people it is essential that discretion be exercised in recording data of a confidential nature. Information relating to the following facts¹ is considered confidential, and should not be recorded on the School Medical Record, but should be kept in a separate file under lock and key:

Findings concerning genitalia.

¹ Findings concerning tuberculosis and venereal disease are recorded on Form 103S (School Medical Record) in code letters available to the medical and nursing staff.

FIGURE 2
HEALTH CARD

Name of Pupil		last name		first name		Date of Birth		Mo. da. yr.		Date		TEACHER'S STATEMENT OF PUPIL'S HEALTH STATUS and BEHAVIOR SYMPTOMS	
Class	Date	School	Eoro	Ht.	Wt.	VISION TEST		Teeth (Use Code)	HEARING (EA Audiometer-Score)		L	R	
						Without Glasses	With Glasses		L	R			
3A	9-38	400	Q	52	63	20	30	Y					Does not enjoy group play. Broke glasses but mother got new ones. I believe camp life might be good for Henry.
3B	2-39	401	Q	52	64	30	30	C					
4A	9-39	401	Q	53	66	30	40	20	20	O.K.			
4B	2-40	403	Q	53	67	40	20	20	20	O.K.			

The Cumulative Health Records

Date	PHYSICIAN'S RECOMMENDATIONS	Date	NURSE'S REPORT
12/28	Advised mother to have child sleep alone; to increase milk consumption. Do not put too much strain on child in class	10/15/29	Glasses obtained. Needs to wear them all the time. To be rechecked at end of year. Tonsils removed during summer. M.C.
6/30	Recommended pri. physician for tonsils and sore throat. Watch child for colds.	7/4	Arrangements made for child to go to Camp W. July 1 st . Child is under care of Dr. X. M.C.
7/4	Child needs complete examination. Parent will take child to Dr. X next week. Give Henry chance to act as leader in games; give encouragement.	Dr. B	Dr. A

BOARD OF EDUCATION AND DEPARTMENT OF HEALTH
THE CITY OF NEW YORK

CODE - V = Effect T = Under Treatment C = Corrected O.K. = Not in Need of Treatment

FIGURE 2 (BACK)

SYMPTOMS OBSERVED BY TEACHER CLASS →		DA	3B	4A	4B
EYES	Syes or Crusted lids				
	Inflamed eyes				
	Crossed eyes				
	Frequent headaches				
	Squinting at book or blackboard				✓
EARS	Discharge from ears				
	Earaches				
	Failure to hear questions				
	Persistent mouth breathing				✓
NOSE AND THROAT	Frequent sore throat				✓
	Recurrent colds				✓
	Very thin				
GENERAL CONDITION AND APPEARANCE	Very fat				
	Does not appear well				✓
	Tires easily				✓
	Poor muscle coordination				✓
	Bad posture				✓

Procedures for the School Health Services

Mental retardation, insanity, criminal acts, and confidential family problems.

Economic status, assistance from family agencies.

The Confidential Record used to record the above data is a plain 5 x 8 inch card on which is written the name, address, and school of the child, and the signature of the nurse. (See Figure 3.) These cards should be filed in alphabetical order, either in a folder of the accordion type or in a plain heavy envelope. If safeguards are not available in the medical room, the nurse will need to file all Confidential Records in the office of the principal or the supervising nurse.

FIGURE 3
CONFIDENTIAL RECORD

Bobby Jones	5000	10th Ave.	Manhattan
P. S. 800			
<hr/>			
Jan. 10, 1942	5B ¹		
Father separated from family Three children in family. Mother receives partial assistance from Dept. of Welfare. Aunt with history of old healed TBC lives with family. C. S. S. in- terested in family. Will talk with social service worker.			

It is essential that the Confidential Record be active and useful and readily available to physician and nurse. The fact that confidential information is available for a child should be indicated in the small space containing *Additional information on file at* found on the upper section of the face of his School Medical Record. The nurse will write in *pencil* in this space the number of the school that the child attends. Pencil should be used because

The Cumulative Health Records

the child may change schools several times, in which case it will be necessary to change the number. The number written here indicates to future readers of the record that additional confidential information is available at that particular school. No code for confidential information is to be used on the School Medical Record other than that stated in footnote¹ page 9 for information concerning tuberculosis and venereal disease.

If the child is transferred to another school, the number of the school written in pencil on the School Medical Record will indicate to the new nurse that confidential information is available in the school having that number. To obtain this additional information the nurse will communicate with the nurse in the school where the child was formerly enrolled, either by telephone or mail, and ask that the Confidential Record be sent to the school where the child is now enrolled. The information should be sent to the school in a sealed envelope addressed to the nurse, and marked "Personal." The Confidential Record is now kept in the file of the school where the child is enrolled; the number of the former school having been erased from the *Additional information* space on the School Medical Record, and the number of the school where the child is enrolled having been inserted.

THE HEALTH CARD

The pupil's Health Card (Form 104S) has been in use in the public schools and a limited number of parochial schools since 1940. A separate card is kept for each child by the classroom teacher. Use of the pupil's Health Card is the chief means that the teacher, nurse, and physician have of exchanging and bringing together the health information that can be obtained for each child. An important feature of the record is that it is cumulative. Observations, recommendations, and follow-up activities related to health are recorded on the same card during the entire elementary and junior high school life of the child. Thus it is pos-

Procedures for the School Health Services

sible to obtain a chronological health history of each child over this entire period.

Although the Health Card is kept by the classroom teacher, it is available to the physician and the nurse, who will need to use it in conjunction with the School Medical Record.

How the Teacher Uses the Health Card

When the Health Card is made out for a child entering school for the first time, the name and date of birth are filled in at the top. Then on or before each school Health Day, which is usually held during the first month of each term, the facts called for under *Class, Date, School*, etc., are entered. Space is provided for making entries once each term during the child's school life. These entries must be made before or on Health Day, a day set aside when the teacher can record any missing items on the pupil's cards. Teachers will take height and weight measurements, make tests for visual acuity by using the Snellen chart, record the status of dental care, record 2A or 4A audiometer test scores when these are available (section 11), and record any symptoms observed which may suggest deviations from normal health. Under the heading **TEACHER'S STATEMENT OF PUPIL'S HEALTH STATUS AND BEHAVIOR SYMPTOMS** should be recorded any other pertinent information gathered at the time. Such facts as the following might be recorded: "Mother reports appendicitis operation during summer" or "Child in summer camp for four weeks." As a result of these Health Day procedures the teacher will accumulate valuable information for the conference which she will have later with the nurse. (See section 3.)

On the back of the pupil's Health Card space is provided for checking a list of symptoms most commonly observed among school children. At the top of the appropriate column the teacher writes the grade in which the child is at present enrolled. Then she

The Cumulative Health Records

places a check mark in the appropriate square if she observes a certain condition. A column is provided for each school term.

In addition to identifying children with possible health problems the check marks serve also as indices of the teacher's ability to observe her children. The better the teacher knows her children, the more value her observations will have.

An opportunity is provided, too, for the teacher to record the number of days a child has been absent because of a certain illness. The notes from parent or private physician stating the cause of the illness are kept in the pupil's Health Card which, when folded, will hold these and other notes concerning the child's health received by the teacher. At the end of the term the teacher makes a permanent record on the card of the number of days absent because of illness, and then destroys the notes. This current information about absences arising from illness is of great value to both school physician and nurse in understanding and meeting the health needs of the child.

It should be emphasized that the pupil's Health Card, must provide a continuous record of the teacher's observations. If at any time during the school year, a behavior problem seems to be persistent or a symptom appears which the teacher believes is significant with regard to the child's health, she should record her observations on the pupil's Health Card. Teachers' notes should be concise and clear.

How the School Physician Uses the Health Card

When a pupil reports to the school medical office, he should take his Health Card with him. The lower left-hand section of the face of the Health Card is reserved for the school physician's recommendations. Following his examination of a child, the school physician will use this space to

1. Answer questions raised by the teacher and comment on observations she has made.

Procedures for the School Health Services

2. Inform her of the physical findings she should know about, the plan for the child, and her part in it.

Recommendations for medical care should be written in abbreviated form, for example, "med.att. for tonsils nec." or "med.att. for below-par con." Even when the physician cannot satisfactorily explain to the teacher the physical basis for the observations and comments made by her, he should indicate, whenever possible, that he has given them consideration in his examination of the child. For example, he might write "nail-biting noted; no med. significance." The physician will write in this left-hand section any suggestions he may have as to how the teacher can aid the child through encouraging him to form certain beneficial health habits, for example, "encourage earlier retiring" or "stress importance of eating green vegetables and fruit." He will also use this space to advise the teacher whenever she is to watch out for special symptoms and report them on the card, for example, "watch out for sore throats and colds"; "observe child for undue restlessness or unusual fatigue." Since these notes will be used primarily by persons who are not acquainted with medical terminology, effort should be made to use words and abbreviations which will be intelligible to the teachers. For this, it is necessary that handwriting should be legible.

How the School Nurse Uses the Health Card

In the lower right-hand section of the face of the pupil's Health Card the school nurse will write the steps taken by her in following up the suggestions made concerning the child. These notations will help the teacher to understand better the child's health problems. She will make concise and informative entries first about plans for securing necessary care and then about recommendations received from agencies giving treatment. Information of a confidential nature must not be recorded on the pupil's Health Card but be kept in the confidential file.

The Cumulative Health Records

STAFF CONSULTATIONS

The school physician and nurse should take the opportunity and time to encourage the interest and understanding of teachers with regard to all problems affecting the health of school children. The clarity and aptness of the notes the physician and nurse write on the pupil's Health Card will help to bring this about. In addition, visits to the teacher in the classroom to discuss and to clarify recommendations which have been written on the Health Card will be beneficial.

2. REGISTRATION PROCEDURES OF THE SCHOOL HEALTH PROGRAM

REGISTRATION WORKERS

THREE DAYS in September and three in January are officially designated as registration days in the elementary public and parochial schools and the junior high schools. At this time the parents of children entering school for the first time are interviewed, and the children are officially registered.

One or two teachers, preferably those trained as health counsellors, are selected by the principal to have charge of the registration for the school health service. Whenever possible a school nurse, physician, or volunteer worker will aid these teachers. The duties of the registration workers are to inform parents about essential immunizations and medical examinations for the child entering school. They will also prepare the Registration Summary Sheet, recording the names of children for whom Form N7 has been received (those who have been examined in child health stations), and those to whom Form 212S has been given (to be examined by private physician).

District health officers are responsible for planning the conduct of registration day procedures, and for instructing registration workers concerning their duties. Insofar as possible the school nurses, physicians, and volunteer workers will be assigned to schools which have the greatest number of new admissions enrolled.

Every child entering school is required to have a medical examination, made either by the family physician, by a clinic physician, by a physician of a child health station of the Department of Health, or by a school physician. The registration worker, after a conference with the parent, decides where the examination will be given. The worker records on a School Medical Record, Form 103S, identifying data, and either notes that Form 212S

Registration Procedures of School Health Program

has been issued, or obtains the parent's signature to the requests for physical examination and immunization if these are to be done by a school physician. In this case the mother is given the lower portion of Form 219S. Definite procedures are followed regardless of where the examination is made.

MEDICAL EXAMINATIONS FOR CHILDREN NEWLY ADMITTED

The medical examination of the child entering school for the first time should be obtained in one of the ways discussed below:

1. *Medical Examination by the Family Physician*

It is the policy of the school health service to promote medical examinations by family physicians, and each registration worker is prepared to discuss with parents the value of having the family physician examine the child. The following reasons for having the family physician give the examination should be emphasized by the registration worker.

- a. The family physician should know the child and his individual health problems better than any other physician.
- b. Periodic medical examinations by the family physician, especially those given just before the child enters school, should help him to adjust to the new experiences awaiting him.
- c. The family physician renders the child an essential and valuable health service when he vaccinates for smallpox, immunizes for diphtheria, corrects remediable defects, and advises parents regarding habits and training.

Two forms are used by the registration worker when she explains to the parent why she should take her child to the family physician.

- a. Form 210S is a letter sent by the Commissioner of Health to the parent advising medical and dental examinations, and stating the need for immunization and vaccination. (See Figure 4.)

FIGURE 4
LETTER TO PARENT OF NEW ADMISSION

THE COMMISSIONER OF HEALTH
City of New York

DEAR PARENT:

Today your child is entering school for the first time. It is a big event for him and for you. You want him to make a good record in school. To do this he must be strong and healthy. For this reason a *physical examination* and *vaccination against smallpox* are required by law for every child when he first enters school.

It is equally important for your child to be *protected against diphtheria*. You probably had this done when he was a baby. The protection has probably worn off by this time, so that he may need one more injection now to be sure he is protected. If it has never been done, the protection should be given now. *Ask your doctor about this when he examines your child.*

The purpose of the school examination is to find out if anything needs to be done for the child's health when he starts school. The most desirable way is to have your own doctor examine the child and tell you what, if anything, needs to be done and how to do it. The examination must be entered on the Pupil's Medical Report, which you take to the doctor. Please return this report to the school nurse within ten days.

Don't forget *your child's teeth*. Make sure that they are in good condition by a visit to your dentist. It is particularly important to keep the first teeth in good condition, so the second teeth will come in right. Bad teeth undermine the general health.

I am sure that you will want to do your part by having the examination and the necessary immunizations made and by following the advice of the physician and dentist.

Sincerely yours,

Commissioner

210S

- b. Form 212S, the Pupil's Medical Report, is given to the family physician to fill out. He is requested to return it to the school after he has examined the child. (See Figure 5.)

Registration Procedures of School Health Program

FIGURE 5
PUPIL'S MEDICAL REPORT

CITY OF NEW YORK

DEPARTMENT OF HEALTH BOARD OF EDUCATION

Name..... Date of Birth.....

First Name Last Name

Address..... School..... Class.....

1. Smallpox Diphtheria Supplementary
 Vaccination..... Immunization..... Diphtheria Toxoid.....

Year Year Date

2. Significant History (e.g. rheumatic fever, chorea, tuberculosis, asthma, otitis, epilepsy, diabetes, etc.) giving dates where possible

3. Communicable diseases

4. Has child any visual or hearing disability?

5. Do teeth need attention?

6. Has child any condition needing medical attention? (Use check to indicate need.)
 Nose and Throat..... Circulatory.....
 Genito-Urinary..... Orthopedic..... Respiratory.....
 Gastro Intestinal..... Others.....

a. Description of above conditions

b. What recommendations do you wish to make to teacher or school nurse which might be of benefit to this student from the point of view of either physical or mental hygiene? (See letter on reverse side.)

7. Is there any specific time you wish to see this student again?.....
 If so, when?

8. (For Vocational High School Students only) (See other side.)
 This student is being trained for

From your knowledge of the student do you think this is suitable?
 Yes No

Your suggestion as to change of vocation

.....M.D.

Date of Examination..... 194.....

Address..... Phone.....

212S

Procedures for the School Health Services

The registration worker will give both forms to parents who intend to take their children entering school for the first time to a family physician for a medical examination.

2. Medical Examination at a Children's Clinic

Registration workers will give the two forms described above also to parents of children who are under regular medical supervision at children's clinics. After the Pupil's Medical Report has been filled out by the clinic physician supervising the medical care of the child, it serves as evidence of the required examination.

3. Medical Examination at a Child Health Station

Preschool children who attend regularly the child health stations of the Department of Health will be examined there prior to their entrance to school. Parents of these children will give the registration worker Form N7 (see Figure 6), on which has been written the address of the child health station where the record of the medical examination is on file. The registration worker in turn will give the forms to the school nurse who will obtain the School Medical Records for the school files. (See section 19.)

4. Medical Examination Given by a School Physician

The registration worker will inform parents who cannot afford the services of a family physician, and whose child does not receive regular medical care at a children's clinic, that the school physician will examine the child some time during the first school year.

The mother should be told at this time that she will be notified in advance of the date and the time to be set for the examination, and should have explained to her that her presence is important because future plans should be formulated cooperatively.

FIGURE 6

NOTICE TO SCHOOL OF PRESCHOOL EXAMINATION

Date.....	
Attention School Nurse:	
A 103S card is on file for	
.....	of
(name of child)	(address)
at: (station stamp)	
By telephoning or writing to the station it will be forwarded.	
NOTICE TO SCHOOL OF PRESCHOOL EXAMINATION	
Bureaus of Child Health and Nursing	
Department of Health, City of New York	
Form N7	

VACCINATION AND DIPHTHERIA IMMUNIZATION OF
NEWLY ADMITTED CHILDREN

Vaccination for smallpox is required of all pupils entering school if they have not been successfully vaccinated. Most parents will present a certificate of successful vaccination signed by a physician. Registration workers will inform only the parents of children who have not been vaccinated that the physician who gives the child his medical examination is to vaccinate him.

All pupils entering school for the first time should be protected against diphtheria. Most children will have been immunized during their first year of life. However, since this early protection is apt to be lost after several years, stimulation of immunity is necessary. The registration workers will, therefore, instruct parents as follows:

1. For children who have never been immunized a complete immunization is necessary.

Procedures for the School Health Services

2. For children with a history of only primary immunization more than three years previously, a stimulating dose of diphtheria toxoid is necessary.
3. For children with a history of primary or supplementary immunization within three years, or negative Schick test within six months, no immediate treatment is necessary.

RECORDING REGISTRATION INFORMATION

The registration assistant should enter on the Registration Summary Sheet information concerning the plan for securing examination for each child. This will give sufficient data to determine the long-range plans that will be set up to meet the particular needs of each group, as well as assist in following the individual child.

SUMMARY OF DUTIES OF REGISTRATION WORKER

To recapitulate, it is the responsibility of the registration assistant to fulfill the following duties:

1. To explain the object of physical examination of the newly admitted child, to determine where the family secures its medical care, and provide parents who have family physicians, or whose children attend pediatric clinics, with Forms 210S and 212S.
2. To obtain Form N7 from parents of children who have been examined at a child health station of the Department of Health.
3. To record identifying data on the School Medical Record (Form 103S), and if Form 212S has been given, to note that fact.
4. To obtain parents' signatures to requests for examination or immunization if these are to be done in school.

Registration Procedures of School Health Program

5. To advise parents of newly admitted children in need of protection against smallpox and diphtheria that vaccination and immunization should be obtained at the time that the child is given his medical examination.
6. To record the information on the Registration Summary Sheet.

3. CASE FINDING BY TEACHER AND NURSE

IN MANY cities school children in need of medical care come to the attention of the physician through routine inspection made by him each year. In some cities all children are examined, while in others only the children in specified grades are given examinations. The first method has not proved satisfactory for under existing conditions it promotes a hurried examination of each child, and the statistics of accomplishment become more important than the values that can be derived from more careful work with fewer children.

In New York City the school health case finding is essentially the responsibility of teachers and nurses who initiate the program for finding children needing medical and dental care. On the basis of symptoms observed in the classroom or on the playground from the child's appearance, work, behavior, and health history, the teacher, or the teacher and the nurse, select the children who are in need of special consideration. Certain of these children should be referred to the school physician who, when necessary, will direct the parents to the family physician, hospital clinic, social agency, child guidance bureau, or some other agency interested in the child's welfare. (See section 7.)

Three well established procedures are followed by the teacher and nurse which make continuous health supervision possible for every elementary and junior high school child. These are:

1. The daily inspections made by the teacher.
2. The series of observations and measurements throughout the year.
3. The scheduled classroom conferences between the nurse and the teacher.

Through these activities children with health problems of all types are discovered, and their care becomes the immediate concern of the school health staff.

Registration Procedures of School Health Program

DAILY INSPECTION BY THE TEACHER

The first few minutes of each school day are used by the teacher not only to appraise the health of her pupils but also to take cognizance of the environment in which she and the children are to work and play together. The following description of the daily inspection by the teacher is taken from the "Course of Study and Syllabus in Health Education for Elementary Schools":¹

The teacher's first duty every morning is to see that the physical conditions under which she and her class are to do their work are made as nearly perfect as possible. This she owes to herself, as well as to the children intrusted to her care. She should give her attention to the heating, lighting, ventilation, and cleanliness of the room as far as she is able to influence these factors.

Her second duty is to inspect her class to detect signs of illness, particularly of contagious diseases, and to take the necessary steps for exclusion where advisable. *No campaign for high per cents of attendance should be allowed to interfere with such exclusions . . .*

The teacher should regard any deviation from the normal in a previously healthy child with suspicion.

Children with the following symptoms should be referred to the school physician or the nurse . . . (or principal, if physician or nurse are not in building).

General malaise	Fever
Drowsiness	Chills
Cheeks flushed or pallid	Vomiting

The beginnings of most children's diseases show one or more of the foregoing symptoms. Depending upon the severity of those symptoms, the pupil should be separated from others and watched, sent to the school physician or the nurse, or sent home with a written explanation to the parents.

¹ Published by the Board of Education, City of New York.

Thus, through the teacher's vigilant supervision and her careful observance of each child at the beginning of each school day, a *continuous* case-finding service is maintained.

CLASSROOM CONFERENCE

The conferences between the teacher and nurse, and in *special* classes between teacher, nurse, and physician, have two very definite objectives, namely, (1) to evaluate individually the health needs of each child in the classroom, and (2) to plan for his health needs. Carrying out the first objective is definitely a case-finding technique, and it is by this means that the cases referred to the school physician are first discovered.

The values coming from conferences of this type have been demonstrated. In most instances the teacher's observations prove to be significant, and children needing attention are immediately brought to medical attention. By delegating certain responsibility to teachers, the nurse helps the teacher to become not only more skilled in this technique, but more interested in this part of her work. Many health needs are revealed through the exchange of information and discussion that takes place between the teacher and the nurse.

In *regular* classes, the problems most often under discussion relate to children who have frequent colds, sore throats, or headaches, and to children who are mouth breathers, squint at the blackboards, fail to hear questions, use the lavatory frequently, are irritable, show signs of chronic fatigue, have poor eating and sleeping habits, or live under unsatisfactory conditions at home. In *special* classes, in addition to the problems mentioned above, such matters as medical supervision, mental hygiene, and need for modified home and school routines often arise.

Teachers and nurses hold their conferences (T N C) in regular classrooms; teachers, nurses and physicians (T N C-M D) in rooms for special classes. The former conferences are held once a

school year; the latter twice. All children in a special class, by definition of the term, have health and medical problems. (See sections 15, 16, and 17.) In the conferences held to discuss the problems of pupils in special classes, the physician will contribute his medical judgment to making the health appraisal, evaluating the child's progress, and planning follow-up procedures.

The participants in the conference should be prepared to devote from 45 to 60 minutes to this meeting. The nurse, or nurse and physician, will bring the School Medical Records and other available information pertaining to the children to the conference. The teacher will have available the pupils' Health Cards and academic and any other records that will contribute to a fuller understanding of the child. The teacher will give the children a work assignment to keep them occupied. The information about each child will be reviewed and discussed, and the child observed at work.

TYPES OF DECISIONS TO BE MADE

During the conference of the teacher and nurse a decision should be reached regarding the health care which may be needed by each pupil.

In *regular* classes, one of the following decisions may be arrived at by the teacher and nurse:

1. No immediate service needs to be given by the school doctor because the child is under adequate medical supervision or because no health problem is observed.
2. The child will be observed again by the teacher for more definite symptoms.
3. The child will be seen by the school physician for rapid inspection and opinion. (This inspection by the school physician is called a screening examination.) (See section 4.)
4. A complete examination by the school physician is necessary for the child.

Procedures for the School Health Services

5. The nurse will interview the child in the medical room or consult with parent or with social or other health agency regarding the child's problem.
6. Under certain circumstances it may be expedient to refer the child (using form 221S) directly to a private physician or medical care agency without first sending him to the school physician.

In *special* classes, the following decisions by the teacher, nurse, and physician are typical:

1. Assignment of the pupil to a special class is no longer necessary.
2. Other modifications of the school program are necessary.
3. A medical reappraisal of the child's condition is needed.

The nurse will describe the health problem and record the decisions reached on the pupil's Health Card and on the School Medical Record. If no health problem is found this fact will also be recorded on both cards.

CRITERIA FOR CONDUCT OF TEACHER-NURSE CONFERENCE

If a nurse is to perform her part of the teacher-nurse conference in the best possible way she should prepare for the conference by considering the factors that will make the conference successful. She might well ask herself the following questions with regard to her responsibilities for preparing for and conducting the conference:

1. Does the teacher expect me?
2. Are the School Medical Records in order?
3. Are my materials—pencils, colored tabs, etc.—ready?
4. Have I reviewed the records prior to the conference?
5. Do I help the teacher to give undivided attention to our conference?
6. Is our discussion quiet? Is it disturbing to the children?

Case Finding by Teacher and Nurse

7. Is there mutual questioning about the children?
8. Are we able to avoid making a child conspicuous when we question him?

With regard to the activities of the conference, the nurse should consider the following points:

1. Have we reviewed adequately the health status of every child in the class?
2. Have I been able to discover from the teacher's conversation or from the types of notations that she makes on the pupil's Health Card that she is interested in the health problems of her pupils?
3. If the teacher is not aware of her responsibility, am I able through questioning or by giving information from the School Medical Records to assist the teacher to do a better job in the future?
4. Am I vitally interested in the school work or behavior of the children?
5. Do both of us—the teacher and I—select the children to be examined by the physician?
6. Does my work with the teacher help her to understand the importance of watching out for behavior symptoms which accompany deafness, infected tonsils, nervousness, or below-par conditions?
7. Do I keep informed about the special health instructions program which the teacher is undertaking with a child or with her class?
8. Am I alert in making suggestions about the following situations:
 - a. Keeping a weight chart when the child is below par.
 - b. Learning why children who own glasses do not wear them.
 - c. Finding out if children who wear glasses have had them re-checked.
 - d. Keeping the teacher informed concerning illnesses or home conditions of children involved.
 - e. Discussing with teacher the notes made on the pupil's Health Card under *Physician's Recommendations*?
9. Do I keep informed about the dental program in the room?
10. Do I keep informed about the audiometer testing in the room?
11. Have I discussed the care of eye-glasses with the teacher?

Procedures for the School Health Services

12. If it seems best to talk with a child during a conference is this done in such a way that the child suffers a minimum of embarrassment?
13. Is the child greeted by name in a friendly manner?

SCHEDULE OF CLASSROOM CONFERENCES

A schedule of classroom conferences should be planned in September, at the beginning of the school year. The nurse must know the total number of classes for which teacher-nurse conferences are to be held and the number of weeks during the school year when conferences are possible. She should then plan her work so that conferences will proceed at the rate of two, three, or four each week, depending on the school registration, number of classes, and the time available.

Conferences in the special classes may begin during September. Conferences in regular classes should be started in October immediately after Health Day. All should be completed early in May, in order to leave time for follow-up work.

After a tentative schedule has been made, the nurse will meet with the school principal and together they will decide on specific dates, after which the principal will be requested to notify teachers of their conference dates.

In departmentalized schools or grades the conferences may be held with the special class teacher, hygiene teacher, or another teacher, depending upon the conditions in the school. As a general rule the greatest benefits come to the children from conferences with the teacher who has the most frequent contact with the children or who is especially interested in the health of the pupils.

4. THE MEDICAL EXAMINATION

MANY PERSONS—teachers, nurses, physicians, dentists, social workers, and others—must share the responsibility of providing health guidance for one million school children of New York City. In section 3 the important part played by teacher and nurse as case finders was discussed. The school physician, of course, also functions as a case finder. As a result of his examinations, children with health problems are referred to family physicians, clinics, or a social agency interested in the welfare of the child.

This section is devoted primarily to the procedures to be followed by the physician when giving examinations. It should be noted that the procedures not only emphasize methods of determining and recording the adverse health conditions which exist, but also call to the physician's attention in almost every instance, the importance of his role as advisor to parents and nurses, and as consultant to teachers and principals. To serve in these capacities satisfactorily he must secure sound information on which to base his judgment, and be allowed sufficient time to carry out his advisory functions. The procedures planned are intended to serve these ends. For example, to further the physician's role as advisor and counsellor, the parent's presence at the examination of her child is insisted upon and emphasis is placed on the physician's paying attention to the teacher's observations. The medical examination can be a valuable experience for a child or his parents only when from it come greater understanding of the health problems involved and improved means of handling them in all their aspects.

TYPES OF EXAMINATION PERFORMED BY THE
SCHOOL PHYSICIAN

The school physician makes two types of examinations; the detailed and comprehensive examination when the parent is invited to be present, and the more simple examination, generally called inspection, when the parent is not invited.

1. *The Examination with Parent Present*

A week or two before the examination is scheduled the school nurse will inform the parent by sending Form 219S to him by the pupil, that the opportunity of having the child examined is at hand. (See Figure 7.) Part of this form is an invitation to the parent to be present when the child is examined. Space is also provided for information to be given by the parent concerning the medical history of the child, and for the parent's signature, which indicates that he has requested the examination. The upper section of Form 219S should be torn off and filed by the nurse in her activity date file¹ to be sent to the parent as a reminder a day or two before the actual date of the examination.

Parents of pupils newly admitted to school and of pupils for whom a special examination is needed (specially referred) are invited to attend the examination. The presence of a parent at an examination gives both school physician and nurse an excellent opportunity to make direct recommendations concerning the health needs of the child. Recommendations sent to parents as notes or on forms are frequently ignored because their significance is not fully understood. It has been shown that when the parent is present at the time of an examination, the health measures recommended are more likely to be carried out. Also the willing

¹ For description see page 153.

response on the part of the parent will reduce the need for many follow-up steps by the nurse. The presence of the parent also makes it possible to discover if there are any health problems among the members of the family. Thus it becomes easier to render constructive family service.

Tact and insight are essential elements of a satisfactory interview with the parent. An unhurried and cordial approach on

FIGURE 7

INVITATION TO PARENT TO ATTEND SCHOOL HEALTH EXAMINATION

CITY OF NEW YORK

Department of Health

Board of Education

Dear Parent:

We are expecting you to be present at the health examination of your child..... by the school physician onat.....o'clock.

Sincerely yours,

.....Principal

Date..... School

Class.....

Dear Parent:

You are cordially invited to be present on..... at.....o'clock at the health examination of your child by the school physician.

It is important to your child that you be present at this examination.

Will you please give the information requested below and return this notice to the school nurse as soon as possible.

Sincerely yours,

.....Principal

Date..... School

Procedures for the School Health Services

FIGURE 7 *Cont'd*

Name..... Date of Birth

To complete the health record of your child, kindly write the YEAR when any of the following occurred:

Measles: 19....; Scarlet Fever: 19....; Whooping Cough: 19....; Diphtheria: 19....; Ear Disease: 19....; Pneumonia: 19....; Rheumatic Fever: (Inflammatory Rheumatism) 19....; Chorea (St. Vitus Dance) 19.....

Does your child have frequent colds? Frequent sore throat? Rupture?

In hospital..... Reason..... Operation.....
Year

Other illnesses

Tonsil operation? (Year and place):

Hour of going to bed..... Hour of rising.....

Appetite: Good..... Fair..... Poor.....

Vaccination.....; Diphtheria immunization.....;

Supplementary Diphtheria Toxoid.....
Year

Year

For new admissions, if diphtheria protection has been received more than three years ago, the Health Department advises additional protection now. Do you wish diphtheria immunization to be given to your child in the school?

Write "yes" or "no"

Do you request that a physical examination be given your child by the school physician?

Write "yes" or "no"

.....
Signature of Parent or Guardian

219S

the part of the health worker will aid in establishing a responsive relationship with both child and parent, and make it possible to obtain the medical, social, and economic background of the

The Medical Examination

family. Only with this knowledge and insight into the family's status will the physician and nurse be in a position to guide the parent in making necessary adjustments, changing wrong attitudes, and securing needed professional care.

The examination of the child when the parent is present generally requires six steps:

1. Taking the history furnished by the parent.
2. Making the physical examination (including diphtheria immunization for the child entering school).
3. Giving parent insight into causes and prevention of health conditions (health instruction).
4. Advising parents regarding medical and social services.
5. Making recommendations to school nurse.
6. Making recommendations to teacher.

History Taking. The history obtained from the parent and teacher should include all information pertinent to the child's present and future health. These data can be conveniently grouped under the heading *History Leads* which is a part of Form 103S.

The following outline shows how the questioning will proceed when the subheads are used as guides:

Development

Did your child thrive as an infant,

If the answer is "yes" proceed to the next item—illness.

If the answer is "no" ask questions relating to birth, weight, feeding, illnesses during infancy, age of teething, walking, etc.; and to use of vitamin D preparations, vitamin C foods, etc.

Illnesses

Inquire about frequency of colds, sore throats, adenitis, running ears, chronic mouth breathing, snoring at night, gastro-intestinal or urinary symptoms, rheumatic manifestations.

Procedures for the School Health Services

Family Diseases

- Is there any chronic illness in your family?
- Does any member have tuberculosis?
- Are other children well?
- Has mother, or any other member of family, had a blood test?

Health Habits

- What time does your child go to bed? Get up?
- Does the child fall asleep promptly?
- What foods does the child consume on a typical day? (Is the dietary adequate? Are eating habits good?)
- Does the child have any nervous habits?
- What school progress is the child making?

Living Conditions

- How many members are there in the immediate family?
- Does the child sleep alone?

Other Information

- Are there brothers or sisters in school? Does the nurse wish to speak to the parent about them?
- Is there any information the parent would like to add?
- Would she like to ask any questions?

The above questions should be asked of all parents. Obviously, a more complete history should be obtained when necessary.

The Medical Examination. The medical examination will include the head (scalp, eyes, ears, nose and throat) neck, chest, heart, lungs (if indicated), abdomen, extremities, skin, and external genitalia (if indicated).

The physician will start his appraisal by observing the child's appearance and behavior as he enters the room. The child may appear vigorous and sturdy, or tired and frail. He may display an alert and responsive or an apprehensive and dependent attitude. These observations should guide the physician in his approach to the parent and child.

The Medical Examination

After the history has been taken the child will strip to the waist. The actual physical examination will start with an appraisal of muscle tone and volume, subcutaneous fat, and posture.

The physician will then examine the heart. If necessary he will examine it in a reclining position and after exercise. The classification of the American Heart Association will be used for recording diagnosis. The lungs will be examined only if there is an indication such as a history of bronchitis, asthma, or other pulmonary condition.

Examination will then be made of the scalp, eyes, ears (externally; otoscope to be used if indicated), nose, mouth, neck, abdomen, and extremities. In most instances, when examining young children, it will be well to examine the ears, nose, and throat last.

The physical examination should be of educational value to the parent and child, that is, through it they should be given the opportunity to *learn* something about health care. Any defects present should be shown to the parent and their correction discussed. The significance of the child's past history, in the light of present physical findings, should be pointed out. The medical examination should be an interesting and worthwhile experience for the child.

Health Instruction. If the physician learns that the parent has erroneous information regarding health habits, prevention of disease, child growth, or medical care, he should attempt to give her a better understanding of these health areas.

Problems of children and parents to which the physician should be alert relate to the following:

1. The need of the growing child for adequate sleep
2. The development of habits of self-sufficiency in the young child
3. The use of a well balanced dietary
4. The value of diphtheria immunization for the preschool and school age child

Procedures for the School Health Services

Advice to Parents regarding Medical and Social Services.

The medical examination will be of little value if parents and children leave the school medical office without concise and practical plans for securing medical care for any physical problems found, and professional guidance and aid for the family's social problems. Plans for securing medical and social services are most satisfactory when suggested by the parent herself because she will be more interested in carrying out plans which she has initiated. However, in most cases the parent will need the professional judgment of the physician and nurse to stimulate her interest and to help her to make the best use of available community facilities. The physician should have a knowledge of the medical facilities, private and public, in the community.

The physician should clearly point out the need for securing medical and social services, and then, with the aid of the school nurse, show the parent how to make her plans for securing these services.

The parent who has the services of a family physician, or who can afford to use the services of one will be asked to consult with a private physician of her own choice. Otherwise the parent will be referred to an appropriate hospital clinic.

Parents in need of the services of social agencies will be referred to the intake worker or registrar of the appropriate agency (see page 67).

Although there may be several medical or social problems involved, whenever possible the parent should be referred to one physician or clinic, or to one social agency. This plan will save the parent much time and energy and will also obviate confusion.

Recommendations to the School Nurse. The school nurse will participate in interviewing the parent and examining the child, and thus be more thoroughly acquainted with the physician's findings and the recommendations made by him to the parent. This information will aid her greatly in making plans for correcting the health problems that have been uncovered. At

the time of the examination the physician may make specific recommendations or requests of the nurse for following up the plans for the child or the family. For example, the physician may recommend that the nurse see the child in her office at weekly intervals to discuss the progress that the child is making in changing poor habits of eating or sleeping. Or, he may request the nurse to make a home visit to learn first hand about the living conditions of the family. The tasks that the physician recommends that the nurse carry out will depend, of course, upon the needs of those involved. (See section 7.)

Recommendations to the Teacher. Information concerning the physical condition and recommendations concerning medical care and special health instruction are valuable to the teacher in increasing her understanding of the child. The physician will record his findings and recommendations for the teacher on the pupil's Health Card which is sent back to the teacher and kept by her as a guide to the health of her pupils.

2. *The Screening Examination; Parent Not Invited*

Four steps are taken by the physician in the examination, namely:

- a. A quick survey is made of the pupil's Health Card, the School Medical Record, and the academic record so that the physician can acquaint himself with the immediate problem and the past observation of teachers, nurses, and physicians.
- b. The child is asked pertinent questions concerning the health problem for which he has been referred.
- c. A rapid inspection of the child is made to determine the presence of an adverse physical condition.
- d. Plans are made with the nurse for follow-up work, based on the findings. (See page 66.)

The physician writes his findings on the School Medical Record, and his recommendations on both the School Medical Record and the pupil's Health Card.

Procedures for the School Health Services

CLASSIFICATION OF CHILDREN EXAMINED BY THE SCHOOL HEALTH SERVICE

Children who are given the complete or the inspection type of examination can be classified as follows:

1. Newly admitted children (examined routinely by private, clinic, or Department of Health physicians)
2. Specially referred children
3. Children referred for screening
4. Children referred for follow-up inspections
5. Children referred for morning inspections to nurse or doctor

Children entering school for the first time and those who have been specially referred receive the complete medical examination to which the parent is invited to be present. The remaining three groups receive the inspection type of examination. Procedures used with children in each of the five groups will be discussed separately.

The Medical Examination of Newly Admitted Children

1. *Examination by the Family or Clinic Physician.* The examinations by the family and clinic physicians are generally made soon after the child is admitted to the kindergarten or first grade, or during the preceding summer. The examining physicians record their findings and recommendations on Form 212S which is then returned to the school nurse by either the child or the parent. The nurse confers with the school physician regarding all reports that are returned. All positive findings will be reviewed by the school physician. Following this review the nurse transcribes on the child's School Medical Record all health facts and recommendations pertinent to his case, together with the name and address of the private physician. Form 212S is then returned to the parent to keep as a record of the examination.

The school physician and nurse will arrange with the principal for whatever adjustments are necessary in any child's school program, and will plan to follow up health problems of the child as indicated by the examining physician.

The nurse will write on the pupil's Health Card the recommendations that need to be noted by the teacher. If no recommendations are necessary, the nurse will write on the card that the child's examination has been completed and that no health problem has been found. It is essential that these statements be made so that the teacher will know which of her children have had their examinations, and which children require the special attention of the school health staff.

2. *Examination by the Preschool Health Service.* Preschool children receiving health supervision at child health stations are usually examined within six months prior to their entrance to school. On registering the child for school the parent will bring form N7, on which is written the address of the child health station where the record of the examination is on file.

The school nurse will either call personally for the record of the examination or arrange for its transfer to the school through the mail.

The examination findings and recommendations are recorded by a physician of the child health station on the School Medical Record. On receiving the record the school nurse will make plans for any adaptations of the school program that are necessary and for following up health problems that have been discovered. The nurse will write pertinent information for the teacher on the pupil's Health Card.

3. *Examination by the School Physician.* The school physician examines all entering children who have not been examined previously. In addition, he will examine children who have been transferred to New York City schools from out-of-town schools if they have not been examined by a private physician prior to

entering. Parents are asked to attend the examination of all pupils entering school for the first time.

Adjustments to the routines of school life are frequently difficult for young school children or for those who have not yet formed friendships in the new school, and the school physician should be alert to discover these problems when examining this group. He can be of great help to both parent and teacher by giving them a better understanding of the child's problems and by bringing about changes in attitude toward the child, both in the home and in the school, which will serve to reduce tensions, fears, and apprehensions.

The Medical Examination of Specially Referred Children

Children who are specially referred for a complete examination are selected by means of the teacher-nurse classroom conferences (p. 30), the screening examination made by the school physician (p. 43), or the morning inspection made by the school nurse or physician (p. 49). Parents of specially referred children are asked to attend the medical examination.

Most of the specially referred children have health needs which require medical follow-up plans. A wide variety of medical, social, and personality problems will be encountered, a partial listing of which follows:

1. *General Appearance*

Under-nutrition, pallor, fatigue, slouched posture, obesity

2. *Respiratory Diseases*

History of frequent colds, sore throat or tonsillitis, nasal obstruction, cervical adenitis, asthma, hay fever, bronchitis

3. *Rheumatic Symptoms and Signs*

Sore throats, joint and muscle pains, chorea, organic heart disease

4. *Skin Conditions*

Acne, impetigo, seborrheic dermatitis, urticaria, ringworm infection

The Medical Examination

5. *Orthopedic Defects*
Flat, pronated feet, spinal curvatures, round shoulders
6. *Genito-urinary Conditions*
Frequency of urination, enuresis, undescended testes, delayed sexual development
7. *Social Problems*
Poverty, overcrowding in the home, failure to use available facilities for play activities, parental neglect or oversolicitude, sibling rivalries, family quarrels, problems arising from divorce or separation in family or placement in foster home
8. *Behavior Problems*
Abnormal shyness, hyperactivity, symptoms of tension, irritability, and chronic truancy
9. *Health Habits*
Poor eating, sleep, and play habits

Before examining the specially referred child the school physician will acquaint himself with all of the information available from the School Medical Record, pupil's Health Card, and academic record. A quick survey of these records should inform him of past problems and may save him considerable time in his interview with the parent.

The details of procedures relating to vision, cardiac, below-par, hearing, dental, and speech conditions are given in later chapters.

The Screening Examination

Children referred for screening examinations are selected by the teacher and the nurse in their classroom conference or may be referred by the nurse from a morning inspection (p. 49). To the teacher and nurse the problems of these children usually appear less serious and not so well defined as those of the specially referred children.

Procedures for the School Health Services

After the screening examination by the school physician, the factors underlying the health problems may still remain obscure, in which case the child will require further examination. If the problem is obvious a plan for referral and follow-up procedures can be made.

The school physician generally finds one of the following four situations:

1. *The child's health problem is obvious.* The school physician will recommend that the nurse interview the parent to explain his findings and refer the child to a family physician or pediatric clinic.
2. *The child's health problem is obscure.* A more comprehensive examination is necessary before reference to a private or clinic physician is justified. The nurse will arrange for an examination, to which the parent is invited, in order to obtain a more detailed history. The child will then become a specially referred child.
3. *The existence of a health problem is doubtful.* The physician will recommend that the child be observed again by teacher and nurse, and brought to the school physician's attention if his needs warrant it (follow-up inspection).
4. *No real health problem is evident.* The school physician will make an adequate explanation to the teacher on the pupil's Health Card.

The Follow-up Inspection by the School Physician

As a result of a previous examination by a school physician, the recommendation may have been made that the child be observed after an interval of three, four, five, or six months. Therefore, in order to note any change in physical findings which were previously observed, children will be seen by the school physician for follow-up inspections at the end of the designated time. After

a follow-up inspection, the school physician will either make follow-up plans or terminate the case.

The Morning Inspection by the School Physician or Nurse

Teachers will refer children with acute health problems to the medical office immediately after their morning inspection of the class. However, if neither the school physician or the nurse is in the school building, children with suspicious signs of communicable diseases will be referred to the principal who will take whatever action he considers necessary.

The child will take Form 194K, Teacher's Referral Form (Figure 8), on which the teacher has written the reason for referring him, with him to the medical room. The nurse or the physician will then give first aid, if necessary, and also make an inspection. Findings, recommendations, and action taken with reference to the case will be written on the lower part of Form 194K, which is sent back to the teacher. Naturally, disposition of a case will depend upon the condition of the child and also on the day's program. Several dispositions of referred cases that the nurse or the physician may make are:

1. The child is excused from school.
2. The child is excluded from school.
3. A screening or a specially referred examination is planned.
4. Arrangement is made to lighten the school program of the child.
5. No further action is taken.

Children with acute illnesses, such as tonsillitis and pharyngitis associated with fever, with symptoms suggestive of appendicitis, with severe nose bleed, and the like, will be excused from school. The principal will take steps to have the child sent home. (See Figure 9.)



Procedures for the School Health Services

FIGURE 8
TEACHER'S REFERRAL FORM

School.....	Grade.....	Room.....
Name	Age.....	
Address	Floor.....	
	Referred to	Doctor
For		Nurse
Date.....	Teacher.....	
Name		
Disposition		
Date		Doctor
		Nurse
DEPARTMENT OF HEALTH—CITY OF NEW YORK		
194K		

A child with a communicable disease or suspected of having a communicable disease will be excluded from school. Precautions will be taken to prevent the spread of infection while the child is in the school building. The school principal is responsible for effecting the actual exclusion of the child. (See Figure 10; also section 8.)

Children requiring further investigation by the school physician will be scheduled for screening or for a "specially referred" examination.

Children returning to school after an illness are readmitted by the principal. If a child had a protracted or a severe illness and shows signs of a below-par physical condition, the teacher will refer him to the medical office. In addition to Form 194K, the

child will bring a note from the parent explaining the reason for his absence. When necessary, the physician will arrange with the principal to have the child's school program lightened. (See section 14.)

FORMS USED IN REFERRING CHILDREN TO TREATMENT AGENCIES

As a result of the examinations and inspections by the school physician, children with health problems are referred to family physicians, clinics, and welfare agencies. In referring cases five types of forms are used, each serving a particular purpose. Two forms are addressed to the parent; three to the physician attending the child.

Forms Addressed to the Parent (Forms 221S and 156K)

1. Form 221S informs the parent that immediate medical attention should be secured for the child. It is used by nurse or physician, after the inspection type of examination, for
 - a. Excusing the child from school.
 - b. Recommending immediate medical care.
 - c. Reminding the parent of return appointments with private physician or clinic.

The back of Form 221S requests the diagnosis and recommendations of the physician giving the child medical attention. The child will return Form 221S to the nurse after securing the necessary medical supervision.

When the nurse refers a child for a follow-up appointment, she will write the following in the space provided on Form 221S: "J—— S—— is referred for a return appointment as you requested."

2. Form 156K is the form used by the school nurse or physician to inform the parent that the child has or is suspected of having a communicable disease, and is therefore *excluded* from school. (See Figure 10; also section 8.)

Procedures for the School Health Services

FIGURE 9
NOTE TO PARENT RECOMMENDING MEDICAL ATTENTION

CITY OF NEW YORK
DEPARTMENT OF HEALTH BOARD OF EDUCATION
SCHOOL HEALTH SERVICE
NOTE TO FAMILY
Name
P.S. Class.....
Dear Parent:
.....
It is advisable to consult your physician about this matter.
Please have him report his opinion on the reverse side of this
form. If you wish to talk with the nurse, please call at the school
on..... at o'clock.
..... M.D.
Date: R.N.
OVER
221S

FIGURE 9 (BACK)

Physician Will Please Use Space Below.
The school will be glad to cooperate in carrying out physi-
cian's recommendations.
Opinion:
.....
Recommendations:
.....
Is child under treatment? Yes () No ()
I wish to see child again on..... M.D.
Address:
Date.....
*This Report is to be returned to the School Nurse by the Parent
or Child*
221S

FIGURE 10

EXCLUSION CARD

DEPARTMENT OF HEALTH, CITY OF NEW YORK

P. S.
, 194....

To the Parents or Guardian:

.....
 (Name) (Address)

is apparently suffering from a communicable disease which may be transmitted to others. This child should receive prompt medical attention and must remain at home until.....

1. A certificate is issued by a representative of the Department of Health
 (Representative will call at home to issue certificate)
 or

2. when he or she may return to school for re-ex-
 (Date) amination

M. D.—Nurse

Approved.....
 Principal

Added instruction to family:.....

156K

Forms Addressed to the Attending Physician (12K, C 12K, and O 12K)

Three forms are addressed to the attending physician and request his opinion and recommendations concerning the child and date for return appointment. Form 12K is generally used. (See Figure 11.) Form C 12K is used for referring cardiac cases. Form O 12K is used for referring orthopedic cases. One of these forms is used by the school physician when he refers a child to the family or clinic physician after a complete examination. The

The Medical Examination

FIGURE 11

GENERAL REFERRAL FORMS

SCHOOL HEALTH SERVICE
CITY OF NEW YORK

DEPARTMENT OF HEALTH BOARD OF EDUCATION

DEAR DOCTOR:

The school health examination given

Name
Address School Class
has disclosed

We request your opinion and recommendations in the matter. Please use the form provided below. Kindly indicate if and when you wish to see the child again so that we may be guided accordingly in referring the child back to you.

Very truly yours,
..... 194..... M.D.
School Physician

Opinion:
Recommendations:

Child is under treatment. Yes No

I wish to see child again on 194.....
..... M.D.

..... 194..... Address

This Report Is to be Returned to the School Nurse by the Parent or Child.

The school will be glad to cooperate in carrying out the physician's recommendations.

12K

Procedures for the School Health Services

nurse also uses these forms when she refers children to their attending physicians for follow-up appointments.

On form 12K the school physician will write briefly, as illustrated in Figure 11, the pertinent history and any physical findings. If the parent is not able to attend the examination, the nurse will arrange to meet her either at home or at school, when she will discuss the reason for referring the child for medical care, and give the form to the parent in person.

5. IMMUNIZATION AGAINST DIPHTHERIA

DIPHTHERIA IMMUNIZATION procedures are a part of the health examinations of children entering school for the first time and the examinations of children entering the upper grades who have come from schools outside of New York City. All physicians examining children in either of these groups will make diphtheria immunization an integral part of the examination.

The Department of Health recommends the following policy regarding diphtheria immunization for children entering school.

1. Children entering school for the first time who have *never been immunized* should receive (a) two doses of diphtheria toxoid, alum precipitated, with a four-week or one-month interval between the doses or (b) three doses of fluid diphtheria toxoid at four-week or one-month intervals.

2. Children who have been immunized longer than three years prior to entrance to school and who have not had a negative Schick test within six months, should receive a single supplementary injection of fluid toxoid.

3. Children who have received either primary or supplementary immunization within three years or who have had a negative Schick test within six months will need no further treatment at this time. It is recommended, however, that all children who have received their primary immunization before the age of six years should have a supplementary injection three years after the primary series.

Immunization by Private Physician

The parents of pupils who have not been immunized by their private physician, or have had no recent negative Schick tests, will be interviewed by the school nurse and arrangements made either to send the child back to the family physician or to im-

Immunization against Diphtheria

munize the child in school. If necessary the school physician will telephone the private physician to determine the exact immunization status of the child and to arrange for a return appointment with the private physician if further immunization or the Schick test is necessary. If the school physician is unable to discuss the matter with the private physician, the problem may be referred to the supervising physician.

Immunization by the School Physician

Children entering school who have had their medical examination at a clinic and who have not been immunized will receive the toxoid in the school from the school physician.

The school physician will also immunize all children entering school for the first time whom he examines, and in addition other pupils as indicated in the succeeding paragraphs.

If three injections of toxoid are necessary, arrangements may be made to have the child complete his immunization at the clinic which administers toxoid in the Health Center or Child Health Station. The parent should be informed of the exact day and time she should appear at the clinic. If it is planned to give the three injections at school, it is not necessary for the parent to be present each time. However, she should be informed through an appropriate note when a toxoid injection will be given. A careful follow-up plan is essential, in order to insure that children who require them shall receive all three injections.

EQUIPMENT AND TECHNIQUES OF IMMUNIZATION

The following equipment is essential for the immunization service:

- a. Tuberculin syringe
- b. Needles $\frac{1}{2}$ inch, 25 gauge
- c. Alcohol lamp

Procedures for the School Health Services

- d. Enamel sterilized dish
- e. Forceps for removing syringe needles

The school physician will be responsible for bringing a tuberculin syringe, ampules of diphtheria toxoid, and ampules of epinephrine. As soon as the physician arrives in the school, the nurse will place needles and syringe in the enamel dish and cover them with water. The water will be brought to the boiling point and maintained at the boiling point for five minutes. The needles will then be placed on sterile gauze. A sterilized needle must be used in giving each injection.

The skin should be prepared for the toxoid injection in the following manner:

- a. Wash skin with 70 per cent alcohol, rubbing until skin is clean.
- b. Allow skin to dry thoroughly.
- c. If any time elapses between cleansing and injection, wipe with 70 per cent alcohol once more immediately before injection. The toxoid should be injected subcutaneously in the deltoid region of the arm.

All parents should be advised that such complications as swollen arm, tenderness, redness, and fever might arise. This information can best be given in a mimeographed note containing the following statement:

Dear Parent:

Do not be alarmed if slight redness or swelling develops following the injection. Make up a boric acid solution by boiling a pint of water to which one-half tablespoon of boric acid has been added. Cool the solution, wet a cloth with it, and apply the wet cloth to the swollen part. Keep the cloth wet with the solution.

This note should be given to each child receiving a toxoid injection.

Although immunizing school children against diphtheria is important, immunizing infants during the first year of life is the

Immunization against Diphtheria

most important step that can be taken in preventing the disease. For this reason, school physicians and nurses will perform a valuable service if they will also inquire of all parents regarding the immunization status of the younger children in the family. Efforts by the school health staff in this direction will contribute inestimably to educating parents as to the ways of maintaining a community free of diphtheria.

Two types of examinations are performed, namely, the complete examination at which the parent is present, and the inspection type of examination to which the parent is not invited.

On the basis of experience and study in the field it has been determined that in a three-hour session a school physician is able to complete from 8 to 12 examinations at which parents are present (specially referred and new admission examination), and from 30 to 40 inspection examinations (screening and follow-up inspections).

The specially referred examination and screening inspections are given precedence over the new admission examinations and the follow-up inspections. It is essential that the health status of these children be determined, and recommendations made as early as possible.

Any combination of types of examinations may be scheduled, depending upon the examinations which are pending and the needs of the individual school. However, the total examination load should fall within the limits mentioned above. For example, a nurse may schedule three new admission examinations for children in the first grade, as well as five specially referred examinations (eight examinations with parent present), and five screening inspections. On another occasion, if the number of pending screening inspections is large, she may schedule from 35 to 40

Informing the Principal of the Physician's Schedule

In this section the types of examinations are referred to by names printed on the form used by doctors and nurses in reporting their work. Specially referred examinations are examinations of children referred to the school doctor because of some special medical need, new admission examinations are examinations of children entering school for the first time.

6. PREPARATION FOR THE PHYSICIAN'S MORNING IN SCHOOL

PLANNING THE EXAMINATION PROGRAM

THE PHYSICIAN'S morning in school is planned around the two types of examinations he performs, namely, the complete examination at which the parent is present, and the inspection type of examination to which the parent is not invited.

On the basis of experience and study in the field it has been determined that in a three-hour session a school physician is able to complete from 8 to 12 examinations at which parents are present (specially referred and new admission examination),¹ or from 30 to 40 inspection examinations (screening and follow-up inspections).

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Preparation for Physician's Morning in School

screening inspections exclusively. Remembering that four inspection examinations can be made in the time that it takes to complete one examination when the parent is present will prevent making the mistake of planning too large or too small a work-load for the morning with resulting confusion, lost time, and wasted effort. The above illustrations of one session's work for the school physician are only suggestive; the work should be planned to make the best use of the physician's time in terms of the particular needs of the children.

Occasionally, when parents do not appear for the examination, the plans of the school nurse are not realized. When such a situation arises, the nurse should select children needing screening and follow-up inspections by the school physician. These children can be called to the medical office at a moment's notice. In this way the physician uses his time productively.

At the beginning of the session the nurse will inform the physician of the number of examinations and inspections that have been planned, thus aiding him in timing each examination. A written statement giving the number of examinations of each type that have been scheduled, placed on the physician's desk on his arrival, has been found helpful.

Informing the Teacher of Examination Plans

Several days in advance of the physician's next visit, the school nurse will inform the teachers which children are to be examined. If children are scheduled to be elsewhere than in their official classroom, for example, in assembly, the teacher will then be able to arrange for their transfer to the medical room without undue delay.

Informing the Principal of the Physician's Schedule

The health officer will forward to the principal, through the nurse, Form CH-4S with the physician's schedule for the month

Procedures for the School Health Services

on it. (See Figure 12.) Reference to the schedule will make it possible for the principal to avoid having interruptions arise from fire drills or other activities during the mornings when the physician is working in the school.

FIGURE 12

NOTICE TO PRINCIPAL OF DOCTOR'S SCHEDULE

DEPARTMENT OF HEALTH, CITY OF NEW YORK									
Our school doctor will be at your school.....									
on the dates circled below at 9 A. M. unless otherwise noted.									
month.....					month.....				
15	19	23	27	31	1	5	9	13	
16	20	24	28		2	6	10	14	
17	21	25	29		3	7	11		
18	22	26	30		4	8	12		

If there are any questions about this schedule, please notify us immediately.

CH-4S Health District

Morning Inspections and Appointments with Parents

On the morning the physician is in school the first fifteen to thirty minutes will be devoted, by both nurse and physician, to the examination of children referred for morning inspection. If a large number of children is referred, nurse and physician will work independently. By 9:30 A. M. this work should be completed and the medical room should be cleared for the morning's program as planned.

Parents should be invited to the examination of their children on an appointment basis. Fifteen minutes should be given to each appointment.

Preparation for Physician's Morning in School

PREPARING THE MEDICAL ROOM

Necessary Equipment for the Examination

The nurse will prepare the following equipment:

- a. Tongue depressors and applicators
- b. Cotton, bandages, sterile gauze
- c. Alcohol, iodine, tincture green soap
- d. Boric acid ointment, boric acid powder
- e. Thermometer
(After each use of the thermometer it should be rubbed well with cotton moistened with green soap and alcohol. The soap and alcohol should then be removed with cold water, and the thermometer placed in a thermometer jar containing 70 per cent alcohol. At the end of the doctor's morning in school, if the thermometer is not to be used again that day, it may be put away in a dry container.)
- f. Aromatic spirits of ammonia
- g. Paper towels or tissues
- b. Health education pamphlets and literature
- i. Medical Reports, pupil Health Cards, academic records, and other information concerning children to be examined
- j. Referral forms
- k. Equipment for diphtheria immunization. (See section 5.)

Arranging and Organizing the Medical Room

Organization of Medical Records, Pupil's Health Cards, and Academic Records. The records of children who are to be examined should be kept in an orderly pile on the desk, arranged in the order in which children will be seen. Materials which are not to be used during the physician's morning in school should not clutter up the desk. Health education pamphlets and literature, arranged in an orderly manner according to content, should be kept on a separate shelf or table in the medical room.

Materials Which the Physician Will Use in His Examination.

The items which the doctor will require for his examination should be neatly arranged on a small tray and made readily available to the physician wherever he works. A paper bag or a paper-lined receptacle should be conveniently placed to receive used tongue depressors and applicators. The diphtheria immunization equipment should be placed on a separate shelf or table, not too far from the doctor's place of work.

The Medical Room Clerk, Monitor or Volunteer Worker.

The success of the physician's morning in school will depend to a large extent upon the efficiency of the appointment system used with the parents. A great help to the nurse in this respect will be a single monitor, volunteer worker, or clerk who acts as a receptionist for parents, and as a messenger to and from teachers. If no volunteer worker or clerk is available the school nurse will make arrangements with the school principal to provide the medical room with a pupil monitor from an upper grade on the day the physician is in school. This service by pupils can be a constructive and profitable experience for them.

Physical Arrangement of the Medical Suite. The ideal medical suite consists of two rooms, an outer room used as a waiting room and office for the clerk or monitor, and an inner examination room.

The outer room should have a sufficient number of chairs to seat the expected number of children and parents. If the appointment system is working smoothly, four chairs will be sufficient. Health education literature should be placed on a table for the use of parents. The clerk should have a small desk at which she may arrange the School Medical Records and other materials for the nurse's use.

The inner examination room requires a desk, a table, four chairs, and couch or table suitable for examining the child in a reclining position.

7. GENERAL FOLLOW-UP PROCEDURES

SEVERAL ASPECTS of follow-up procedures have been briefly discussed in section 4.

On many occasions authorities in the field of school health have pointed out that merely finding physical defects in children serves no useful purpose. It is essential that the finding of cases be followed by intensive and coordinated efforts to secure the specific help which the child or his family requires. Guiding parents to seek adequate medical care when it is needed, and teaching them the value of good health habits are the educational objectives of the follow-up program.

Physicians, nurses, and teachers take part in the follow-up program. It is expected that the nurse will carry the larger share of the work. The conferences in the home, in the school, and with other community agencies, are chiefly her responsibility.

Follow-up work is not to be confined to children who secure medical care from clinics. Children of families who have private physicians will receive equal consideration. This policy has received the almost unanimous sanction of private physicians in New York City and throughout the country. A survey of private physicians in New York City indicated that 94 per cent would welcome follow-up care of their cases. A similar survey of pediatricians throughout the country¹ showed that 98 per cent were willing to have the school nurse talk with the parent regarding the need for medical attention. Apparently it is in the follow-up work with children needing long-term medical supervision that the degree of cooperation between the school and the private physician is best revealed.

¹ *Report of Committee on School Health and School Health Education, Seventh Annual Meeting of the American Academy of Pediatrics, Journal of Pediatrics, 11:140, July 1937.*

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THE SCHOOL PHYSICIAN'S PART IN THE FOLLOW-UP PROGRAM

The opportunities of the school physician for follow-up services are many and varied. He may discuss a pupil's health status with a family physician. Similar discussions may be necessary with social service workers in hospital clinics or in social agencies. The school physician may be called upon to explain special recommendations to the nurse, teacher, or principal. It may be necessary for him to interpret to the school personnel the medical findings of an attending physician.

Parents of children who are under the follow-up care of the school health service may consult the school physician regarding home care or medical supervision.

Finally, the school physician may be called upon to discuss a child's problem with the child himself or he may be asked to inspect again a child who is being followed up by the school nurse or teacher.

THE TEACHER'S FOLLOW-UP SERVICES

The teacher can also render valuable service in the follow-up program. She is in close touch with her pupils and frequently is acquainted with the parents. If she is well informed regarding the health status of her pupils and the specific recommendations that have been made concerning their health habits and medical supervision, she can utilize her knowledge and authority to good advantage by giving the children the guidance and supervision they need. It is essential therefore that the teacher be adequately informed of a child's health needs and any recommended follow-up plans, through the medium of the pupil's Health Card and through consultations with physician and nurse.

THE FOLLOW-UP SERVICES OF THE SCHOOL NURSE

The ultimate success in carrying out health recommendations is frequently dependent upon the nurse's skill since so much of

General Follow-up Procedures

the responsibility for follow-up services falls on her. Her services are of four major types:

1. *The Nurse Sees Children in the School.* The nurse usually reminds a child of his return appointments to a family physician or a clinic. At this time she will, if needed, again provide the child with the appropriate referral forms 221S, C 12K, or O 12K, and seek to obtain a reevaluation of his health status.

She may discuss with the child his health habits—those relating to sleep, diet, recreation, etc.

Studies show that conferring with children individually is the follow-up procedure most frequently used by the nurse.

2. *The Nurse Sees Parents in the School or in the Home.* Giving guidance to parents is, without doubt, the nurse's most important follow-up work. The primary objectives of this work are:

- a. To provide specific and necessary guidance regarding care for health deviations in the school child and other members of the family
- b. To aid the parent in obtaining necessary help from welfare and medical agencies
- c. To provide parents with sound health information

Consultations with parents may be held either in the school or in the home. Although home visiting is an important procedure used by the nurse, consultations with parents in the school are generally employed except when

- a. The parent cannot come to school.
- b. Special information is required regarding the health of the entire family, or the nature of the home environment.
- c. Family problem is such that adjustment and health teaching can best be done in the home.

3. *The Nurse Sees Principal and Teachers.* In addition to her teacher-nurse conferences (section 3), the nurse interviews

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teachers and principal regarding the problems of particular children. These discussions with principal and teachers are generally concerned with the following:

- a. Securing the cooperation of teachers in carrying out the plans for improving the child's health.
- b. Interpreting medical recommendations to principal and teachers.
- c. Obtaining and giving additional information regarding children who are being followed up.
- d. Arranging and providing for adaptations of the school program to the needs of the children individually.

4. *The Nurse Discusses Pupils with Social Agency Workers.* With certain types of problems it is necessary for the nurse to exchange information with a social worker in a hospital clinic, a public welfare agency, or a private welfare agency. The major objectives of this type of contact with social workers are:

- a. To refer a problem to a social agency.
- b. To plan a cooperative follow-up program with a social worker.
- c. To exchange information.

Social agencies make many contributions to the health work of school nurses, doctors, and teachers. The Department of Welfare, family welfare agencies, children's group-work organizations, neighborhood houses, etc., all operate within the welfare field. It is important, therefore, that the school health workers become familiar with the work of the agencies located in their vicinity. A directory of social agencies, placed in the principal's office, should be referred to whenever necessary.

The Welfare Council (44 East 23rd Street, New York City; Tel.: AL 4-5500) maintains a central clearance bureau for most welfare organizations in the city. Should a school nurse or a physician desire information regarding agency contacts which a particular family has had, she or he can obtain this information

General Follow-up Procedures

by clearing the case through the Social Service Exchange of the Welfare Council, using the form which is available in the Branch Office of the Health Department. The notation "Cleared for information only" should be made on the form. If the information is needed immediately it can be obtained by telephone. However, the Council prefers to send the information by mail whenever time permits. With the knowledge obtained from the Social Service Exchange, the school nurse is able to refer the family to a social agency already acquainted with their problems. The information obtained from the Social Service Exchange should be kept on the Confidential Record. (See page 9.)

The Council's information service is also available to the school authorities. Principals have the necessary blanks for clearing cases for information.

Should the school nurse desire to confer with a social agency she should communicate with the agency and meet with the particular social worker who is, or has been, active with the case.

Social workers desiring information may communicate with the school nurse, either directly or through the supervising nurse. The extent to which social service agencies are used is indicative of the alertness of the school health personnel to the available community facilities. Improved rapport and closer working relationships with these agencies will add to the effectiveness of the school health service and bring better care to the children.

GUIDE FOR THE NURSE-PARENT CONSULTATION IN THE SCHOOL

The consultation with a parent at school can be an extremely valuable educational technique. When the parent responds to the nurse's invitation to come to school the first step has been taken in obtaining her cooperation. Consultations are an important aspect of health education, and health education is a part, conscious or unconscious, of every public health contact. During

Procedures for the School Health Services

the consultation period the public health nurse not only helps to work out a practical plan of action with the parent, but attempts to change or strengthen attitudes about health. The more conscious the participants are of these educational objectives, the more far-reaching will be the benefits from the consultation. Nurses will request parents to attend the consultation in school by sending to the parent by means of the child Form 218S. (See Figure 13.)

To aid the nurse in improving her conferences with parents the following questions are posed, by means of which it is hoped the nurse can evaluate her own accomplishment:

1. Relationships to Parent

- a.* Is the parent immediately welcomed and made to feel at ease?
- b.* Does the parent have an opportunity to tell the nurse of any health problems or other problems that are on her mind?
- c.* Is the nurse sympathetic in her approach and does she assist the parent in solving her problems?
- d.* Is the parent persuaded through use of facts rather than threats of dire consequences?
- e.* Does the parent indicate that she is grateful for advice or nurse's interest?

2. Techniques of Interview

- a.* Does the nurse indicate that she is expecting the parent?
- b.* Does the nurse say something favorable and personal about the child to show that she knows the child as an individual?
- c.* Does the nurse have any information about the child's school work or behavior in the classroom?
- d.* Does the nurse give the parent an opportunity to suggest *plans* for meeting the health problem?
- e.* Does the nurse inquire as to habits or situations within the home which may affect the child's health?
- f.* Does the nurse give any simple directions to be followed by the mother, which may affect the physical or mental hygiene of the child in the home?
- g.* Is a *definite* plan worked out?

FIGURE 13
PARENT CONSULTATION

CITY OF NEW YORK	
DEPARTMENT OF HEALTH	BOARD OF EDUCATION
	Date.....
Dear Parent:	
Please call at the Health Room No.	
Fl.	on
at.....o'clock, in regard to an important matter concerning your child.....class.....	
If this appointment is not convenient for you, please let me know so that I may arrange for another time.	
Sincerely yours,	
.....	
School Nurse	
.....	
School	
Principal	
218S	

- b. Does the nurse inquire about other members of the family, not neglecting, when appropriate, to emphasize the need for immunization and supervised care of infants and preschool children?
- i. Does the nurse review plans and give the parent a memorandum at close of interview?
- j. Does the nurse thank the parent for coming?
- k. Does she clearly state how the parent may see or communicate with her in the future?

3. *Appraisal of Selection of Case*

- a. Was a preliminary checking with the child or teacher neglected which would have made it unnecessary to invite the mother?
- b. Would it have been better to have made a home visit with regard to the case?

GUIDE FOR THE HOME VISIT OF THE NURSE

Using the home visit to acquire knowledge in order to understand a family's problems; to give the family direct health instruction, and to help plan a course of action is just as important to the school health field as to other health areas. The questions which follow focus attention on the significant features of a satisfactory consultation in the home:

1. *Preparation*

- a. What is known about this family from the records?
- b. Why is this visit being made? What is the immediate reason for the visit? What is the underlying purpose?
- c. What is the plan for this visit?
- d. What equipment is needed?

2. *Home Visit*

- a. How are you greeted? Do you seem welcome? Do you know the family? Does the family know why you have come for a visit?
- b. How do you gather the facts?
- c. What attitude does the family display? Interest? Indifference? Fear? Willingness to assume responsibility? Resentful? Other?
- d. What questions were asked, or what did you observe that will guide you in teaching now or later?
- e. What problems showed up in the home that you were not aware of before your visit? How did you meet them?
- f. Did you have all the information you needed to answer the family's questions? To direct to available resources?
- g. Who made the plan for further action? Did the family or the nurse? Or, was it a joint plan?
- b. Did you summarize the visit? Did the family or patient seem to understand?
- i. Was there any evidence that the family had learned from previous instructions?
- j. Did you carry out the plan you made before the visit? If it was changed, did the change benefit the family?

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- k. How did you record the visit? What plan did you make for the next visit?

3. Evaluation of Visit

- a. In what way do you think the visit was successful?

- b. How do you think you could have improved this visit?

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8. THE CONTROL OF COMMUNICABLE DISEASES

THE CONTROL of communicable diseases in the schools is an ever-present problem, the responsibility for which must be shared by many people if the program for control is to be successful. Principals, teachers, school nurses, school physicians, family physicians, the Bureau of Preventable Diseases, the Bureau of Tuberculosis, the Bureau of Social Hygiene of the Department of Health and parents—all must share this responsibility.

The adequately informed and alert parents who keep their children at home when illness or symptoms suggestive of a communicable disease appear make, perhaps, the most valuable contribution in the control of diseases among children. The education of parents in the recognition of the early symptoms of contagion should, therefore, be an important community function of the school.

The initial steps in the control of communicable diseases are: first, early recognition of symptoms, and, second, prompt separation of the sick from the well. These steps will limit the disease to the person affected and will prevent its spread from one person to another. The great difficulty encountered in limiting the spread of certain diseases, for example, measles, is due to the fact that the time when the disease is most infectious is the early stage—either just before or during the period when the first visible symptoms appear. Transmission to others occurs almost before signs of the disease are visible. On the other hand, certain diseases have a very limited infectious period, and are transmissible during only part of the period while the person is ill.

The procedures for dealing with communicable diseases among school children which are outlined in this chapter are intended to provide protection at the correct time and in the most effective manner. How shall we recognize cases? What

must be done with the suspicious case? When and how should a case be excluded? When and how are children readmitted after they have recovered from a communicable disease? An effort has been made to describe the control steps that are most effective in meeting these and other situations.

CASE FINDING, REFERRAL, AND ISOLATION OF CHILDREN WITH SUSPECTED COMMUNICABLE DISEASES

Case Finding. In the health inspection of her pupils at the opening of each school day and in her observations throughout the day, the teacher will be on the alert at all times to detect early signs of communicable diseases or other illnesses.

The early signs of most communicable diseases are not specific; usually those evidenced are a running nose, cough, flush, general malaise, or definite fever. These, together with other more specific signs, such as skin rashes and enlargement of the glands of the neck, are guide posts for the teachers and nurses in their detection of suspected communicable diseases.

Referral of Suspected Cases. Immediately upon discovery of one or more signs of a suspected communicable disease, the teacher will refer the pupil or pupils (*a*) to the school nurse or, if she is not in the school building (*b*) to the principal.

In referring pupils the teacher will use Form 194K (Figure 8) on which will be recorded the name of the pupil, his class, age, address, and the reason for the referral.

Should the nurse or the school physician (if he is present) decide that the condition is, or may be, a communicable disease, and that exclusion is necessary, Form 156K (Figure 10) is sent to the principal to notify him. The principal will then take the steps described below.

Isolating Suspected Cases. To help prevent the spread of infection from one child to another a pupil suspected of having a communicable disease should be separated from well children in-

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sofar as possible, and should be separated from any other child who is suspected of having a communicable disease. It is important to follow this procedure because the children under observation may have different diseases and unless separated will expose each other to several diseases.

All isolated children should have adequate supervision until they can be sent home. The manner in which isolation and supervision are provided will necessarily vary with the facilities in the school building; they cannot be carried out in the same manner in all schools.

CLASSIFICATION OF COMMUNICABLE DISEASES

The Sanitary Code of New York City and regulations of the Department of Health constitute the authority for excluding children with communicable disease. As medical knowledge progresses, changes in method and approach will be inevitable. It is understood that any changes in the Sanitary Code will automatically change this section correspondingly.

A distinction is made in the handling of the different diseases. From an administrative point of view they may be classified according to the different requirements as to exclusion and readmission.

Group I. Certificate required for readmission; contacts excluded

1. Diphtheria
2. Scarlet Fever
3. Smallpox

This group includes what is commonly spoken of as major contagion. Because of their potentialities these diseases are regarded with concern and are regulated by relatively strict measures.

In diphtheria ~~and scarlet fever~~, furthermore, "carriers" play an important part in the spread of the disease. Thus healthy children may carry in their noses and throats the disease organisms which bring havoc to other children.

The Control of Communicable Diseases

Exclusion

When notified that a child is suspected of having a disease in this group, the principal will summon the parent of the child to school. Until the parent can arrive the child will be adequately isolated. If neither parent can be reached at home or at work by telephone, messenger, or through the neighborhood police station, the principal will call the borough office of the Bureau of Preventable Diseases of the Department of Health and request that a diagnostician be sent to verify the diagnosis and arrange for the removal of the child to a communicable disease hospital.

If the diagnosis of the disease is made outside of the school, the principal will be notified on Form 396V (Fig. 16) ~~and should enter the name of the child on the register "Communicable Diseases in the Schools", Form 36K, which is to be forwarded to~~
to the nurse.
Readmission

The pupil *must* present either Form 302V (Figure 14) of the Department of Health, or Form SR-3063 A (Figure 15) of the Department of Hospitals, which must be signed by a duly authorized representative of one of these departments.

If a child returns to school without a 302V or SR-3063 A, the school nurse (or principal, if the nurse is not in school) will telephone the District Nursing office to ascertain what disposition is to be made of the case.

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FIGURE 14

DEPARTMENT OF HEALTH CERTIFICATE RE FREEDOM FROM COMMUNICABLE DISEASE

CITY OF NEW YORK
 DEPARTMENT OF HEALTH
 BUREAU OF PREVENTABLE DISEASES

.....19.....

THIS IS TO CERTIFY THAT.....

of.....has been examined and
 found to be free from any communicable disease, and may return
 to school or work on.....19

Issued by

 Title

302V

FEB 1 8 1942

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FIGURE 15

DEPARTMENT OF HOSPITALS CERTIFICATE RE FREEDOM FROM COMMUNICABLE DISEASE

DEPARTMENT OF HOSPITALS
 CITY OF NEW YORK
 Division of Communicable Diseases
 School Certificate

..... 194.....

This is to certify that.....
 of.....has been examined and
 found to be free from any infectious disease, and may return to
 school on.....194.....

Hospital

Superintendent

SR-3063 A

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FIGURE 16

COMMUNICABLE DISEASE POST CARD

DEPARTMENT OF HEALTH, CITY OF NEW YORK

Name..... Age..... Address.....

is suffering fromonset.....

The Following Children Living at this Address Attend your School:

(In this space on the original form are reproduced Sections
94 and 95 of the Sanitary Code.)

.....by order of the Board of Health.....

Date Medical Inspector—Nurse
396V

Exclusion and Readmission of Contacts

The names of children who are contacts to cases of communicable diseases in Group I are sent, on Form 396V (Figure 16), to the principal of the school which the contacts attend. The principal excludes these children from school and enters their names in the register "Communicable Diseases in the Schools," Form 36K.

Contacts to diseases listed in Group I, who have been excluded, will be readmitted by the principal only on presentation of Form 302V (Department of Health) or Form SR-3063 A, (Department of Hospitals) signed by an authorized representative of one of these departments.

Group II. Certificate required for readmission; contacts not excluded

4. Typhoid Fever
5. Paratyphoid Fever
6. Ringworm of the Scalp

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Since the danger of transmission of the disease is not ended until certain laboratory tests are negative, children who have had any of these diseases may not be readmitted without a certificate from the Department of Health. It is not necessary, however, to exclude contacts.

or Dept. of Hospitals (except ringworm)

Exclusion

When notified that a child is suspected of having a disease in this group, the principal will summon the parent to the school and keep the child isolated until he can be taken home.

If the diagnosis of the disease is made outside of the school, the principal will be notified on Form 396V (Figure 16) and should enter the name of the child on the register "Communicable Diseases in the Schools," Form 36K. **which is to be forwarded to the nurse.**

Readmission

properly (Hospital) Pupil must present Form 302V (Department of Health) signed by a representative of that Department. The Department of Hospital Form SR-3063 A is not acceptable for diseases in this group. **In ringworm of the scalp only 302V is acceptable.**

Group III. Certificate not always essential for readmission; contacts not excluded

2. Streptococcal sore throat including scarlet

7. Anterior Poliomyelitis (Infantile Paralysis) **fever.**

8. Meningitis (Meningococcus)

9. Measles

10. German Measles

11. Mumps

12. Chicken Pox

13. Whooping Cough

This group includes both serious and relatively mild diseases but it is not necessary to exclude contacts, and there are more alternatives for readmission.

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Exclusion

This is handled in the same manner as for Group I except that if the parents of a child suspected of having any of the diseases in Group III other than poliomyelitis or meningitis, cannot be reached and the child is not acutely ill, it is usually safe to isolate him until he can be received and cared for in the home, rather than sending him to a hospital immediately.

Readmission

All children will be interviewed by the principal or a person designated by the principal. Either Form 302V or Form SR-3063A is acceptable for readmission to class, or a physician's written statement certifying recovery and freedom from communicability.

If none of the above statements is presented, the principal may readmit the pupil provided the period of isolation is completed, as specified in the Sanitary Code. These periods of isolation are as follows:

Anterior Poliomyelitis	Until end of febrile stage (considered
Meningitis	to be when temperature has been normal 24 hours)
Measles	5 days after appearance of rash
German Measles	5 days after appearance of rash
Mumps	When all swelling of glands is gone
Chickenpox	7 days after onset
Whooping Cough	21 days after whoop appears

Addendum to Group 3. Streptococcal sore throat including scarlet fever see see page 82A

Group IV. Minor Communicable Diseases—Special Handling

14. Scabies
15. Impetigo
16. Acute Conjunctivitis (Pink-eye)
17. Vincent's Infection
18. Pediculosis (see p. 83)
19. Ringworm (Except Ringworm of the Scalp, see p. 80)

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VIII

- Page 76: Group I - delete "2. Scarlet Fever";
4th line from the bottom - delete "and scarlet fever"
- Page 77: line 12) -(delete "and should....., form 36K." and
- Page 81: line 10) (replace with "which is to be forwarded to the nurse."
- Page 80: Under "Exclusion and Readmission of Contacts" -
Line 4 - delete "and enters....Form 36K."
- Page 81: Under "Readmission," paragraph 1 should read: "Pupil must
present Form 302V (Health) or SR-3063A (Hospitals), properly
signed. In ringworm of the scalp, only 302V is acceptable."
line 4: insert after Department of Health "or the Department of
Hospitals. (except ringworm)."
- Under Group III: Insert "2. Streptococcal sore throat, including
scarlet fever."
- Page 82: Addendum to Group III:
Streptococcal Sore Throat, including Scarlet Fever is now in-
cluded in Group III and subject to all provisions for this group
with the exception of readmission. Since it is essential to have
a physician's opinion before the patient is discharged, a child
suffering from this disease may be readmitted only if he presents
Form 302V or Form SR 3063A or a physician's statement certifying
freedom from communicability. In an uncomplicated case this may
be as short as 7 days after onset, while in complicated cases it
may be many weeks.
- Page 84: Under "Reporting...Cases," insert: "The school physician is
responsible for reporting any reportable disease as specified in
the Sanitary Code."
Paragraph 2 - delete "and measles."
Paragraphs 3 and 4 - delete entirely.
Group V. Change "Gonorrhoeal Vaginitis" to "Gonorrhoea."

MANUAL OF SCHOOL HEALTH PROCEDURES - Changes in Section

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Page 101: Group 1 - cases of diphtheria, tetanus, and pertussis.

Page 102: Group 2 - cases of scarlet fever, measles, mumps, and rubella.

Page 103: Group 3 - cases of typhoid fever, paratyphoid fever, and shigellosis.

Page 104: Group 4 - cases of meningitis, encephalitis, and poliomyelitis.

Page 105: Group 5 - cases of tuberculosis, syphilis, and gonorrhea.

Page 106: Group 6 - cases of leprosy, Hansen's disease, and other chronic infections.

Page 107: Group 7 - cases of malaria, hookworm, and other parasitic diseases.

Page 108: Group 8 - cases of skin diseases, including scabies, eczema, and impetigo.

Page 109: Group 9 - cases of eye diseases, including conjunctivitis and trachoma.

Page 110: Group 10 - cases of ear, nose, and throat diseases, including otitis media and tonsillitis.

Page 111: Group 11 - cases of dental diseases, including caries and periodontitis.

Page 112: Group 12 - cases of injuries, burns, and other accidents.

Page 113: Group 13 - cases of mental health problems, including depression and anxiety.

Page 114: Group 14 - cases of drug and alcohol abuse.

Page 115: Group 15 - cases of other health problems, including asthma and allergies.

The Control of Communicable Diseases

Exclusion

When notified that a child is suspected of having one of these diseases, the principal will exclude the child and, should the nurse not be in the school, give the parent instructions about the medical care the child is to receive. Until the child is dismissed from school, personal contact with other children should be strictly avoided.

Readmission

Children excluded because of diseases listed in Group IV, except for Ringworm of the Scalp (see p. 80) will be readmitted by the principal upon presentation of a physician's written statement certifying recovery or lack of communicability, or if the child has no further signs of the infectious condition.

PEDICULOSIS

The procedure regarding children who show evidence of nits or pediculi will be as follows (Board of Education, Special Circular No. 61, 1942-1943):

1. Teachers will refer children directly to the principal for exclusion.
2. Principals will notify parents of the suspected condition and suggest immediate treatment giving them Form 18K, directions for treatment.
3. Before readmission to school, the principal or a person authorized by him will make a careful inspection of the hair to make certain that there is no evidence of nits or pediculi.
4. Only in difficult cases will the principal seek the advice of the school nurse.

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Group V. Communicable Diseases and Contacts Excluded Only by Order of the Bureau of Social Hygiene and the Bureau of Tuberculosis of the Department of Health

20. ~~Gonorrheal Vaginitis~~ **Gonorrhœa**
21. Syphilis (in a communicable form)
22. Pulmonary Tuberculosis (in a communicable form)

Because of the nature of these diseases, cases are referred to specific Bureaus of the Department of Health for careful consideration so that the child may obtain the type of supervision which is best for him.

EXCLUSION AND READMISSION OF CASES AND CONTACTS

Children will be excluded or readmitted by the principal only after he has been informed by the school nurse that such exclusion has been authorized by the Department of Health. The school nurse will not divulge the diagnosis or the name of the bureau authorizing the exclusion.

REPORTING OF EXCLUDED SUSPECTED CASES

The principal will report to the school nurse the names of all pupils excluded because of suspected communicable disease.

The nurse will report the names of pupils excluded for the diseases in Group I (Diphtheria, Scarlet Fever, Smallpox) and Anterior Poliomyelitis, Meningitis and Measles in Group III to the borough office of the Bureau of Preventable Diseases.

~~The nurse will also report to her supervising nurse the names of children excluded because of the other diseases of Group III (German Measles, Mumps, Chickenpox, Whooping Cough). Such reports may be given to the supervising nurse (a) when the nurse reports in person at her local headquarters for morning assignment, or (b) when she telephones the district nursing office.~~

~~The nurse will make no report on children excluded because of diseases in Groups IV and V.~~

The school physician is responsible for reporting any reportable disease as specified in the Sanitary Code.

FOLLOW-UP PLAN FOR CHILDREN AFTER RECOVERY

Children readmitted to class by the principal after recovery from a communicable disease and who present evidence of below-par condition, will be referred by the principal and teacher to the school nurse.

The school physician will examine these children and render an opinion regarding the advisability of further medical care, modification of the school program, or placement in a Health Improvement Class. (See section 4.)

PROCEDURES FOLLOWED DURING ABNORMAL INCIDENCE OF COMMUNICABLE DISEASE

1. In the event one or more communicable diseases become prevalent in the community or in the schools, it will be the duty and responsibility of the Department of Health, through the district health officer, to confer with the assistant superintendent of schools in his respective district. Together they will arrange for a meeting of all the principals within the district to familiarize them with the existence of the prevalent disease, its symptoms, and modern methods of control and prevention. The district health officer and the principal will then arrange to instruct groups of teachers, with regard to both the symptoms of the prevailing communicable disease and the methods of control and prevention.

2. In the event a disease which has not already been called to the attention of the district health officer breaks out in any school, it will be the duty of the principal to call upon the district health officer for advice and aid in arresting and preventing the further spread of the communicable disease.

3. When advisable, the Department of Health will give to principals a letter to send to the parents informing them of the prevalence of a particular disease, a description of its symptoms, and the methods to be followed in its control and prevention.

9. THE CARE OF CHILDREN WITH VISION DEFECTS

CONSERVING the vision of school children and helping them to secure the best possible care for any vision defects they possess or may develop, are the true objectives of the program. Two major efforts are involved: (1) testing semi-annually every child in the elementary school systems for visual acuity, and (2) carrying out a well planned follow-up program for all children whom the test has shown to have defective vision. The efforts of teachers and nurses, and the cooperation of parents, and all agents concerned are essential to success.

EYE INSPECTION AND VISION TESTING ¹

On or before Health Day, teachers will test each child in the class for visual acuity. The Snellen chart will be used and the score recorded on the pupil's Health Card. This step in the screening process is usually taken first to discover children in need of ophthalmological care. During the school year the teacher will note on the pupil's Health Card symptoms of impaired vision which she has observed. History of past illnesses and the child's behavior while he is being tested, are considered when selecting children for referral to the school nurse.

In order to increase the effectiveness of the screening process, which in any case is a tentative means of finding children with impaired vision, standard techniques and conditions of testing should be used by both teacher and nurse. The following should be considered by the examiner in selecting children who may need further medical attention.

¹ Abstracted from "Eye Inspection and Vision Testing. A Screening Process." National Society for the Prevention of Blindness, 1790 Broadway, New York. 7 pp.

The Care of Children with Vision Defects

Signs or History

1. Normal childhood activity
 - a. Does he play easily with other children in games requiring (1) distant vision or (2) near vision?
 - b. Does he progress normally in school activities requiring reading, writing and drawing abilities?
2. Past illnesses related to vision
3. Form of illness
Headache, nausea, dizziness, sensitivity to light, blurred vision.
4. Conditions indicating visual disturbance
 - a. Crusts on lids among lashes, red eyelids, styes, swollen lids, watery eyes.
 - b. Apparent lack of coordination in directing the gaze of the two eyes.
5. Behavior indicating visual difficulties among children
 - a. Attempts to brush away blur; rubs eyes frequently; frowns.
 - b. Stumbles frequently or trips over small objects.
 - c. Blinks more than usual, cries often, or is irritable when doing close work.
 - d. Holds book or small playthings close to eyes.
 - e. Shuts or covers one eye, tilts or thrusts head forward when looking at objects.
 - f. Has difficulty in reading or in other school work requiring close use of the eyes.
 - g. Is unable to distinguish colors.

EQUIPMENT FOR VISUAL ACUITY TEST

Type of Chart

Careful selection of the type of chart to be used is essential to accurate testing. The chart should be:

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1. Standard Snellen
 - a. Symbol E (to be used from about three years of life and above)
 - b. Line of letters
2. Clean
3. Dull white finish for daylight illumination
4. Soft light-gray for artificial illumination

Lighting

The intensity of illumination on the chart will have a definite bearing on the results of the test. Too much light tends to offset defects and lessens the chances of discovering them. Glare, shadow, and inadequate light handicap even those with normal sight. Measuring the light on the chart and in the room with a light meter is the most accurate means by which to test the lighting. If one room is used for all vision testing, standard lighting may be provided by testing the light on the chart and in the room under varying conditions, such as a dull day, morning and afternoon lighting, etc., and making adjustments accordingly. A light meter might be used when first arranging the room for vision testing and again from time to time to check the lighting in the room.

1. Provide 10 foot candles of light evenly diffused over the chart without glare.
2. Avoid contrasts. Allow no bright light in the child's field of vision.
3. Provide general illumination in the room not less than $\frac{1}{2}$ of the chart illumination, that is, not less than 2 foot candles of light.

Distance of Chart

Rays of light from a distance of 20 or more feet are practically parallel when they reach the eye, and a minimum amount of ac-

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accommodation is required to focus them on the retina, therefore the eye is in the most satisfactory state of rest when looking at a distance. Snellen charts are drawn to an *exact scale for use at 20 feet.*

1. Mark *exact* 20-foot distance from the chart and subdivide at 5, 10, and 15 feet.
2. Place chart so that the child's eyes will be level with the 20-foot line.
3. Child may sit or stand.

Distances shorter than 20 feet are used *only* for the purpose of teaching small children to use the chart, not for the actual test. Those who cannot see the 200-foot line at 20 feet should move to the 15-10-5-foot line, or closer, if necessary. A 10-foot distance and a mirror are used occasionally, but in this case a good mirror must be used and glare eliminated. In most instances it is possible to find one room in the school of proper size with adequate lighting for vision testing. It might be desirable to set aside one room for vision testing to be used by all teachers and the nurse.

TECHNIQUE FOR TESTING

Preparation of the Child

Quiet and privacy are essential.

It is important for the child to understand the testing procedure and its significance for his own well-being. Undue fatigue or emotional upset may affect the results of vision tests. Preparation of the child should include the following steps:

1. Gaining his confidence and cooperation.
2. Making sure that he understands the procedure. When the Symbol E Chart is used a large letter E may be turned in various positions to show the child how to indicate the direction of the shafts.

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3. Making sure that he understands that this is a test of his ability to see, and not of his scholastic achievement.
4. Teaching him how to use the cover cards;
 - a. New card or folded paper for each child to be destroyed after use.
 - b. Keep both eyes open during the test.
 - c. Place card or paper over one eye, resting obliquely across nose.
 - d. Avoid pressure on eye.
 - e. Hold card or folded paper at edge.

Testing

A standardized routine avoids confusion and facilitates recording. Window cards (9 x 11½ inches) which have slightly larger holes than the letter on the line to be read call attention to one letter or symbol at a time and are helpful, particularly when working with the young child. To prevent older children from memorizing the chart, cards of solid cardboard may be used to cover the part of the chart not in use.

1. If child wears glasses, test first with glasses, then without.
2. Test the right eye first, then test the left eye, then test both together.
3. With children suspected of having low vision begin at the top of the chart.
4. With other children begin with the 50-foot line and proceed with test to include the 20-foot line.
5. It is unnecessary to test beyond the 20-foot line.
6. Move promptly and rhythmically from one symbol to another at the speed that the child can keep.
7. The order in which the symbols on a line are read should be varied among children and between the two eyes.
8. Encourage the child to do his best to read the symbols but avoid permitting him to strain. Be patient.

The Care of Children with Vision Defects

9. Remember that the young child has a short span of attention. Avoid fatigue. A retest may be needed for young children.
10. When using the Symbol E chart, show one vertical and one horizontal symbol on a line and move to the next. In the last line read correctly or in the 20-foot line use all four symbols.
11. Reading three out of four symbols or letters is usually considered evidence that the child sees that line satisfactorily.

Observing during Test

It is important to observe the child's behavior during the test. Ability to read the 20-foot line at a distance of 20 feet is not always evidence of good vision. If the child strains in order to see, do not permit him to go on but record the last line read correctly without strain. Some indications of strain are:

1. Thrusting the head forward
2. Tilting the head
3. Eyes watering
4. Frowning or scowling
5. Puckering the face
6. Closing one eye during the test of both eyes
7. Excessive blinking

Recording the Findings

1. Record visual acuity in order given for right eye, for left eye, for both eyes.
2. Record visual acuity as if it were a fraction. The numerator equals the distance from the chart, the denominator the line on the chart read correctly. 20/20 therefore means that the child reads accurately the 20-foot line at a distance of 20 feet.
3. Visual acuity is recorded on the pupil's Health Card by the teacher and on the School Medical Record by the nurse for those children who are retested by her.

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4. Correlate all findings. Record visual acuity, observation of behavior during test, eye conditions noted in inspection and behavior observed in classroom.

Evaluating Results

General systemic diseases and focal infections have a close relationship to eye health. All findings regarding eye health and general health should be correlated. Visual acuity, observation of behavior during the test, eye conditions noted on inspection, behavior observed in the classroom—all reveal children in need of medical examination.

Refer for Further Medical Attention

1. Children who consistently present symptoms of visual disturbance regardless of visual acuity.
2. Children who have a visual acuity of 20/40 or less with or without symptoms.

FOLLOW-UP PROGRAM

Studies have shown that the teacher's accuracy in vision testing is high among children whose visual acuity is 20/50 or worse. In fact she is usually correct in 95 out of 100 cases. Among borderline cases, however, that is, children with 20/40 vision, the nurse generally confirms the teacher's findings in only about one half of the cases. Retesting of the first group of children by the nurse is unnecessary; she will reexamine only the children in the latter group.

The various procedures will be described in detail under the following classification: (1) children who do *not* wear glasses and (2) children who wear glasses.

Children Who Do Not Wear Glasses

The Teachers' Classifications. After the teacher has finished testing the children in her class, she lists for transmission to the

The Care of Children with Vision Defects

FIGURE 17

VISION LIST—TEACHER HEALTH DAY
(Children who have not previously worn glasses)

School.....	Grade.....	Boro.....	
District.....	Teacher.....		
Date.....	Nurse.....		
20/40	Name of Child	20/50 or worse	Name of Child
			Vision Score
.....			
.....			
.....			
Normal eye test—Symptoms of eyestrain			
.....			
.....			
DEPARTMENT OF HEALTH—CITY OF NEW YORK			
454K			

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school nurse, on Form 454K (see Figure 17), the children who do not wear glasses and who are considered to have defective vision for one of the following reasons:

- a. Vision of 20/40
- b. Vision of 20/50 or worse
- c. Vision of 20/20 or 20/30, but with symptoms of eyestrain

Retesting Children with 20/40 Vision. When Form 454K is received from the teacher, the school nurse retests those children whom the teacher listed as having 20/40 vision, retaining in her record for follow-up only the names of those whom she confirms as having defective vision.

Parent Consultation. The nurse will interview parents of children with defective vision. She will explain the nature of the

findings, and help in planning for medical care and obtaining glasses, should they be necessary.

Securing Examinations and Glasses

The nurse should determine, on an individual basis, whether the family should be referred for private or clinic care. While it is not desirable to set up definite economic ratings as to "ability to pay," services rendered without charge should not be abused.

(1) Private Physician or Nondepartment Clinic

It is important that both nurse and teacher know whether the glasses which the child has obtained correct his vision, and whether the treating agency has made specific recommendations as to when glasses should be worn, seating arrangements, etc. For this reason, the nurse, when she refers a child for eye care, should give parents Form 167K (Figure 18) with instructions to return this form to her when glasses have been obtained and the examination is completed.

In hospital eye clinics, children receiving prescriptions for glasses are usually referred to the optical department of the clinic, where ordinarily a fee is charged. Part of this fee may be paid by an organization, for example, parent-teacher association, mothers club, and Junior Red Cross, associated with the school which the child attends. To obtain this assistance, children should be referred to the principal of the school, who usually has charge of funds from private agencies to be used for this purpose.

(2) Department of Health Eye Clinics

Children should be referred to these clinics when care elsewhere is not readily available. Since all cases must have appoint-

FIGURE 18

REPORT OF VISION CORRECTION WITH GLASSES

To SCHOOL NURSE, P.S.....	Date.....
Name of child	Class.....
Diagnosis.....	Return date.....
Vision score without glasses, Rt. Eye.....	Left Eye.....
Maximum correction obtainable, Rt. Eye.....	Left Eye.....
When are glasses to be worn.....	
Other recommendations.....	
.....	
.....	
.....	Signature
.....	
.....	Address
DEPARTMENT OF HEALTH—CITY OF NEW YORK	
167K	

ments, the nurse will explain to the mother that notice of a definite appointment will be sent to her through her child, as soon as it is received. The nurse then fills in Form 457K (see Figure 19) checking "new case," and sends it to the eye clinic registrar who fills in an appointment date and returns the form to the nurse.

If glasses are ordered after the examination, the parent may have the prescription filled by any optician or may select one of the eye clinic's "panel of opticians" who offer reduced rates. If financial aid is necessary it should be arranged through the principal as in (1) above. At the time of the original prescription the mother will be given a return appointment to the eye clinic for evaluation of correction with the glasses. After this evaluation, the eye clinic registrar will send Form 167K to the school nurse.

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FIGURE 19

EYE CLINIC REFERRAL AND APPOINTMENT CARD

DEPARTMENT OF HEALTH—CITY OF NEW YORK

School No. District No. Date.....

.....

..... Name Address

.....has been given appointment at.....o'clock

Class

on.....

..... Date

Reason for appointment: New Case

Broken appointment on.....

..... Date Date Date

(check one) Periodic Reexamination

.....

..... Eye Clinic Registrar

457K

Clients of the Department of Welfare may have a prescription for glasses filled by presenting it to the medical social worker of the district in which the child lives. In this case, the Department of Welfare clinic will reexamine the child after his glasses have been fitted. Therefore, the eye clinic nurse or registrar will give the parent Form 167K for delivery to the medical social worker with the prescription. The Department of Welfare will send Form 167K back to the eye clinic where the prescription was originally given. The clinic case record will be completed and the form then sent to the school nurse.

The Care of Children with Vision Defects

Children Who Wear Glasses

The teacher is responsible for continued observation and follow-up work with all children who wear glasses but periodic medical examination is necessary. The frequency of examination depends upon the child's vision defect and is determined by the treating physician or agency.

Immediate action is indicated if any of the following situations exist:

1. If children no longer obtain the best possible correction with glasses.
2. If glasses have been lost or broken.
3. If children show signs of eye strain despite having worn glasses and having followed the physician's recommendations for one month.

The procedure will vary with the following groups:

(1) *Private physician or nondepartment clinic cases*

The teacher will instruct parents to take the child to the physician or clinic where he received treatment, when periodic examination is due or when immediate examination is necessary.

(2) *Department of Health clinic cases*

(a) Periodic reexamination of children wearing glasses is usually done at intervals of six months or one year. The clinic is responsible for sending Form 457K with an appointment date to the school nurse, who will forward it to the teacher to give to the child, when such examination is due. When the examination is completed, Form 167K will be sent to the school nurse in the usual way.

(b) Where immediate examination seems to be indicated, the teacher will refer the child to the school nurse, who will request an appointment at the clinic on Form 457K (checking "periodic reexamination," and making a brief

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statement concerning why she is requesting examination at this time). A telephone appointment may be made if the case appears to need more urgent attention.

When glasses are lost or broken, or the prescription is lost, the clinic physician will decide whether a duplicate prescription may be given, or whether a new examination is required. A duplicate prescription may be attached to Form 457K or a new appointment made, and the form returned to the school nurse.

SIGHT CONSERVATION CLASSES

The purpose of this class is to help compensate for the poor eyesight of children, who, because of this defect cannot keep up with the work in a regular grade, and to conserve, and if possible, improve the eyesight of these children. The standard generally used for admission is: vision of 20/50 or poorer in the better eye after refraction, a pathological or progressive condition, or a post-illness weakness.

All applications for admission or withdrawal, whether originating in Department of Health eye clinics or outside sources such as private physicians, and hospital eye clinics, will be sent to the supervising ophthalmologist of the Bureau of Child Hygiene. He will review the application and if there is any disagreement, communicate with the original source of recommendation to discuss the case and arrive at an understanding about the proper class for the child. The application with the recommendation of the supervising ophthalmologist will then be forwarded to the Inspector of Sight Conservation Classes, Board of Education.

This program which has been adopted by the Department of Health as its major aim finds the following:

10. DENTAL CARE

BECAUSE DENTAL decay is almost universal and recurrent among school children, dental care is one of the most important parts of the school health program.

Ideally dental care should begin when the child is two years of age for then nearly all the deciduous (baby) teeth will be in position. Care should be continued at regular intervals, thereby assuring preservation of the teeth and minimizing the loss of teeth. Experience and practice have clearly shown that the most effective means of maintaining a good set of teeth is to eat the proper foods, chew well, clean the teeth properly, and pay particular attention to the correction of small defects, thus preventing progressive loss of tooth structure and eventual loss of the teeth. A full set of teeth assists mastication and proper enunciation. Because of defective anterior teeth young people often develop psychological problems. The teacher should not fail to stress the importance of well formed, clean teeth to the pupil's appearance.

One of the greatest problems of the school dental health service is the inability to take care of the dental needs of all children. The best that can be done is to choose the group among which the most beneficial results can be obtained and to utilize in the most effective manner possible the corrective facilities available.

To choose the group of school children to be given dental service is not an easy task. Some will feel that the older children with the greatest need should receive first consideration. Since this procedure is reparative, its effectiveness is limited. Remedial care among older children can continue indefinitely and if the dental service is given only to this age-group the result is a constant supply of new patients from the younger groups, whose teeth are in as bad or worse condition through neglect.

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This program which has been adopted by the Department of Health has as its major aims the following:

1. To inform parents of the need and importance of proper care of the teeth, by conducting a wide educational program emphasizing the importance of eating the proper foods, chewing well, and keeping the teeth and mouth clean.
2. To urge parents to arrange for children to visit the dentist at regular intervals (twice a year if possible) for the purpose of discovering tooth decay and other abnormalities, and securing reparative and corrective attention early.
3. To maintain dental clinics where examination, instruction concerning brushing teeth properly, prophylaxis, fillings, and extractions are available to children whose parents are unable to obtain such services from a private dentist or a part-pay clinic.

Direct dental service in the schools, therefore, usually extends from the kindergarten through the fourth year, but also provides for certain preschool children and for children who wish to obtain their working papers. The latter are considered emergency cases. The program attempts, during the early critical years, to follow children in as thorough a manner as possible. Every attempt is made to impress the parents with the importance of carrying on from this point. It is hoped, too, that having removed the accumulated defects, parents will be able to take care of the annual recurrence or incremental needs.

To maintain the program outlined above requires the collaboration of the school authorities, health authorities, and parents.

All available community resources should contribute to the Dental Health Program—the private dentist to the fullest extent possible, the dental facilities of hospitals, social and welfare organizations, and other child-care organizations, as well as the Department of Health clinics. Principals and district health officers are urged to acquaint themselves with local facilities in order that full use may be made of the services available.

THE DENTAL CLINICS OF THE DEPARTMENT OF HEALTH

The dental clinics of the Department of Health located in school buildings offer services to children up to and including the fourth year, giving preference to those from kindergarten through the second year. Dental clinics in health centers usually treat preschool children and those above the fourth year. However, the district health officer may permit sessions at the health center to be given to children up to the fourth year.

The school with a clinic serves the schools that do not have clinics. Each school in the vicinity of the dental clinic gives a specific number of days or hours or a certain number of appointments for individuals. The district health officer gives or mails to each principal in his district a schedule stating the days and the numbers of hours and appointments available for his school.

Each principal selects a teacher in his school who makes appointments for children according to the schedule of the neighboring school dental clinic or health center. By mutual agreement of the principal and the district health officer this arrangement may be modified to suit the needs of the school.

The teacher in charge of making the dental appointments refers children by using Form 31K. (See Figure 20.) The children are also instructed to bring their parents to the dental clinic on the initial visit.

THE ROLE OF THE CLASSROOM TEACHER IN THE DENTAL PROGRAM

As part of the regular classroom instruction in health, teachers emphasize the importance of the following:

1. Adequate diet
2. Chewing food well
3. Daily care of the teeth (brushing)
4. Regular visit to the dentist

Procedures for the School Health Services

FIGURE 20

CLINIC REFERRAL FORM

DEPARTMENT OF HEALTH CITY OF NEW YORK	
Name	194.....
Address	
Take this card to	
Days and hours	
Referred for	
Sent from (name and address of clinic, center, station, etc.)	
	R. N.
31K	

On Health Day the teacher sends a notice to the parents of each child in her room recommending a dental examination and requesting a note from the dentist concerning the child's dental status. The Board of Education furnishes Form 378 AA (not illustrated) for this purpose. The teacher should not send notices if they have already been distributed by the dental hygienist in connection with her work in the particular school.

Depending upon the economic status of the family and other circumstances, the teacher will refer parents to one of the following persons or agencies through which dental care may be obtained:

1. Private dentist
2. Dental clinic of hospital or social welfare agency
3. Teacher in charge of making appointments at the Department of Health dental clinics

REFERRALS TO DEPARTMENT OF HEALTH CLINICS

The dental hygienist or the teacher responsible for making appointments with the Department of Health clinics will refer the younger children first, giving preference, however, to those whom the hygienist, in her inspection, has found to have the greatest dental needs. Emergency cases should be given immediate care. Children above 12 years of age who are clients of the Department of Welfare should be referred to the clinics maintained by that department.

Recording

The dental care which each child receives should be recorded by the classroom teacher on the pupil's Health Card.

THE ROLE OF THE NURSE AND PHYSICIAN

When dental needs are discovered by the school physician and nurse and the child is not receiving dental care, the parents should be referred to one of the following:

1. Private dentist
2. Dental clinic of hospital or social welfare agency
3. Teacher in charge of making appointments at the Department of Health dental clinics

The school physician should consider dental health education a part of every health examination made by him, and every consultation of nurse with child or parent should include inquiries and helpful information concerning dental health. It is suggested that the physician and nurse utilize the specialized knowledge of the dental hygienist and dentists in the schools.

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THE WORK OF THE DENTAL HYGIENIST

The dental hygienist of the Department of Health has the following duties:

A. *Clinical*

1. Assist the dentist
2. Provide prophylaxis for children treated by school dental service
3. Inspect the mouths of all children from kindergarten through the fourth year to determine urgency of need for dental care. These inspections will be made in the classroom on days arranged with the principal by the district health officer

B. *Organizational*

1. Make appointments for Department of Health dental clinic which she serves
2. Cooperate with teachers by referring children to family dentists or other dental facilities

C. *Educational*

1. *Classroom instruction:* This may take the form of a talk to the class or instruction in tooth brushing or the preparation of educational material for classroom projects. All of this is arranged through the district health officer and the school principal.
2. *Individual instruction:* The hygienist utilizes all individual contacts, inspection, prophylaxis, etc., as an opportunity for explanation of the importance of oral hygiene.
3. *Follow-up Work:* Cases that have not responded to recommendation for dental care will be followed up by the dental hygienist.

Dental Care

- a. Conference with parent in school, by appointment
- b. Home visit in cooperation with nursing service

WORK OF THE DENTIST IN THE SCHOOL

The duties of the dentist in a school clinic are concerned with treatment and consultation. The primary function of the school dentist is to render adequate dental service to each child that comes within the scope of the clinic's service. This treatment is directed along the lines of prevention of loss of teeth and of emergency care.

The dentist should be available during his hours on duty for consultation and to advise parents, children, or members of the school staff seeking authoritative information beyond the scope of the hygienist's activity.

11. THE CARE OF CHILDREN WITH HEARING LOSS

IMPAIRED HEARING in a child is a serious educational handicap. A child with a hearing deficiency is of special concern to the school physician, nurse, and teacher because the condition usually requires close supervision and often, as in the case of a child with a serious loss of vision, a special type of education.

Children who can hear only moderately well are frequently helped by certain medical treatment. Impacted wax, a chronically infected upper respiratory tract and chronically infected ears are the most frequent causes of hearing deficiencies among school children. Other more serious causes are diseases that involve the auditory nerve. The latter causes usually produce an irremediable hearing loss which if sufficiently serious will require the child to be placed in a school for the deaf. Assigning the child who is moderately hard of hearing (less than 20 decibels in both ears) to a front seat may be sufficient to overcome his educational handicap. Children with a hearing loss of 20 or more decibels in both ears, however, usually require instruction in lip reading.

Teachers, physicians, and nurses should be alert to the possibility of detecting hearing deficiencies among children who appear shy, fail to hear questions addressed to them in the classroom, do not play with other children, have little interest in school work, or have chronically infected or draining ears.

The child who does not have normal hearing is one of the most neglected children in our schools today. Without periodic audiometer tests to reveal the hearing defect, the condition is seldom detected in its early stages by the school physician or observed by the teacher. The child who is hard of hearing generally learns to compensate for his loss as quickly as possible and detection is therefore difficult.

The Care of Children with Hearing Loss

CASE FINDING AND TESTING OF CHILDREN WITH HEARING LOSS

Role of the Teacher. The teacher is in an excellent position to discover children who have moderate hearing loss. Although the detection of this condition is difficult, there are significant leads which she may use in discovering the child who is hard of hearing. Significant behavior symptoms, history of repeated colds, and diseased and enlarged tonsil and adenoid tissue may indicate a child whose hearing is impaired.

Role of Nurse and Physician. If the school nurse and physician constantly bear in mind that hearing loss may be a possible cause of school retardation or behavior problems, and if they are aware also of the importance of a history of repeated upper respiratory infections and chronically infected ears, more children with mild or moderate hearing deficiencies will be discovered than is now the case.

Audiometer Tests. The audiometer test conducted annually will aid in the discovery of children with loss of hearing in its early stages. Between annual audiometer tests, teachers may observe symptoms in their pupils which may lead them to suspect impaired hearing. Every effort should be made to have such a child tested with the 4A audiometer. Since the apparatus is in use somewhere in the district arrangements can usually be made for having the child tested in the school where the apparatus is located. After the test has been made the case should be handled in the same way that those tested routinely in the school are handled.

The group audiometer test (4A) should be conducted annually. It provides a more accurate means of discovering pupils with impaired hearing. Whether normal or defective, the findings of each pupil's hearing test should be recorded on his Health Card. Before teachers enter such information they should make certain of its accuracy. If the hearing test indicates that the pupil's hearing is normal, the teacher should enter under *Hearing* the let-

Procedures for the School Health Services

ter *N* (normal). If it is definitely established by retesting with the 4A audiometer that hearing loss is present, the score of hearing loss, for example, 9-12-15, in one or both ears, should be entered on the health card. If, the retest shows that *more than 10 per cent* of all the children tested have a hearing loss, the chances are that something is wrong with the machine, with the environment, or with the testing technique. These conditions, if present, should be corrected before proceeding with further tests, recording findings on the Health Card, or referring the child to nurses, parents, or outside agencies.

Only pupils with definitely known hearing loss should be referred for a subsequent 2A audiometer test. The scope of this test should also be entered on the pupil's Health Card. It is hoped that arrangements may be made to establish a center in each borough to which pupils may be sent for the 2A audiometer test. In the meantime principals should continue, when possible, to refer pupils in need of the 2A test to the School for the Deaf, 225 East 23rd Street, Manhattan, or to the New York League for the Hard of Hearing, 480 Lexington Avenue, Manhattan.

Since schools are now required to conduct annually the group audiometer tests of their pupils, it is essential that care be exercised to arrange for the proper conduct of the tests, to select the proper personnel from the teachers (often health counselors) to direct and administer them, and to keep accurate records of the results. Furthermore, continued effort should be made to have each child with a hearing defect receive medical attention. His Health Card should always indicate that he is under medical supervision.

Following the 4A audiometer test, children whose score shows 9 or more decibels hearing loss in one or both ears should be referred by the principal for the 2A audiometer test. It is recognized, however, that because of limited facilities, all children will not have this test.

The Care of Children with Hearing Loss

PROCEDURES FOLLOWED IN THE CARE OF HEARING DEFECTS

Children who show a hearing loss of 15 decibels or more on the 4A or 2A audiometer test, and children who present symptoms or give a history of ear disease will be referred to the nurse. She will initiate a plan as she would for any known defect. Pertinent facts, such as symptoms of ear disease, date of the 4A or 2A audiometer test, with hearing loss found, will be recorded on the face of the School Medical Record under "Additional Notes and Examinations."

The nurse will arrange for a conference with the parent either in school or at home, to discuss the child's health problem and arrange for medical care. Form 221S, with exact data concerning symptoms and results of audiometer tests recorded on it, should be used in referring the child either to a private physician or to the ear, nose, and throat clinic. When the report from the agency giving treatment is received, the nurse should confer with the principal and the teacher to discuss the child's problem. Recommendations for adjustment in the school program are made at this time and recorded on the pupil's Health Card under "Nurse's Notes." The nurse will confer with the school physician regarding recommendations, and keep him informed about the progress of the case.

12. FINDING AND REFERRING CHILDREN WITH SPEECH DISORDERS

EVERY EFFORT should be made to secure as early as possible the necessary medical treatment and speech education which children with speech defects require, for speech defect is often an important handicap to a child's emotional, social, and educational development.

CASE FINDING AND FOLLOW-UP CARE

Procedures for Finding and Referring Children with Speech Disorders

The Department of Speech Improvement estimates that from 5 to 8 per cent of the school population have speech defects that are clinical in nature and that prevent pupils from communicating with others or making satisfactory social adjustments. These defects are of such a nature that they require individualized instruction by specially trained persons.

The speech therapists from the Department of Speech Improvement are responsible for identifying the pupils who have speech defects. The teacher is also expected to refer her pupils to the therapist when she needs advice about a pupil's speech. The therapists diagnose all such cases and decide whether there is a physical basis for the defect. If a physical basis is found, the pupil is referred to the school health service for an examination by the school physician and subsequently referred to a treatment agency.

In the approximate 300 elementary and junior high schools that do have the services of a speech therapist, principals, teachers, and particularly nurses should refer all children with speech defects to the Department of Speech Improvement of the

these speech therapists. Where no speech therapist is assigned, children should be referred to

Finding and Referring Children with Speech Disorders

Board of Education, 110 Livingston Street, Brooklyn. This procedure is in accordance with a ruling by the Superintendent of Schools contained in General Circular No. 18, February 4, 1937;

. . . private doctors or other specialists are not to be recommended to pupils or parents for the correction of speech disorders. All inquiries concerning such matters should be referred to the Division of Speech Improvement, Mrs. Letitia Raubicheck, Director, 110 Livingston Street, Brooklyn.

In schools that do not have the services of speech therapists, the school nurse and the physician can assist greatly in identifying pupils with speech defects. and in referring these children to the office of the speech improvement director.

SUGGESTED DEFINITIONS OF TERMS

The following definitions, prepared by the Department of Speech Improvement, should be of assistance in identifying these children:

1. *Choreatic (arhythmic) speech* shows spasmodic interruptions without reference to the difficulty of the sounds, and without reference to outside circumstances.
2. *Stammering or stuttering* is any repetition, hesitation, or prolongation of sounds in speech.
3. *Mutism* is characterized by complete absence of normal articulation caused by malformation or imperfect innervation of the organs of articulation.
4. *Articulatory defects* are those disorders of speech characterized by the substitution, addition, omission, and distortion of speech sounds.
5. *Lisping* is an articulatory disorder characterized by any marked deviation in the production of the sibilants.
6. *Lingual protrusion lisping* is characterized by the tongue protruding between the teeth when producing any or all of the sibilants.
7. *Lateral emission lisping* is characterized by issuing the sound from one or both sides of the mouth when producing sibilants.

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8. *Nasal emission* is characterized by issuing the sound through the nose when producing sibilants.
9. *Dental lisping* is characterized by the pressure of the tip of the tongue against the upper or the lower teeth in producing sibilants.
10. *Lalling* or *lallation* is any unintelligible speech or the inability to pronounce the sounds of *r* and *l* because of the sluggishness of the tongue.
11. *Other sound substitutions* include those not covered by a specific grouping in the outline.
12. *Foreign accent* includes all those omissions, substitutions, and additions of sounds or syllables, and all those changes in intonation caused by the influence of a language other than English.
13. *Voice defects* are all those faults and disorders of voice caused by physical disability, emotional disturbances, or habit.
14. *Nasality* is a defect of voice characterized by the chronic emission of vocal tone through the nasal orifice.
15. *Denasalization* is the lack of adequate resonance in the production of the sounds of *m*, *n*, *ng*.
16. *Aphonia* is lack of voice usually characterized by breathy whispering, impairment of vocal activity through physical disability or emotional disturbance.
17. *Pitch anomalies* are self-explanatory.
18. *Hoarse voice* is a disturbance of vocalization caused by an emotional disturbance or a physical disability which affects the vocal cords.
19. *Aphasia* is the inability to comprehend, formulate, or express ideas through speech, usually arising from injury or disease of the central nervous system.

13. THE CARE OF CHILDREN WITH DISEASED TONSILS AND ADENOIDS

SCHOOL PHYSICIANS will designate on the School Medical Record and on the pupil's Health Card that tonsils and adenoids require attention *only* when there is a clear medical indication, such as:

1. History of frequent upper respiratory infections, including colds, sore throats, tonsillitis, and swollen glands.
2. Ears have a chronic discharge and the medical findings show that tonsils and adenoids are so enlarged that they obstruct breathing or interfere with swallowing.

Children having a medical history or findings similar to the above will be referred to their physician. The school physician will write on the referral form (Form 12K) a brief description of the important history as well as physical findings. "Tonsils" or "diseased tonsils" are terms not sufficiently informative to be useful.

In the absence of a history or of physical findings such as the above cases with tonsils that are cryptic, infected, or associated with palpable cervical glands should be designated and placed "under observation," with the approximate date for reexamination by the school physician written on the School Medical Record. No recommendation for medical attention by another medical agency or the family physician should be made until evidence of disease or obstruction, as mentioned above, is verified.

A brief statement of the doctor's opinion and the plan for observation or disposal of the case (or a definite statement that no such observation and no medical attention is necessary when this is the case) should be placed on the pupil's Health Card.

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Terminating Follow-up Procedure

Cases in which diseased tonsils or adenoids diagnosed according to criteria stated above have been found by the school physician may be released from further follow-up effort by the nurse if the tonsils or adenoids have been removed, or if a note from the physician in charge states that no treatment is recommended, or if, after a period of observation, no significant history of disease or obstruction is recorded.

Children having a medical history or findings similar to the above will be referred to their physician. The school physician will write on the referral form (Form 12K) a brief description of the important history as well as physical findings. "Tonsils" or "diseased tonsils" are terms not sufficiently informative to be useful in the absence of a history or of physical findings such as the above cases with tonsils that are enlarged, inflamed or associated with palpable cervical glands should be designated and placed "under observation" with the approximate date for re-examination by the school physician written on the School Medical Record. No recommendation for medical attention by another medical agency or the family physician should be made until evidence of disease or obstruction, as mentioned above, is verified. A brief statement of the doctor's opinion and the plan for observation or disposal of the case (or a definite statement that no such observation and no medical attention is necessary when this is the case) should be placed on the pupil's Health Card.

14. THE CARE OF THE BELOW-PAR CHILD

BELOW-PAR is a relatively new term used to designate those children who, though they do not show signs of any specific illness, are obviously not well or sturdy children. The term is broader than terms formerly used, for example, malnourished or undernourished. The latter terms carry a connotation of a food deficiency often unwarranted because the underlying causes may not be directly related to food. Below-par is a more apt term, quite general and nonspecific to be sure, but nevertheless indicative of subnormality expressing itself in a generally poor physical condition.

Characteristic signs of a below-par condition which may manifest themselves singly or in combination are:

- a. Pronounced skinniness
- b. Poor posture
- c. Flabby musculature
- d. Appearance of excessive fatigue or weakness
- e. Slow response
- f. Pronounced or unnatural pallor
- g. Hyper-irritability
- h. Antisocial attitude
- i. Feelings easily hurt
- j. Frequent colds or other illnesses often resulting in absence from school
- k. Inattention and lack of interest
- l. Retarded increase in both height and weight

The children having the above characteristics are not vigorous or healthy looking. It is obvious that something is wrong, and that some effort should be exerted to discover the underlying causes.

FINDING THE BELOW-PAR CHILD

The physician's approach to these problems will be to learn the history of the case, asking both parent and teacher for information. The course of development during the early years, illness, past and present diets, health habits, home life as it relates to opportunities for sleep and rest and play, or to the child's happiness, pleasant associations—all these factors may require exploration for information with which to supplement the physician's direct medical observations and the special examinations or tests that are indicated. The possibilities of the child's having tuberculosis, rheumatic fever, diabetes, etc., are not to be overlooked in this connection.

Special attention is called to the child returning to school after an acute illness. Weakness resulting therefrom may call for a modified program for a month or more.

As a result of past experience in selecting what was called the malnourished child, one caution should be pointed out. The custom of placing reliance on height-weight tables as the principal means of rapid selection of undernourished children has been discarded as a health criterion. The present-day expert believes that this practice is not sound. Even though less objective than the weight-for-height measures, it is believed that the subjective medical judgments supported by detailed histories are better means of selecting below-par children who merit follow-up work. The child's own progress should be observed carefully and the height and weight measurements should be recorded once each school term on the pupil's Health Card to aid the teacher, nurse, and physician in discovering children who appear to be growing too slowly or too rapidly. Failure to gain weight over a period of a year should, of course, be taken under consideration.

RECOMMENDATIONS FOR THE BELOW-PAR CHILD

Children with physical defects which are remediable will, of course, be referred for medical care.

If home conditions are such that they operate to the detriment of the child's and family's health, referral will be made to social welfare agencies, family welfare agencies, child guidance clinics, the Department of Welfare, boy and girl scout organizations, neighborhood houses, and other social organizations.

If the child's health habits are poor, his teacher's help will be enlisted in helping to formulate his educational program. The physician will record the child's poor health habits and his recommendations on the pupil's Health Card.

MODIFIED SCHOOL REGIMES FOR BELOW-PAR CHILDREN

In addition to prescribing medical care and advising concerning social adjustments in the home, it may be desirable to alter the child's school program for a period of time. A number of arrangements may be provided which will bring about satisfactory results. A child who attends a regular class may be given a rest or study period in place of the gymnasium period; he may be permitted a shorter school day, arriving later and leaving earlier; his lunch period may be lengthened; he may be provided with mid-morning nourishment or a regular hot lunch; or, to prevent strain, an arrangement may be made for his having an extra set of books so that he need not carry heavy books to and from school every day; or he may be assigned a period each day when he can rest on a cot in a quiet room.

A more extreme step may be taken, if the situation calls for it; a child may be assigned to a Health Improvement Class full time. This class offers certain advantages to the child whose regime needs to be entirely modified. Cots are provided during stated rest periods. The school regime is often lightened. The enrollment in such a class ranges from 15 to 25 pupils. A special teacher is assigned to this class and with a smaller registration it is possible for her to give more attention to each individual.

In general, it may be said that assignments to the Health Improvement Class are made for those who are not likely to respond

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to special attention in the regular class. The special class regime, as well as modifications in the regular class in the interest of health, is under study and further clarification of these procedures may be expected in due time.

RESPONSIBILITIES OF PHYSICIAN, NURSE, TEACHER, AND PRINCIPAL

The responsibility for recommending placement in the Health Improvement Class and prescribing changes in school programs for children in both special and regular classes rests with the school physician.

If a recommendation that a child be placed in a Health Improvement Class comes from a source other than a school physician, the health status of the child will be reviewed by the school physician and his approval obtained before placement can be effected.

The school physician may recommend that children be placed in a Health Improvement Class for varying lengths of time. For example, a child returning from convalescence after an acute illness and unprepared to carry a full program, may be recommended for placement in such a class for a period of one, two, or three months, depending upon the physical status of the child.

Children will be removed from the Health Improvement Class after the school physician's recommended period of stay has elapsed, a period that should not be less than one month. If, at the termination of the stipulated period, the teacher or nurse questions the wisdom of transferring the child to a regular class, the school physician on his next visit will reevaluate the physical status of the child and make the decision. Should a recommendation for removal from the Health Improvement Class be received from an agency outside of the school, for example, the clinic physician, family physician, or the parent, no action will be taken until the school physician has confirmed the recommendation.

The school physician may recommend that the child be removed from the Health Improvement Class to a regular class in which some modification of the program can be established (such as is described on p. 117).

All recommendations that the school physician makes or approves should be effected by the school principal as soon as possible. If facilities are not available, or if there is any question regarding the method of effecting the recommendations which have been made the school principal or the school physician will arrange for a joint conference to discuss the best alternative program. Principal, physician, nurse, and teacher may participate, and if necessary, the supervising school physician and supervising nurse may be invited to the conference for consultation.

The principal will inform the office of the Bureau of Physically Handicapped Children of the Board of Education regarding all children in special classes and in regular classes whose school programs are modified as recommended by the school physician. In addition she will forward to that Bureau the names of all children who have again taken up the regular class program. If the needs of a child cannot be met in one school the Bureau for Physically Handicapped Children may be able to transfer the child to another school where satisfactory facilities are available.

The teacher, nurse, and school physician will hold a classroom conference once each term, usually in September and in February, to review the progress of each individual in the Health Improvement Class and make such adjustments as are indicated.

PROCEDURES FOR PAROCHIAL SCHOOLS

When a child in a parochial school is recommended for a Health Improvement Class by the school physician, or when such a recommendation is received from an outside source and is approved by the school physician, the recommendation will be brought to the principal of the parochial school. The final dis-

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position of the case will rest with the parochial school authorities. Arrangements may be made to provide modifications within the parochial school, or a transfer to a school with a Health Improvement Class may be effected.

15. THE ORTHOPEDICALLY HANDICAPPED CHILD*

FOR PURPOSES of this service an orthopedically handicapped child is defined as an individual under 21 years of age who, through hereditary, congenital or acquired defects of his skeletal structure or neuromuscular mechanism, is so handicapped, or who, because of the progressive nature of his condition may be expected to become so handicapped as to be unable to compete on terms of equality with a normal individual of the same age.

The register referred to in this chapter is a listing of the names of orthopedically handicapped children with accompanying case history material. It is maintained by the Division for Physically Handicapped Children of the Bureau of Child Hygiene, Department of Health, on the basis of case reports submitted by the various agencies within the City of New York. It is used to evaluate the present and potential needs of individual children and to estimate the needs of the city as a whole in meeting these individual problems.

The number of orthopedically handicapped children is not known, but it has been estimated that there are about 19,000 of these children in New York City.¹ In 1940 there were 16,843 orthopedically handicapped children listed on the register of the Division for Physically Handicapped Children representing a prevalence of 7.7 per 1,000 population under twenty-one years of age, and a prevalence of 2.3 per 1,000 total population.

The Division for Physically Handicapped Children, Department of Health, is given the responsibility for assisting in the coordination of community services for physically handicapped children. This means that through the Division the community

* Experimental work is being done in several health districts and these procedures may be subject to change in the near future.

¹ The Crippled Child in New York City. Report of the Commission for Study of Crippled Children, published by the Commission, 1940. 218 pp.

is endeavoring to bring into increasingly close cooperative relationship community resources serving the total health, educational and vocational needs of the orthopedically handicapped child. For this reason all children with orthopedic handicaps should be reported to the Division regardless of the present status of their educational or medical needs provided the disability is severe enough to constitute a handicap in obtaining employment later on. These reports should include children with absence of any part of upper or lower extremity as well as those having limitation in function from other causes.

The school health service is concerned with the total health needs of the child. Defects other than orthopedic should be followed and corrections arranged for the orthopedically handicapped child as for any other child. There are orthopedic surgeons employed through the Division for Physically Handicapped Children of the Department of Health, who are available to the school health service for consultation service upon request.

The procedure for referring a child to a physician or hospital for orthopedic care is the same as the procedure for referring children with other conditions. If the child is not under medical care for his orthopedic disability the school physician and nurse will plan with the parent as to where the child should go for diagnosis, treatment, and recommendations for needed care.

Due to the fact that the child with orthopedic disability often receives care from several agencies simultaneously, it is of particular importance that all such agencies work in close cooperation. In this way duplication of service may be avoided and the child's needs met most adequately.

FINDING THE CHILD WITH ORTHOPEDIC HANDICAP

The school nurse and teacher are responsible for being aware of and bringing to the attention of the family physician or school physician any child with a physical condition or a mannerism

The Orthopedically Handicapped Child

which is different from the normal range of individual variation. It is important to note seemingly small peculiarities which may be the first clue to a serious condition. For example, it is important to note:

1. How the child holds his head
2. Whether the appearance and use of fingers, hands, arms, or shoulders vary from the normal
3. Whether there is a difference or peculiarity in the child's manner of walking or using his feet and legs when climbing stairs or running about the school grounds
4. Whether there is indication of an unusual amount of "nervousness" or emotional tension in the performance of routine school activities

While such deviations may not indicate an orthopedic disability, early medical review of them may assist in preventing the development of some other handicap, making early treatment possible and perhaps saving the child inestimable discomfort.

Posture and Feet. Because of their potentially handicapping nature it is considered wise to report children with painful or severe flat feet, lateral curvature of the spine, or extremely poor posture persisting over an extended period of time. Asymptomatic flat feet or the poor posture of the below-par child will not be reported. Considerable care will be necessary in reviewing these foot and back conditions so that the children actually needing orthopedic supervision may be singled out and given attention immediately.

The school physician is in a position to observe deviations from the normal range of structure and function. His initial diagnosis of an orthopedic disability may lead to referring the child to his family physician or clinic for necessary medical study and treatment. Thus the school physician plays an important part in the function of case finding and of referral for care.

Procedures for the School Health Services

REPORTING CHILDREN WITH ORTHOPEDIC HANDICAPS

Who Should Be Reported

All children, regardless of class placement, who are known to have an orthopedic handicap, or who, through screening examination given by the school physician, are found to have such handicap, should be reported² unless such report has already been submitted.

Instructions Regarding Reporting

The nurse should report each child on form CC 60.³ This should go through her district office to the Division for Physically Handicapped Children, Bureau of Child Hygiene, Department of Health, 125 Worth Street, New York City. As much information as possible should be obtained from the parent or the child regarding past medical care and this information recorded in the available space under item 10 on Form CC 60.

Information Available Through the Division for Physically Handicapped Children

Upon receipt of the report from the school nurse, the Division for Physically Handicapped Children, if requested, will forward available information to the school nurse for guidance of the school health service in arranging for proper medical treatment for the child.

Reporting Should Be Recorded

Only those children should be reported for whom there is no notation on the School Medical Record (103S) that a report

² See Sanitary Code of the City of New York, Section 200-Regulation 21, as adopted August, 1942.

³ This is the official report form submitted by physicians, social agencies, et cetera, to the Division for Physically Handicapped Children, Department of Health, through which an orthopedically handicapped child is placed upon the New York City register for crippled children. Copies may be secured from that division.

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has previously been submitted. In order to avoid duplication it should be noted on the Medical Record under "Notes by School Nurse" at the time of reporting, that this has been done.⁴

ARRANGING FOR ORTHOPEDIC CLASS SERVICE, TRANSPORTATION, OR HOME INSTRUCTION

Recommendations for the adaptation of the child's school program should come from the private physician or the hospital providing care. These recommendations from the medical authority caring for the child are submitted to the Division for Physically Handicapped Children of the Department of Health for review and disposal.

Medical Approval by the Division for Physically Handicapped Children, Bureau of Child Hygiene, Department of Health

Approval of the Division is required for:

1. *All Original Requests for Modification of School Program.* These requests on Form O 12K are to be forwarded to the Division for Physically Handicapped Children, Department of Health, for review and approval prior to the granting of service.
2. *Changes in School Adaptations.* When subsequent reports received on Form O 12K carry information regarding changes in condition or recommendations which would modify the class placement status of the child, these should be forwarded immediately to the office of the Division for Physically Handicapped Children, Department of Health, for review and approval of indicated changes before the changes are made.
3. *Continuance of Placement in Special Class.* The nurse sends a new Form O 12K to the Division for Physically Handi-

⁴This report is for registration purposes only and does not release the school health service from the responsibility for seeing that the child receives direct medical care.

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capped Children, Department of Health, once each year for children with orthopedic handicaps who have been in a special class for more than a year; and once each six months for those who have been in a special class for less than one year.

4. *Termination of Special Service or Special Class Attendance.* When information received on Form O 12K indicates that educational adaptations are no longer necessary the nurse should send the O 12K to the Division for Physically Handicapped Children of the Department of Health for review and approval of the indicated change. If in the opinion of the teacher, the school nurse, and the school physician, discontinuance of special facilities is desirable or is undesirable, but is not in accord with the wishes of the physician under whose direction the child is receiving care, such information should be submitted to the Division for Physically Handicapped Children, Department of Health, for review and further consideration.

For new cases not known to the school health service, the hospital or private physician may forward the original request for school adaptation directly to the office of the Division for Physically Handicapped Children, Department of Health, 125 Worth Street, New York City.

For children under the supervision of the school health service, the Form O 12K carrying the request of the private physician or the hospital for school adaptations may be returned to the nurse by the physician or hospital and in turn forwarded by the nurse to the office of the Division for Physically Handicapped Children, Department of Health, through her district health office as is done with regard to other reports. The nurse should note on the child's School Medical Record the date and information that the Form O 12K has been sent by her to the Division office.

There is space available on Form O 12K which may be used by the school to note information which the school physician and

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nurse may feel should be presented to the child's clinic or private physician at the time of examination. On this form should be recorded:

1. Findings of the school physician, or
2. Observations of the school nurse or school teacher, with
3. Request for recommendations regarding specific problems encountered or observed by the physician, nurse, or teacher.

After this information is recorded on the Form O 12K it should be given the parent to take with the child to the examining physician. The parent should be instructed to return the form to the school nurse after it is filled out by the examining physician, unless the physician desires to mail the report to the nurse or to the Division for Physically Handicapped Children of the Department of Health.

Assignment to Specific Service or School Made by Division of Physically Handicapped Children, Board of Education

After the Division for Physically Handicapped Children, Department of Health, has reviewed the Form O 12K this Division forwards the form with recommendations to the Board of Education where it is reviewed by the Division of Physically Handicapped Children, Board of Education, and assignment is made to the designated specific service.

If the recommendation is made for special class service, assignment is made to a school having a special class. Arrangements are also made for transportation when such service is required. The Board of Education notifies the principal of the school to which the child is assigned and forwards to him Form O 12K carrying the stamp of approval of the Division for Physically Handicapped Children of the Department of Health and of the Board of Education. The principal, in turn, obtains the permission of the parents and makes provision for the child to enter the special class.

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Orthopedic class service is restricted to grade school pupils. In case the recommendation is made that a child be taught in the home, assignment of the child to a home instruction teacher will be made by the Division of Physically Handicapped Children of the Board of Education.

Home instruction is arranged for both grade and high school students.

Transportation to a school in which there is an orthopedic class or to high school that has an elevator is provided orthopedically handicapped children when it is necessary.

ROUTING AND USE OF FORM O 12K WITHIN THE SCHOOL

The principal of the school is responsible for transmitting each copy of Form O 12K received by him to the school nurse when it is received from the Board of Education, at which time the nurse records on the School Medical Record (103S) all information not already recorded by her.

Recording of Information on Form 103S. Under the section "Additional Notes" record medical diagnosis, other positive physical findings, part of the body affected, degree of disability, recommendations, appliances worn, and school placement recommendations, with date and source of information. Under the section "Notes by School Nurse" should be recorded restrictions in walking and stair-climbing, other limitations, and date of next appointment.

On receipt of the original Form O 12K the information should be recorded fully. Upon receipt of subsequent forms the nurse should note only date of receipt of form with any changes in information or recommendations. While the nurse may not wish to delay the recording of the medical information received on Form O 12K until the school physician's next visit, she should bring the information to his attention the next time he is in the school so that he may have the opportunity of following the re-

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sults of his request for care or observation to the attending physician and when indicated may explain to the school nurse and school teacher the recommendations made by the attending physician.

The school nurse is responsible for transferring Form O 12K to the classroom teacher. When the form is received by the nurse the recommendations should be discussed with the classroom teacher and pertinent information recorded on the pupil's Health Card by the teacher to guide her in classroom supervision of the child.

Recording of Information on Pupil's Health Card. Under "Physician's Recommendations" should be recorded medical recommendations especially affecting the supervision the teacher is able to provide in the education and care of the child in the school. Under the section "Nurse's Report" the nurse may wish to suggest desirable ways of providing prescribed care to guide the teacher in the classroom supervision of the child. Only the current Form O 12K will be retained by the teacher to be filed in the pupil's Health Card for her guidance. Old forms may be destroyed as new ones are received.

Procedures Used in Parochial Schools

When an orthopedically handicapped child in a parochial school is recommended for an orthopedic class, the recommendation will be brought to the principal of the parochial school by way of the District Health Office after the recommendations have been approved by the Division for Physically Handicapped Children, Department of Health. The final decision regarding the child's school program will rest with the parochial school authorities. Arrangements may be made to provide modifications within the parochial school, or a transfer to a public school with an orthopedic class may be effected through the diocesan office and the Board of Education.

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RELATION OF SCHOOL HEALTH SERVICE TO PRIVATE AGENCY NURSING SERVICE

Certain private physicians and hospitals in the city have requested that orthopedic nursing supervision be given to some of their patients in schools by private agencies having skilled workers in this field. Thus joint responsibility should be assumed by the school nurse and the specially trained orthopedic nurse in working out a program for meeting the health needs of each child in the class.

CRITERIA FOR SELECTION OF CHILDREN FOR HOME INSTRUCTION AND FOR CLASSES FOR THE ORTHOPEDICALLY HANDICAPPED

The following two sets of criteria have been devised to assist attending physicians in their medical recommendations regarding necessary educational adaptations.

Criteria for Selection of Orthopedically Handicapped Children for Home Instruction

1. General health and orthopedic condition are such that home instruction may be given without being medically hazardous to child or teacher.
2. Mental equipment is such that a child may profit from home instruction.
3. Temporary indications for home instruction:
 - a. Convalescence lasting more than one month requiring bed rest or restricted activity.
 - b. Emotional and social components indicating the advisability of home instruction during a readjustment period. When this is necessary the recommendation of the Bureau of Child Guidance, Board of Education, is required.
 - c. Conditions necessitating three or more clinic visits per week.

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4. Possible permanent indications for home instruction:
 - a. Certain severe chronic and/or progressive diseases which make locomotion impracticable (severe polio, progressive muscular dystrophy, etc.)
 - b. Incontinent or unable to care for toilet needs without assistance.
 - c. Grossly deformed.

What Home Instruction Offers

Home instruction offers regular academic school curriculum with promotion and graduation from the affiliated school.

Criteria for Selection of Children for Classes for the Orthopedically Handicapped

1. General health and orthopedic condition of the child are such that he can attend school.
2. Inability to adapt to normal class program because of permanent extensive orthopedic handicap, but not so extensive as to warrant home bound instruction.
3. Need for a program of limited activity during convalescence.
4. Need for individualized instruction to meet the requirements of the particular handicap.
5. Need for transportation to school.
6. Mental ability is such that the child may profit from school instruction.
7. Emotional and social components which indicate the advisability of the consideration given by a special class during his readjustment period.

What the Classes for the Most Part Offer

1. Individualized instruction.
2. Specially trained teachers.
3. Small classes.

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4. Ground floor classrooms, or elevator or ramp facilities.
5. Adjustable seats.
6. Toilet facilities accessible to classroom.
7. Facilities for rest.
8. Facilities for serving noon day meal.
9. Outdoor and indoor facilities for appropriate activities.
10. Transportation to and from school.

16. CARE OF CHILDREN WITH CARDIAC DISABILITY*

FOR PURPOSES of this service a cardiac handicapped child is defined as an individual under twenty-one years of age who, through congenital or acquired disease of the cardiovascular system, is so handicapped, or who, because of progressive conditions which may lead to cardiovascular disease may be expected to become so handicapped as to be unable to compete on terms of equality with a normal individual of the same age.

The number of cardiac handicapped children in New York City is unknown. According to various studies the prevalence has varied from 5 to 15 per 1,000 children of school age. Approximately 90 per cent of heart disease among children of school age is caused by rheumatic fever. The peak of incidence of first attacks of the rheumatic infection is between the sixth and eighth years. New attacks and recurrence of rheumatic manifestations are more common in the winter and spring. Throughout childhood there is an uninterrupted rise in the incidence of rheumatic manifestations with a decline of new attacks and recurrences after puberty.

The school service for cardiac disabled children is only one part of the care of heart disease among children. Rheumatic fever and rheumatic heart disease constitutes a public health problem of the greatest magnitude which must be dealt with from many points of view.

The school health service may play an increasingly significant role in the overall plan for care of cardiac handicapped children by assisting in the early location of such children, by referral for medical supervision, as well as by carrying out a planned follow-up program. This service can assist by referring these children to

* Experimental work is being done in several health districts and these procedures may be subject to change in the near future.

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their attending physician for medical recommendations, or for recommendations which shall change the educational program to suit their needs.

FINDING THE CARDIAC HANDICAPPED CHILD

The school nurse and school teacher should be responsible for obtaining information and noting early signs and symptoms of rheumatic manifestations so that such children may be brought to the attention of the school physician for prompt examination and referral to the attending physician for necessary study and care.

A rheumatic attack may begin with one or more of the characteristic manifestations of the disease. General constitutional disturbances, such as loss of appetite, malaise, fretfulness, and fever are invariably present. Joint symptoms are apt to be mild in young children. The involved joint may be tender, swollen, warm, painful and occasionally red. The number of joints involved at any one time is usually small. The condition is most frequently seen in the knee, ankle, hip, elbow, and small joints of the wrist or the foot. The pain may be poorly localized and may be referred to the muscle, causing what has been mistakenly called "growing pains." The onset may be accompanied by symptoms resembling those of chorea which include irritability and emotional instability. The choreiform movements may begin on one side of the body and are characterized as involuntary, asymmetrical, purposeless, and irregular. These characteristics may show in altered handwriting, in "face-making," or in changes in speech. Frequent nose bleeds may also be an early symptom. Frequent attacks of tonsillitis may be related to the rheumatic syndrome. Subcutaneous nodules may be present over bony prominences, particularly about the elbows and knees. Occasionally there is a dull pain over the heart, and breathlessness. There is usually a gradual loss of weight and a more noticeable anemia. Children with such symptoms may become short of breath and may tire easily following average activity.

Care of Children with Cardiac Conditions

While such manifestations may not necessarily indicate an active rheumatic infection, early medical review is advised in order to locate children definitely infected as soon as possible and to refer them for study and treatment. Early, adequate care during and following an initial attack is most important if permanent cardiac damage is to be prevented.

EXPLANATION OF CARDIAC CLASSIFICATION¹

Functional Classification of Patients with Heart Disease

Class I. Patients with cardiac disease and no limitation of physical activity, whose ordinary physical activity does not cause discomfort, are assigned to regular class.

Class II (formerly IIa). Patients with cardiac disease and slight limitation of physical activity may be assigned to a special (health improvement) class.

Class III (formerly IIB). Patients with cardiac disease and marked limitation of physical activity may be assigned to a home teacher.

Class IV (formerly III). Patients with cardiac diseases who are unable to carry on any physical activity without discomfort are placed on the suspense register, which indicates that they are too sick for supervision by a home teacher.

Therapeutic Classification of Patients with Heart Disease

Class A. Patients with cardiac disease whose physical activity need not be restricted are assigned to normal activity program in a regular class.

Class B. Patients with cardiac disease whose ordinary physical activity need not be restricted, but who should be advised against

¹ Taken from: "Nomenclature and Criteria for Diagnosis of Diseases of the Heart," Fourth Edition. New York Heart Association, New York, 1939.

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unusually severe or competitive efforts are assigned to normal activity program exclusive of strenuous physical training.

Class C. Patients with cardiac disease whose ordinary physical activity should be moderately restricted, and whose more strenuous habitual efforts should be discontinued may be assigned to modified activity program in a regular class, or a restricted activity program in a special (health improvement) class.

Class D. Patients with cardiac disease whose ordinary physical activity should be markedly restricted, if permitted to attend school, are given a restricted activity program in a special (health improvement) class.

Class E. Patients with cardiac disease who should be at complete rest, confined to bed or chair, are placed on suspense register, or assigned to a home teacher.

Potential Heart Disease

A record should be kept of patients in whom no cardiac disease is discovered, but whose course should be followed by periodic examinations because of the presence or history of an etiological factor which might cause heart disease. The etiological diagnosis should also be recorded. These patients should be assigned to a regular class. When, however, there has been recent active rheumatic infection they may be assigned a modified activity program in a regular class or to special (health improvement) class.

Possible Heart Disease

Patients with symptoms or signs referable to the heart but in whom a diagnosis of cardiac disease is uncertain are assigned to a regular class.

Example of Diagnostic Pattern (Cardiac Diagnosis):

Etiological: Rheumatic Fever (Polyarthritis, Chorea, etc.)

Active ————— Inactive —————

Care of Children with Cardiac Conditions

Anatomical: E.H., M.I., M.S. (Enlarged Heart, Mitral Insufficiency, Mitral Stenosis)

Physiological: N.S.R. (Normal Sinus Rhythm)

Functional: Class II (see above)

Therapeutic: Class C (see above)

Accompanying Conditions: Active Rheumatic Fever, Recent Upper Respiratory Infection, Anemia, etc.

REFERRING CHILDREN FOR MEDICAL CONSULTATION AND CARE

Whenever cardiac disease is present or suspected, the procedure to be followed will vary according to whether the pupil has a regular private physician or has been under the care of a clinic for a cardiac condition. No follow-up is to be done, however, if the condition is definitely stated to be non-cardiac.

Because of the danger of creating an unnecessarily anxious state of mind, care should be taken in the choice of words when discussing heart findings with parent or child. When referring a child for medical examination or care, it is suggested that the physician emphasize the need and value of a more complete "health examination" rather than a "heart examination."

Occasionally the school physician may observe children with evidence of active rheumatic infection. Such children should be sent home with specific instructions for rest in bed and for securing immediate medical care.

Procedure When Question of Heart Disease Arises As A Result Of:

Report from a private physician or a clinic (212S, 12K, 221S, etc.), or

Examination by a school physician, when pupil has a regular private physician or has been under care of a clinic for a cardiac condition —

1. C12K is sent to private physician or clinic.
2. Treatment agency (private physician or clinic) returns C12K directly to Division for Physically Handicapped Children, Bureau of Child Hygiene, 125 Worth Street, New York 13, N.Y., where it will be reviewed, stamped, and finally returned to the school nurse; (N.B. If C12K is returned directly to school nurse through error and does not bear the official

stamp of the Division for Physically Handicapped Children, it should be forwarded directly to that Division immediately by the school nurse.)

3. When the C12K, officially stamped by the Division for Physically Handicapped Children, is returned to the school nurse, the physician's recommendation should be noted on the 103S and on the pupil health card, the information given to all teachers involved (and to the Chairman of Health Education in vocational high schools), and the C12K filed with the medical record. (See below for procedure when special placement, program adjustment or school transfer is involved.)

Procedure When Question of Heart Disease Arises As a Result of:

Examination by a school physician when the pupil has no regular private physician, or has not been under care of a clinic for a cardiac condition —

Pupil is to be referred directly to the Cardiac Consultation Service for further clarification of his cardiac status, unless he is acutely ill, in which instance he should be referred directly to a private physician or an approved cardiac clinic. Procedure for referral to Cardiac Consultation Service is as follows:

1. The school nurse sends to the Cardiac Consultation Clinic form 457K bearing the child's name and identifying information, with the findings of the school physician and his questions on the reverse side of the card. This card will be retained by the Cardiac Consultation Clinic.
2. The Cardiac Consultation Clinic will forward a new 457K to school nurse with appointment date.
3. The school nurse is then responsible for seeing that the parent receives the appointment. It is essential that the parent be present at the cardiac consultation. If, however, it is impossible for the parent of a vocational high school pupil to be present, the Cardiac Consultation Clinic will admit him.
4. The report of the findings and recommendations of the Cardiac Consultation Clinic will be made on form C13K. If medical supervision is recommended, the choice of a private physician or clinic will be discussed with the pupil and parent at the clinic and an appointment made. A copy of form C13K will be

sent by the Cardiac Consultation Clinic to the treatment agency of choice and another copy via the Division for Physically Handicapped Children to the school. On receipt of the C13K, the nurse should note the recommendations on the 103S and the pupil health card, give the information to the teachers involved (and to the chairman of Health Education in vocational high schools), and file the C13K with the medical record. It will then be her responsibility to see that the pupil has been placed under the medical supervision advised. (See below for procedure when special placement program adjustment or school transfer is involved.)

REQUEST BY PRIVATE PHYSICIAN FOR REFERRAL TO CARDIAC CONSULTATION SERVICE.

1. When C12K bearing request for referral to Cardiac Consultation Service comes to the Division for Physically Handicapped Children for review, the Division will forward C12K directly to the proper Cardiac Consultation Clinic.
2. Cardiac Consultation Clinic will retain the C12K and forward 457K with appointment to the school nurse.
3. The school nurse is then responsible for seeing that the parent receives the appointment. It is essential that the parent be present at the cardiac consultation. If, however, it is impossible for the parent of a vocational high school pupil to be present, the Cardiac Consultation Clinic will admit him.
4. The report of the findings and recommendations of the Cardiac Consultation Service will be made on form C13K. One copy will be sent to the referring physician and another copy, together with the original C12K, will be sent via the Division for Physically Handicapped Children to the school. On receipt of these records, the nurse should note the recommendations on the 103S and the pupil health card, give the information to the teachers involved, (and to the Chairman of Health Education in vocational high schools) and file the records with the medical record. (See below for procedure when special placement program adjustment or school transfer is involved.)

RECOMMENDATIONS FOR SPECIAL PLACEMENT IN THE ELEMENTARY SCHOOLS.

Whenever a recommendation is approved for a child to remain in a special class or for transfer from regular class to special class, or from special class to regular class, the C12K, or C13K, or both, properly stamped, will be forwarded by the Division for Physically Handicapped Children to the Board of Education, (Division of Physically Handicapped Children). The latter will make the class assignment and forward all forms to the principal of the child's school. He will effect the transfer and send all forms to the nurse. Unless the child is in a special class, in which case the forms are to be sent first to the teacher who will transfer any information she needs into her history book and forward the forms to the nurse. The nurse will then enter the recommen-

copy of the Cardiac Rehabilitation Clinic to the treatment agency of choice and another copy to the Division for Physically Handicapped Children to the extent of the clinic. The nurse should note the recommendations on the form and the parent health card. Give the information to the parent and to the children of health treatment in your clinic with notes. Add the clinic with the medical records. It will then be her responsibility to see that the child has been placed under the medical supervision advised. (See notes for procedure when special placement program adjustment or school transfer is involved.)

REPORT BY PRIVATE PHYSICIAN FOR REFERRAL TO CLINICAL CONSULTATION SERVICE

When a clinic hearing request for referral to Cardiac Rehabilitation Service comes to the Division for Physically Handicapped Children for review, the Division will forward clinic directly to the clinic for clinical consultation.

Cardiac Rehabilitation Clinic will receive the clinic and forward copy with explanation to the school nurse.

The school nurse is then responsible for seeing that the parent receives the information. It is essential that the parent be present at the clinic consultation. However, if it is impossible for the parent or a vocational high school child to be present, the Cardiac Rehabilitation Clinic will advise him.

The copy of the findings and recommendations of the Cardiac Rehabilitation Service will be made on form C-12. The copy will be sent to the referring physician and school nurse, together with the original C-12, will be sent to the Division for Physically Handicapped Children to the school. On receipt of these reports, the nurse should note the recommendations on the form and the parent health card. Give the information to the teacher involved. (See notes for procedure when the school of health education is vocational high school.) (See notes for procedure when special placement program adjustment or school transfer is involved.)

RECOMMENDATION FOR SPECIAL PLACEMENT IN THE ELEMENTARY SCHOOLS

However a recommendation is approved for a child to remain in a special class in the regular class, the child will remain in a regular class to regular class, the child on C-12 or C-12, or both, as appropriate, will be forwarded to the Division for Physically Handicapped Children to the Board of Education. Division of Physically Handicapped Children. The latter will make the class assignment and forward all forms to the principal of the child's school. He will effect the transfer and send all forms to the nurse. Unless the child is in a special class in which case the forms are to be sent first to the teacher and will be forwarded and information the nurse into the district book and the forms will then enter the treatment.

dations on the medical record and the pupil health card, inform any regular class teachers concerned, and file C12K or C13K, or both, with the medical record. If the transfer involves a change of school, all records will be transferred in the usual way.

NOTE: Form PHC2 of the Board of Education is essentially identical with C12K and is used occasionally for children in hospitals. In the schools, form PHC2 should be handled in the same way as C12K.

RECOMMENDATIONS FOR SCHOOL OR WORK ADJUSTMENT OR SCHOOL TRANSFER IN VOCATIONAL HIGH SCHOOLS.

1. If the C12K or C13K bears a recommendation for a change in vocation, school transfer or other adjustment of program, it is the responsibility of the school nurse with the assistance of the school physician, if necessary, to interpret the medical problem to the principal and to see that the recommendation is carried out.
2. If the recommended adjustment cannot be made, the school nurse should refer the matter to the Chief of Secondary School Health Services through the district health officer.
3. *Bus Transportation.* Where bus transportation is recommended, C12K or C13K, or both, will be forwarded by the Division for Physically Handicapped Children to the Board of Education (Division of Physically Handicapped Children), where all necessary arrangements will be made. The C12K or C13K, or both, will then be forwarded from the Division of Physically Handicapped Children in the Board of Education to the school principal, who will be responsible for informing the school nurse of the adjustment or transfer to be made. If the pupil remains in school, the C12K or C13K, or both, should be given by the principal to the school nurse for filing and future reference. The nurse will be responsible for interpreting the medical problem to the principal and for seeing that the recommendation is carried out. If the pupil is transferred, the principal will so inform the school nurse, who will then transmit to him all health records for transfer.

FOLLOW-UP OF CARDIAC CASES.

1. For all children with definite, potential, or possible heart disease, a new C12K should be issued once each year. Procedures for this will be the same as those for the original C12K.
2. Interim reports should be secured from the treatment agency on all special class students at least once each term. These reports need not be on C12K but may be on the regular medical report form (221S or 12K). The nurse should see each cardiac pupil before his next scheduled appointment with his physician or clinic to be sure that this appointment will be kept. If at this time the nurse or school physician wishes any additional information on the child, such information should be requested by the school physician on Form 12K or 221S. If the returned 221S or 12K indicates a change in diagnosis or recommendation, the report should be forwarded to the Division for Physically Handicapped Children for review.

... on the physical record and the pupil health card. In any
... class register maintained, and the GIRL or BOY, with
... the medical record. It is essential that a change of school,
... will be forwarded in the usual way.

NOTE: FOR THE PURPOSE OF THE BOARD OF EDUCATION IS ESSENTIALLY IDENTICAL
... GIRL and is used occasionally for children in hospitals. In
... GIRL. For more details see Circular No. 100.

REGISTRATION FOR SCHOOL OR WORK AUTHORITY OR SCHOOL TRANSFER IN
VOCATIONAL HIGH SCHOOLS

1. If the GIRL or BOY needs a recommendation for a change in voca-
tional school transfer or other adjustment of program, it is the
responsibility of the school nurse with the assistance of the
school physician, if necessary, to interview the medical group
and to see that the recommendation is
carried out.
2. If the recommended adjustment cannot be made, the school nurse
should refer the matter to the Chief of Secondary School Health
Services through the District Health Officer.
3. For transportation, where the transportation is recommended,
GIRL or BOY, will be forwarded by the Division for
Physically Handicapped Children to the Board of Education (DHE-
and of Physically Handicapped Children), where all necessary
arrangements will be made. The GIRL or BOY, will then
be forwarded from the Division of Physically Handicapped Children
in the name of education to the school principal, who will be
responsible for informing the school nurse of the adjustment or
transfer to be made. If the pupil remains in school, the GIRL or
BOY or BOY, should be given by the principal to the school
nurse for filing and future reference. The nurse will be respon-
sible for interpreting the medical problem to the principal and
for seeing that the recommendation is carried out. If the pupil
is transferred, the principal will so inform the school nurse,
who will then transmit to him all health records for transfer.

ROLL-UP OF DENTAL CARDS

1. For all children with dentures, potential or possible heart dis-
ease, a new GIRL should be issued once each year. Procedures for
this will be the same as those for the regular GIRL.
2. In any agency should be secured from the respective agency in all
special cases at least once each year. These reports
need not be on GIRL but may be on the regular medical report form
(GIRL or BOY). The nurse should see each carded pupil before his
next scheduled appointment with his physician or dentist to be sure
that this appointment will be kept. If at this time the school
school physician wishes any additional information on the child,
such information should be requested by the school physician or
nurse for GIRL or BOY. If the record GIRL or BOY indicates a change
in diagnosis or recommendation, the report should be forwarded to
the Division for Physically Handicapped Children for review.

Care of Children with Cardiac Conditions

MODIFICATION OF ROUTINE

Regular Classes

Many school routines can be modified for cardiac children in regular classes. These changes sometimes include:

1. Late arrival, early departure
2. Longer lunch period
3. A second set of books (one to be kept home)
4. Rest periods when the child reclines
5. Study periods
6. Limited climbing of stairs

Limited climbing of stairs means limitation after the child reaches his classroom. The pupil should remain on his classroom floor, or not more than two floors above or below, throughout the school day. If limited climbing of stairs has been recommended, lunch should be provided in school.

Rest periods during the day may be arranged for in several ways:

1. Study periods in the school library or nature room instead of the regular gymnasium period.
2. Rest period in the health improvement class.

Limited homework assignments can be arranged, or the child can be given permission to work on home assignments during the regular gymnasium period.

Since conditions and facilities in schools will vary, conferences of school physician, nurse, principal, and teacher should be held periodically to plan for the best school adjustments for cardiac children.

Health Improvement Classes or Cardiac Classes

The adaptation of the school program can readily be carried out in the Health Improvement Classes or Cardiac Classes.

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Teacher, nurse, and school physician should hold a classroom conference in these classes at the opening of each school term to determine health needs and program of the children. The follow-up procedures for the special classes are no different from those carried out in regular classes.

Cardiac Classes

In certain schools separate cardiac classes are organized because the physical facilities for Health Improvement Classes are not available on the ground floor. It is hoped that eventually all Health Improvement Classes will be located on the ground floor and include the cardiac cases. (For procedure as to adaptations, see preceding paragraph on Health Improvement Classes.)

CRITERIA FOR SELECTION OF CHILDREN FOR VARIOUS SERVICES

The following three sets of criteria have been devised to assist attending physicians in their medical recommendations regarding necessary educational adaptations.

Criteria for Selection of Children for Health Improvement or Cardiac Classes

1. General health of the child is such that he can attend school.
2. Inability to adapt to normal class program because of permanent cardiac handicap, but not so extensive as to warrant home instruction.
3. Need for program of limited activity following recent recovery from rheumatic infection within the last year. Such a child should be in a special class at least one term.
4. Need for transportation to school.
5. Mental ability such that the child may profit from school instruction.
6. Need for protection from respiratory and other infections.

Care of Children with Cardiac Conditions

What Health Improvement or Cardiac Classes Offer

1. Individualized instruction.
2. Specially trained teachers and small classes.
3. Ground floor classrooms with accessible toilet facilities.
4. Facilities for rest and for serving noon meal.
5. Outdoor and indoor facilities for appropriate activities.
6. Transportation to and from school.

Criteria for Selection of Cardiac Handicapped Children for Home Instruction

1. General health is such that home instruction may be given without being medically hazardous to child or teacher.
2. Mental equipment is such that child may profit from home instruction.
3. Temporary indications requiring home instruction:
 - a. Active rheumatic infection.
 - b. Convalescence from other infection lasting more than one month requiring bed rest or restricted activity.
4. Possible permanent indications requiring home instruction:
 - a. Chronic active rheumatic infection.
 - b. Advanced cardiovascular disease of such severity that bed rest or restricted activity at home is required.

What Home Instruction Offers

Home instruction offers regular academic school curriculum with promotion and graduation from the affiliated school.

Criteria for Selection of Cardiac Handicapped Children for Modified Program in a Regular Class

1. Inability to adapt to normal class program because of permanent cardiac damage which is not extensive enough to warrant placement in a special class.
2. Need for a program which limits activity, following a period in a special class.

17. THE CARE OF CHILDREN WITH BEHAVIOR PROBLEMS

EVERY CHILD occasionally behaves in ways that the observant mother, teacher, doctor, or nurse notes as being different from his usual behavior or from that of other children. Often this type of behavior is transitory, a response to a factor in the child's environment to which he has not made immediate adjustment. Many times, however, a child develops attitudes or antisocial habits which do not disappear but become characteristic of his personality.

Failures to make satisfactory adjustments to home and school life show themselves in many ways. Most of the difficulties which children get into through being too aggressive are symptoms of these failures; so, too, are the entirely different behaviors such as day-dreaming, lying, and retreating from cooperative games and work with other children.

The shy child is less frequently regarded as having a problem by teachers and parents than his more obstreperous neighbor. He follows directions; he doesn't talk back; he obeys without question. He doesn't cause his mother, teacher, or nurse trouble. On the other hand the chronic truant is usually thought of as a "bad boy." His problem, however, is not as simple as that. The difficulties underlying truancy are often obscure; sometimes truancy is a symptom of the school's failure to provide a program adapted to the child's special needs. Thus, shyness and truancy, although very different, are similar in that they are symptoms of something basically wrong in the child's life.

The root of the problems of many children lies within the home. Poverty, overcrowding, broken homes, sibling jealousies, and parental neglect may contribute, each in its own way, to producing some of the problems among school children.

The Care of Children with Behavior Problems

Another set of environment factors which may be responsible for developing behavior problems is within the school itself. Being placed in a class which is too difficult or too easy, failing to adapt to a prescribed curriculum, developing tensions in speed tests and drills, failing to find security with teachers or classmates—these are potential causes of emotional disturbances among children.

Not all personality difficulties, however, are caused by the environment. Sometimes a personal trait can be traced directly to the effect of a physical defect or deformity. Again, a lesion in the central nervous system caused by birth trauma or encephalitis, for example, may provide an organic basis. A hearing deficiency, vision defect, acne, obesity, and other unusual physical appearances may play important parts in determining social behavior in children. Chronic infections, fatigue, and inadequate dietaries are likewise recognized as influencing children's behavior.

CASE FINDING AND REFERRAL OF CASES

All the staff should watch for children needing special psychological or psychiatric help. The teacher may discover a child in her classroom who needs further study; the school physician and the nurse may get sufficient evidence from talking with a parent during the medical examination. The nurse and teacher, when they pool their facts in conference, may decide a child needs attention other than medical, and the nurse in appraising the situation that she finds during a home visit may see the immediate need for psychiatric guidance for a member or members of the family.

Through these case-finding situations will come the children who should be referred to one of the mental hygiene clinics listed below. The school physician and nurse are not expected to do intensive work with these children. Their chief functions are: (1) to discover serious personality disorders in the early

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stages of their development, (2) to refer the problems to the most suitable agency, and (3) to assist teachers and principals to obtain a better understanding of children's personality problems and to show them how the school could help the child with his problem.

MENTAL HYGIENE CLINICS IN NEW YORK CITY

The following mental hygiene clinics are those to which children may be referred. (If social problems loom large in any behavior situation, referral should be made to a family social agency.)

Manhattan

Bureau of Child Guidance—Board of Education

Headquarters Unit: 228 E. 57 St. (Wickersham 2-8118)

Other units: P.S. 65, 46 Forsyth St. (Orchard 4-7330)

P.S. 24, 22 E. 128 St. (Lehigh 4-2886)

Bellevue Hospital, 30th St. & 1st Ave. (Cal. 5-1133)

9 A.M. to 3 P.M.; Saturday 9 A.M.-12 M.

Flower & Fifth Ave. Hospital, 5th Ave. & 105 St. (Lehigh 4-3300)

Lenox Hill Hospital, Park Ave. & 76 St. (Butterfield 8-5500)

Monday-Friday by appointment. Fee 50 cents.

Mt. Sinai Hospital, Madison Ave. & 100 St. (Atwater 9-2000)

Daily 9-11 A.M. Fee 25 cents or free. Services restricted to residents of Manhattan and the Bronx.

New York Hospital, 525 E. 68 St. (Regent 4-6000)

Daily except Saturday 2-5 P.M. Saturday 9 A.M.-12 M.

Fee \$1.50. By appointment. Serves selected cases.

New York Infirmary for Women and Children, 32 E. 15 St.

(Stuyvesant 9-7703)

Monday 1:30-3 P.M. By appointment. Fee 25 cents.

The Care of Children with Behavior Problems

New York Post-Graduate Medical School and Hospital, 303 E. 20 St.
(Gramercy 5-7080)

Daily except Saturday 1-3 P. M. By appointment.

New York State Psychiatric Inst. & Hospital, 722 W. 168 St.
(Wadsworth 3-5200)

Tuesday, Thursday 2-4:30 P.M. Fees: Maximum \$1 first visit;
Revisits 50 cents.

Vanderbilt Clinic, W. 168 St. & Broadway (Wadsworth 3-2500)

Bronx

Bureau of Child Guidance, Board of Education

P.S. 61, 1550 Crotona Park E. (Intervale 9-0147)

Fordham Child Guidance Clinic, Fordham Univ. Graduate School
(Sedgwick 3-2700)

Tuesday 2-5; Saturday 9 A.M.-1. P.M.

Lebanon Hospital Association of the City of New York, Westchester &
Caldwell Aves. (Melrose 5-3285)

Tuesday, Thursday, Saturday 9-12 M; by appointment only. Fee
25 cents or free.

Morrisania Hospital, 168 St. & Gerard Ave., Bronx (Jerome 6-3400)
Monday-Friday 9 A.M.-12 M.

Brooklyn

Bureau of Child Guidance, Board of Education

P.S. 15, 383 State St. (Triangle 5-0385)

P.S. 180, 16 Ave. & 57 St. (Windsor 6-3970)

Brooklyn Child Guidance Clinic, 823 Eastern Parkway (Slocum 6-3125)

Long Island College Hospital, Henry, Pacific & Amity Sts.
(Main 4-4000)

Monday 10 A.M.

Brooklyn Hospital, DeKalb Ave. & Ashland Place (Nevins 8-2900)

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Brooklyn Juvenile Protective Assn., 201 Montague St.
(Triangle 5-5060)

Tuesday, Friday 9 A.M.-5 P.M.

Israel Zion Hospital, 4802 Tenth Ave. (Windsor 6-9700)

Queens

Bureau of Child Guidance, Board of Education

P.S. 103, 166 St. & 65 Ave., Flushing Heights, L. I.
(Flushing 9-4491)

Mary Immaculate Hospital, 152-11 89th Ave. (Jamaica 6-6400)

Queens General Hospital, 82-68 164th St., Jamaica (Jamaica 6-8600)
Daily 9 A.M.-5 P.M.

18. FIRST AID AND EMERGENCY TREATMENT

THE NEED for immediate first aid and emergency treatment occasionally arises among children in school as in any other population group, when it becomes necessary for assistance to be rendered by teachers, nurses, principals, or school physicians. However, if the school physician is in the building he should assume full charge of the situation and see that *all* necessary care is rendered.

In most instances the injuries calling for first aid are minor in nature. Any situations that arise, however, should be used, whenever possible, as opportunity for teaching children, not only the principles of simple first aid measures but also the methods by which the accident might have been prevented. First aid for children's ills too often tends to be a matter of finding the most expeditious method of caring for a child and getting him back into the classroom. It can, however, often be turned into a beneficial experience for the class, from which a practical and significant health lesson can be learned.

Principals are given the responsibility of informing the parents about any accident that has happened to their child, and about the necessary medical care to be administered in the home. If the injury to the child or the child's condition warrants immediate emergency medical care or the services of a hospital, the school principal will call an ambulance by notifying the Police Department. At the same time the parents will be informed of the child's condition by means of messenger service.

If the school physician is not in the building, the nurse or teacher or principal may render first aid, as prescribed in the *Red Cross Manual on First Aid*. The following emergency measures commonly taken are abstracted from this manual:

Animal Bites. Wash wound to remove saliva. Holding wound under a running tap is an excellent method. Dry with

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gauze, apply iodine, let dry and dress. Advise regarding Pasteur treatment. Report incident to Police Department and the local health officer.

Foreign Bodies in Eye. Do not rub eye; do not attempt to remove an embedded body. Flush eye with boric acid solution. If necessary invert upper lid. If foreign body is seen, gently remove it with clean cotton applicator which has been moistened with boric acid solution. If body is not removed easily, cover lightly with compress and bandage. Advise immediate medical attention.

Bruises. Apply ice or cloths wrung out of very cold water.

Burns. For minor burns apply boric acid ointment. Cover with sterile dressing. Notify parent of need for medical care. Severe burns should not be touched, but medical attention secured immediately.

Choking. A sharp slap between the shoulder blades may dislodge the object. Lowering the head over a table, chair or couch will aid in the removal. If this is not successful obtain immediate medical aid.

Cramps or Pain in Abdomen. Have child lie down. Notify parent of need for medical care (Form 221S). Advise principal that child should be sent home immediately. Caution against the use of laxatives.

Epileptic Seizures. Lay child down on flat surface. To avoid biting of the tongue, insert a tongue depressor wrapped with gauze between the teeth. Loosen clothing. Do not restrain convulsive movements of child. Keep child quiet after seizure.

Fainting. Place patient's head lower than the rest of the body. If pillow is handy, place under feet, not under head. Loosen any tight clothing; secure plenty of fresh air. Cotton or gauze moistened with aromatic spirits of ammonia held under the nose may be effective. Keep child lying down until completely recovered.

Infection. Apply sterile dressing. Advise immediate medical care.

First Aid and Emergency Treatment

Nose Bleeds. Have child sit up with head thrown slightly back, breathing through the mouth; loosen clothing around neck. Apply cold wet compresses over the nose. Press the nostrils together firmly. If bleeding continues, insert cotton plug in nostrils. Have patient avoid blowing nose for a few hours. If these measures do not stop bleeding, medical treatment should be sought at once.

Toothache. Notify parent of need for dental treatment.

Wounds. Wash hands before treating wounds. Alcohol is the most suitable preparation for removing dirt from wounds. Apply 2 per cent iodine into and around the wound. Let dry before covering with sterile dressing. Do not disturb blood clots. Never re-apply iodine. Do not apply iodine near eye or on mucous membranes.

Fractures, Sprains, Strains. Do not move injured part. Notify principal and advise calling an ambulance if necessary. Keep child warm and in a comfortable, lying position.

Severe Arterial Bleeding. Apply pressure on the artery between the bleeding point and the heart, and at some point where the main artery lies close to a bone. Notify principal and advise calling an ambulance or physician.

19. THE TRANSFER OF RECORDS AND THE SCHOOL MEDICAL FILES

NEARLY ONE THIRD of the school children change their place of residence in the course of one year. This movement of the school population requires the transfer of many academic records, pupil Health Cards, and School Medical Records from one school to another. In the past, a large number of School Medical Records have been lost in transit, or have failed to be included among the records that were transferred. It is exceedingly important that no loss of health records occur. A lost or misplaced record means the defeat of a primary objective of school health service—continuous accumulation of information about each child; it may mean neglect in follow-up of conditions already discovered; it may mean unnecessary and expensive duplication of the work of doctor, nurse, and teacher.

THE TRANSFER OF RECORDS

The transfer procedure requires that the school clerk include all three above-named records in the transfer envelope which is forwarded to the clerk in the new school. The pupil's Health Card to be transferred will be obtained from the teacher.

If the school nurse is not present in the school at the time that the transfer takes place, the school clerk will remove the child's School Medical Record from the files in the medical office, and leave a note for the nurse giving the names of the children whose records have been removed. He should put on this note in pencil any date which may appear above the child's name on the School Medical Record so that the nurse can locate the tally card in her activity file.

Should a child transferring to a new school fail to present all three records, the clerk in the new school will communicate with

The Transfer of Records and Files

the clerk in the school that the child formerly attended and arrange for the transfer of any missing records.

REGRADING OF RECORDS

During the last week of the school term, each teacher will enter the new school grade on the pupil Health Cards of the children in her class. In addition to this, each teacher will receive the medical cards from the nurse and will enter the new grade in the proper space on these cards. The regrading of all records will be completed by the beginning of the new school term.

THE ACTIVITY FILE

The school health program, serving as it does large numbers of children and involving numerous activities, requires careful planning and organization. To assist the nurse in making the most productive use of her time in the school health service, the activity file has been developed.

This file helps the nurse distribute her case load throughout the school year and acts as a reminder for daily work. It is a means of planning service for the child with immediate problems and yet not losing sight of children in need of less urgent care. It lessens interruptions in classrooms. It aids in determining the amount of nursing and medical service needed in a school as it presents an overall view of the active case load. It provides a uniform method of tabbing and organizing work and enables a nurse new to the school to carry on without loss of time. It may be used as a teaching tool for new staff and student nurses and provides a method of evaluating and analyzing health service in a school.

Materials and Arrangement of the Activity File

1. Tally cards (430K) (Figure 21a) for each child for whom service is planned. All notations on tally card are written in pencil.

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2. Twenty-seven guide cards (3x5) for sections arranged as follows (Figure 21b): current month—1st week, Monday through Friday (5), 2nd week, Monday through Friday (5), 3rd week—4th week—5th week—succeeding months (9) (except July and August), new admissions—doctor.

Setting Up and Operation of File

All cases, from whatever source derived, which require nursing or medical action or both, are included in the activity file. All the School Medical Records will be reviewed to locate those for which some activity is indicated.

Begin by analyzing medical records in special classes. If service is indicated, make out a tally card, tab and file it directly back of the guide card for the month in which service is to be given. Note in pencil on the medical record (103S) directly above the child's name, the number of the month in which the tally card is filed and the color of the tab used, as: January Blue (1 BL), February Brown (2 BR). No date is entered on the tally card except for children under observation by the physician. When the child is seen by the physician a line is drawn through the date on the tally card.

Continue this procedure from the highest to lowest grade, filing each card successively in the section of the month in which service is planned. With this method all children in a class receiving service during the month may be seen during one session.

If a child is to be interviewed on a specific date, as for example: to arrange for a definite clinic appointment, the tally card will be marked URGENT and filed in front of all other cards in the day service is to be given.

New admissions to be examined are not tabbed and are filed in their own section until a specific appointment is made for examination. Then the card is filed in that day.

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When a child is selected for screening, specially referred examination or follow-up by the physician, the tally card is filed in the doctor section. Note on the 103S either D.G.—D.W.—or D.P.

FIGURE 21a
TALLY CARD

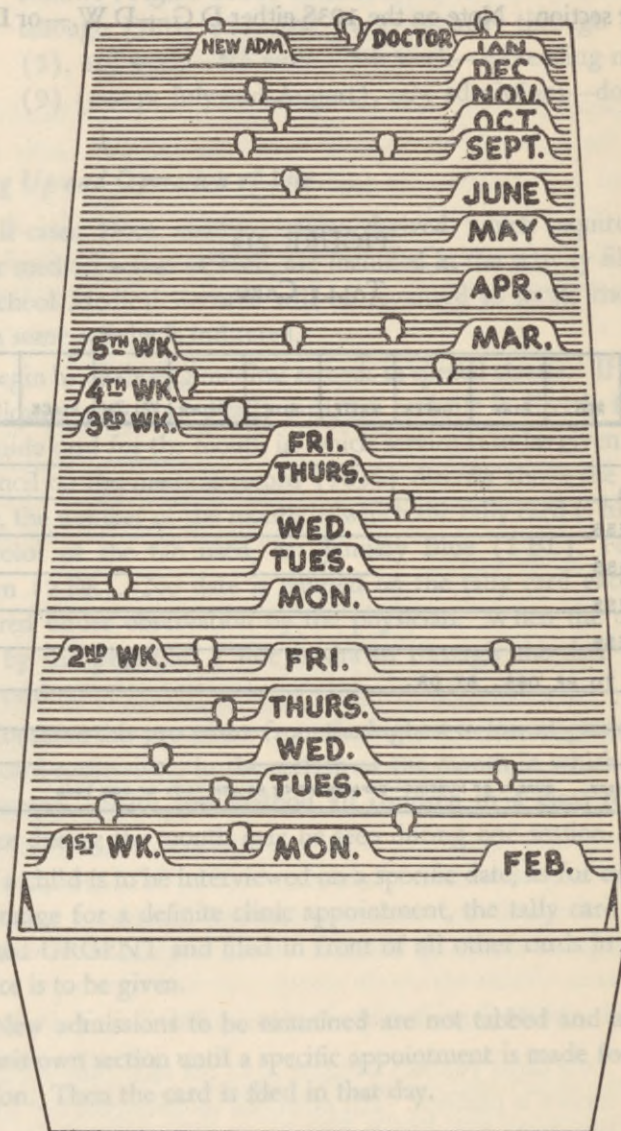
	RED	PINK	GREEN	WHITE	BLUE	BROWN	YELLOW	BLACK	
NAME									
CLASS									
ADDRESS									
ADDRESS									
ADDRESS									
ADDRESS									
DATE TO BE OBS. BY DR.									
FORM 430K BUREAU OF NURSING—DEPARTMENT OF HEALTH—CITY OF NEW YORK									

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The Transfer of Records and Files

FIGURE 21b

ACTIVITY FILE



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The doctor's session is planned for only one or two visits in advance.

When further follow-up is to be given, the tally card is moved back to the proper section and filed with the other cards for the child's class in that section. When a tally card is moved from one section to another, the notation above the child's name on the 103S is erased and a new notation is entered, as for example, 1 B1 becomes 2 Br; 2 Y becomes D.W.

It is advisable to have a section for one day at the end of the current month relatively free so that work planned for the month may be completed. This section may also be used for children who were absent at the time the nurse originally planned to see them.

The number of children to be seen within a day will depend on the length of time the nurse is in school and the activities planned, such as: teacher-nurse conference, conferences with parents, teachers, agencies or a doctor session in school.

If the nurse cannot complete the work planned for a day, she will file the remaining cards in the following day's section, being certain that cards marked URGENT are kept in front. When work for a day is completed, the division card is moved back to set up the same day, two weeks hence. When work for a week is completed, the division card is moved back to set up a new week's work.

When all follow-up is terminated, the tally card is filed alphabetically in the inactive section of the activity file. When a child transfers to another school, the tally card is sent with his medical record.

Other Uses of the Activity File

1. When a child, who was referred by the teacher after daily inspection, is to be seen again by the nurse the upper section of the 194K is filed in the day she wishes to see him.
2. The upper section of the 219S, made out simultaneously with the lower section, is filed in the day it is to be sent to the parent. Appointment time is noted on the tally card.

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3. Appointment for teacher-nurse conference is noted on a tally card and filed in the day when the conference is scheduled. Information on the card should include the teacher's name, grade, classroom, and appointment time.
4. Consultation slip 218S is filed in the day it is to be sent to parent. The tally card tabbed yellow is filed in day appointment is scheduled.

Color Code

The color code on the tally card is used to indicate type of service to be performed.

- Red —designates a child with a special defect and is currently used only for those with actual heart disease.
- Pink —designates a child whom the physician wished to observe again or a child who is to be referred to the physician for follow-up inspection.
- Green —designates a child who has been selected for screening examination.
- White —designates a child referred to the physician for complete examination.
- Blue —designates a child whom the nurse wishes to interview.
- Brown —designates a child about whom nurse wishes to confer with teacher.
- Yellow—designates a child about whom nurse wishes to confer with parent in school.
- Black —designates a child about whom nurse wishes to confer with parent in the home.

20. REGULATIONS FOR NURSES AND PHYSICIANS

NURSE'S UNIFORMS

THE NURSE is required to wear a coat type of uniform which will entirely cover her dress. It must have long sleeves, and button all the way down the front, or have a lap of sufficient width to cover the front of the dress. Only a coat uniform of a solid color may be worn in school.

SCHEDULE OF NURSE'S TIME

At the beginning of each term, the school nurse with the help of the supervising nurse, will plan the distribution of her time. Copies of her schedule should be given to the superintendent of school nurses, the principal, the supervising nurse, and other interested individuals. (See Figure 22; Form 389K.) A copy should also be posted on the door of each medical office. If it is necessary for the nurse to leave the medical room during the scheduled hours, she should post a notice on the outer door stating when she will be back or where she may be reached in case of an emergency.

TIME OF ARRIVAL AND DEPARTURE OF PHYSICIAN AND NURSE

Since it is, of course, important for the principal to know when the physician and nurse are in the school, it is necessary that they notify his office of their arrival and departure. Should the school physician be delayed, he will telephone the district health officer, who will, in turn, notify the school principal and make arrangements for a substitute.

The nurse will arrange with the principal that teachers be notified of her arrival in the school. Teachers will be instructed by the principal that children with acute conditions will be seen by the nurse or physician during the first 15 to 30 minutes.

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FIGURE 22
SCHOOL NURSE'S SCHEDULE

Nurse: _____
 Supervising Nurse: _____ Date: _____

School
Mon.
Tues.	.....	.....	.....	.....	.....
Wed.	.....	.....	.....	.....	.....
Thurs.	.....	.....	.....	.....	.....
Fri.	.....	.....	.....	.....	.....
Sat.	.....	.....	.....	.....	.....

One copy for principal, one on door of nurse's room in school, two to supervisor.
 When schedule is changed send one corrected form to principal and two to supervisor.
 BUREAU OF NURSING, DEPARTMENT OF HEALTH, CITY OF NEW YORK
 389K

FIGURE 22 (BACK)

Write the following on cards sent to supervisor but not on cards retained in school.

School	Address	Phone	Name of Principal	
School No.	Name, if Not Public	Registration	New Admissions	No. of Classes

Total for Public Schools: _____
 Total for Parochial Schools: _____

Regulations for Nurses and Physicians

PHYSICIAN'S TIME CARD

At the end of each week the school physician will mail his weekly time card (Form 444KVT) to the district health office; the exact time of his arrival and departure for each day of the week will be stated thereon.

21. THE DAILY REPORT OF SCHOOL HEALTH ACTIVITIES

A SCHOOL health service requires many accurate records, as other chapters in this manual have indicated. One record not yet discussed is that which summarizes the activities which the Central Office and the district supervisory staff need in order to keep intelligently informed about the progress of health work for children. This record, entitled "School Activities—Daily Tally," is Form 451K (not illustrated).

The purpose of Form 451K has received a great deal of thought. Much more information—useful information too—could be requested, but the aim has been to select only those questions which bear on one major point, namely the progress of the work, the minimum number of items has therefore been used. Information concerning the progress of the work is needed by the supervisor, therefore this sheet has been constructed to serve as a supervisory tool. It furnishes the supervisor with a clue concerning what is going on, what more needs to be done, and what needs to be done differently.

USE OF FORM 451K

One copy of Form 451K is used in each school each month of the school year. The nurse makes daily entries on it, writing the days of the month in the boxes at the top of the sheet.

After the last session of each month, the school nurse sends Form 451K, untotaled, to the supervising nurse who forwards it to the Central Statistical Division, 125 Worth Street. All reports must be in the Central Statistical Division by the fifth of the month following.

When the Central Statistical Division has finished totaling and tabulating the entries on the forms, they are returned to the Health Office for reference and filing.

The Daily Report of School Health Activities

Any questions that arise concerning the interpretation of these instructions about 451K should be cleared by the supervising nurse with the Central Statistical Division (Worth 2-6900, Ext. 321). Explicit directions for filling out the form are printed on the reverse side of each sheet.

THE WORK OF THE CENTRAL STATISTICAL DIVISION IN CONNECTION WITH THE RECORDING OF SCHOOL HEALTH ACTIVITIES

On receipt of Form 451K from the schools, Central Statistical Division makes summaries for the health districts and for the city as a whole, and prepares the following reports:

1. *Monthly Report on Work Pending.* Within a day after the receipt of Form 451K from each district, a table is prepared for the health officer showing the distribution of work pending in each school, so that health officer, supervising physician, and su-

FIGURE 23

SCHEDULE OF DOCTORS' TIME NEEDED IN SCHOOL
(Based on Work Pending)

<i>Date</i>					
<i>District</i>					
Name of School	Pending Examinations End of (month)				Percentage of Available Doctor's Time Needed
	New Admissions	Specially Referred	Screenings	Follow-up Inspections	

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pervising nurse will have an accurate basis for assigning staff to the schools. Local situations may lead to modifications of such assignments but the determination of work pending has been found a useful basis for assignment of staff in most districts.

A monthly report on work pending is submitted to each health district in a form somewhat like the following. The form may vary from time to time.

In making out a monthly schedule for the doctors of the school district, the total number of doctor's sessions *available* to the district may be multiplied by the "Percentage Available Doctor's Time Needed." For instance, if the percentage for a given school is 5 and the available number of doctor's sessions is 40, $.05 \times 40$ or 2 sessions may be allotted to this school.

2. *Monthly Memoranda on Misinterpretation of Items.* A memorandum indicating any items which have been answered incorrectly on the record, is sent to the supervising nurse so that she can correct any misunderstandings that the nurse may have regarding the meaning of the items on Form 451K.

3. *Quarterly Indices of Work.* Four times during a school year the Central Statistical Division prepares indices of the work for each district, which have been arrived at on the basis of Form 451K. These indices are then presented to the technical staff concerned with the school service in the Central Office. This procedure is followed in order to enable those responsible for the conduct of school work to keep in close touch with activities in the schools.

Based on these quarterly statements of indices, together with supplementary notes, the directors of the Bureaus of Child Hygiene and Nursing prepare written comments on the work in each district and forward them with the table to the supervisory staff in the district.

These reports and comments should be interpreted in the districts with due consideration of varying local factors, such as extent of community health facilities, health awareness on the part

The Daily Report of School Health Activities

of the school personnel, and economic status of the population. They represent material useful in evaluating and planning the school health program in the district and should be presented at regular district staff meetings of medical and nursing personnel. The health officer will also find certain items of interest to educational authorities and should assume responsibility for transmitting such information to these authorities as indicated.

The Daily Report of School Health Activities

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