Tennessee School Health Screenings Guidelines
TENNESSEE DEPARTMENT OF EDUCATION

Tennessee School Health Screenings Guidelines

March 2008

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School Health Screening Guidelines Revision Committee
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It is my hope that school health staff utilize this updated *Tennessee School Health Screenings Guidelines* as a tool to successfully screen students for a variety of health concerns. With the expansion of Coordinated School Health to all school systems in Tennessee, all students in grades PreK, K, 2, 4, 6, 8, will receive vision and hearing screening. Those same grades except for PreK will be screened for blood pressure and height/weight. One grade of high school will also be screened for blood pressure and height/weight. Oral Health screenings for students are encouraged but not mandated as is scoliosis screening for 6th graders.

Why screen students for these types of health concerns? Everyone knows that healthy children learn better. For example, if a child cannot hear very well it would be very hard for him/her to concentrate on school work. Likewise, if a student cannot see the board then it will be difficult for him/her to comprehend a classroom lesson. When a health concern is identified early through a regular school health screening, steps can be taken to access needed health care so that health and academic issues do not develop into serious problems.

Take your time and read through the entire manual. You will find helpful sample forms in the Appendices and various resources listed to support your school health screening efforts.

You never know when you might discover a child with hypertension, scoliosis or dental disease whose life will be forever altered because a caring school health professional took the time to ask questions and screen for these types of conditions.

Be well.

Sincerely,

*Connie Givens*

Connie Givens, Director
Office of Coordinated School Health
Tennessee Department of Education
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GENERAL SCREENING GUIDELINES

WHO CAN CONDUCT SCREENINGS?
Historically, school nurses have been in charge of facilitating and/or conducting school health screenings. In order to complement and expand health care services capacity in school systems it is important to develop community partnerships. Potential partners include employees of local universities, health departments, community hospitals, and non-profit organizations.

Prior to screening, students should be given an explanation of the screening procedures which will take place. This explanation will help to reduce stress and fears of the procedures. Class time before and after the screening could be utilized to teach students about health.

An orientation must be provided to all staff and volunteers that include a review of the general screening guidelines prior to conducting any school health screenings. If trained properly, student nurses, community-based nurses, HOSA students, health science instructors, clinical instructors, school nurses and other community-based volunteers such as members of a local Lions Club can conduct school health screenings. Several sample parent/guardian screening notification forms are available in Appendix B. Also, a couple of sample screening results forms for school records are available in Appendix C. All school personnel should follow local school system protocol regarding the use of background checks needed for all non-school volunteers. Be sure that all volunteers understand that they will not have access to student identifying information that was collected during a school health screening.

PARENT/GUARDIAN NOTIFICATION

Parents/Guardians that do not want their children screened for any health concerns have the right not to have their child screened.

Every student will be screened, unless parents/guardians refuse by signing and returning a form that will be sent home. This is called presumed or passive parental consent (i.e. parent must sign form to decline permission to screen). Several parent/guardian permission examples can be found in Appendix A.

CONFIDENTIALITY

Protecting the confidentiality of student health information is mandatory. All school systems should develop a school district policy regarding student health information confidentiality. A confidentiality agreement form must be signed by anyone outside of the school system who performs school health screenings. Two sample confidentiality forms are provided in Appendix D. Data provided to an external evaluator should not contain any student names.

Questions may be asked about who has access to the STAR STUDENT HEALTH screening/health records. A school official may be asked to sign or disclose the purpose
of their request for the health records of a student. Please note the FERPA guidelines regarding student confidentiality:

**FERPA Regulations Title 34 § 99.31** An educational agency or institution may disclose personally identifiable information from an education record of a student without the consent required by § 99.30 if the disclosure meets one or more of the following conditions: (1) The disclosure is to other school officials, including teachers, within the agency or institution whom the agency or institution has determined to have legitimate educational interests. School officials include persons employed by the district as an administrator, supervisor, teacher, or support staff member (including, but not limited to transportation personnel); or a person, agency, or company with whom the District has contracted, or otherwise arranged to perform a special task or service. Such individuals have a legitimate educational interest if s/he needs to review an education record in order to fulfill his or her professional and/or official responsibility. A legitimate educational interest also exists where the staff member or other individual works directly with students and needs to review education records to increase his/her awareness of steps necessary for the safety and welfare of students and staff members. (FERPA-Appendix B)

Several resources are provided to develop a policy if needed.

*Protecting the Privacy of Student Records: Guidelines for Education Agencies*

*Guidelines for Protecting Confidential Student Health Information*

*Privacy Standards for Student Health Records*

**RECORD KEEPING**
If your school system has or plans to utilize the STAR Student data collection system, we suggest that all screening results data be entered in the STAR Student health section. The local LEA will need to develop a policy to address an appropriate plan of action for referrals.

**POST-SCREENING REFFERRALS**
There is no state law or policy that specifies how many attempts a school nurse should make to contact a parent/guardian. The 'rule of 3s' is required for parent/guardian notification for Special Education and in the hospital setting.

Remember that making a referral is only part of the intervention; it is the outcome of the referral that is most important. If you have attempted to reach the parent/guardian, preferably using multiple modalities (letters, phone calls, trying to make contact with the parent/guardian when they come for the parent-child conference, etc.), and you have documented your attempts, then you need to turn over the 'file' to the principal and let him or her decide what steps should be taken next (for example, should a social worker get involved?). When a school nurse sends the information to the principal, always copy
your supervisor, so that he or she knows what steps have been taken and the current status of the situation.

Sending letters home with the student is not recommended, thus making other forms of communication important. However, when using written communication, it is important to keep communication simple - short sentences, easy to read format. General language should be used to describe the student’s condition. A request for the parent to contact appropriate staff can be made. Another approach is to assign a home visit by a school nurse or family resource center staff.

It is helpful to provide information about the appropriate services available in the area, the average cost of a visit, and what to expect from the examination. Families of students in managed healthcare programs may need to contact their health insurance plan for information on how to access the appropriate services, including treatment that is available to them.

Source: Dr. Selekman, DNSc, RN, Professor - University of Delaware, Newark, Delaware, editor of "School Nursing: A Comprehensive Text". This publication is sponsored and officially recognized by the National Association of School Nurses and is regarded as the Gold standard for School Nursing Practice.
Coordinated School Health Grant
Required Health Screenings

OVERVIEW SHEET

Parents/Guardians who do not want their child screened for any health concerns have the right to not have their child screened.

**Vision**

All students in grades PreK, K, 2, 4, 6 and 8 are screened annually. This screening does not require parental/guardian permission; however, parents should be notified of screening results. Other students that should be screened are those new to the school system and those suspected of having a vision problem by their teachers. Specific local school system protocols must be followed.

**Hearing**

All students in grades PreK, K, 2, 4, 6 and 8 are screened annually. Specific, LEA protocols must be followed.

**Blood Pressure**

All students in grades K, 2, 4, 6 and 8 and one year of high school (usually wellness class) are screened annually.

**Body Mass Index (BMI) (Height and Weight)**

All students in grades K, 2, 4, 6, 8 and one year of high school (usually wellness class) are screened annually. This screening requires passive parental/guardian permission. Staff and volunteer training for BMI screenings is required. Specific protocols must be used.

**Scoliosis**

Schools are encouraged to screen all students in 6th grade for scoliosis. Staff training for scoliosis screenings is required. Specific protocols must be used.

**Dental Screening**

All schools are encouraged to screen students for oral health problems.

**Well Child Visits**

Well Child visits need to be encouraged by school staff for all students on an annual basis. These visits can be provided through the school system, the county health department or through a private health care provider.

**Health Insurance**

It is imperative to ask parents/guardians regarding their access to health care for their children. If they need assistance, you should provide information about TennCare, CoverKids and local county health department services.

**Partnerships**

In order to compliment and expand health care services capacity in school systems it is important to develop community partnerships. Potential partners include but are not limited to: universities, health departments, community hospitals, and non-profits.

**Correspondence with Parents**

Please include student information about all health screenings on one letter. Do not single out Body Mass Index results.
VISION SCREENING

Vision Screening Law – T.C.A. 49-6-5004.
Upon registration or as early as is otherwise possible and appropriate, public schools, nursery schools, kindergartens, preschools or child care facilities are encouraged to make reasonable efforts to apprise parents of the health benefits of obtaining appropriate eye and dental care for children.

POLICY: At a minimum, all students in grades PreK, K, 2, 4, 6, and 8 shall receive a vision screening once a year. Screening one year of high school is optional, however whatever year of high school that is selected must be then screened year after year. For example, if the wellness classes were chosen then wellness classes should be screened every year thereafter. If a PreK student has already been screened prior to school entry, then the data from their permanent record can be used instead of re-screening these students. At any point, a student can be referred for screening per local school district protocol.

RATIONALE: According to Prevent Blindness America (1998), vision problems affect one out of twenty preschoolers and one in four school-age children. They report that over 80 percent of preschool and school-age children never receive a vision screening. Most persons are visual learners, acquiring approximately 85 percent of all knowledge through vision. Therefore, it is imperative that a possible visual problem be identified as early as possible. Vision screening is the responsibility of the general education program. Each school system in the state of Tennessee is required to conduct system-wide grade level screening. Students in all classrooms in the specified grade level must be screened. This screening does not require active parental/guardian permission; however, parents/guardians should be notified of screening results. Other students who should be screened are those who are new to the school system and those suspected of having a vision problem by their teachers. School systems may utilize school personnel, volunteers, or agencies to conduct their system-wide screening. Minimum procedures for vision screening include distance and near vision acuity. Muscle balance, visual field, depth perception, and color perception may also be included. The Vision Screening Results Form may be used to record the results of vision screening.

If a student fails any of the areas below, a second screening should be done as confirmation of the problem. This second screening is a continuation of the initial screening and should be administered on a different day. The practice of confirming the results of the initial screening should reduce errors and/or over-referrals. Failure in one or more of the following areas should be confirmed by a second screening:

- An acuity of 20/40 or less in either eye for distance or near vision for children grades K through 3
- An acuity of 20/30 or less in either eye for distance or near vision for children grades 4 through 12
- A difference of two lines or more between eyes

It is not necessary for students who have already been identified with visual impairments to undergo vision screening and/or a referral to an eye specialist.
REFERRAL FOR EYE EXAMINATION
A vision screening program must include the capacity to make a referral for an eye examination. Follow-up procedures should include appropriate medical examination and intervention. Screening personnel should notify those responsible for follow-up when students fail the screening. Results of the final screening should be recorded in the student’s cumulative record or STARS system. Distance and near vision screening results are usually reported as visual acuity and represent central field vision. The optimal distance for testing distant visual acuity is twenty (20) feet. Visual acuity is recorded as a fraction in which the numerator represents the test distance and the denominator represents the row of letters that can be read on the chart. For example, acuity of 20/100 indicates that a child reads at 20 feet what the normally seeing child should be able to read from a distance of 100 feet.

METHODS OF SCREENING FOR POSSIBLE VISION PROBLEMS

Screening of Distance Vision
Screening of distance vision may be done in three major ways: 1) screening at optical distance using a stereoscopic instrument, 2) screening at physical distances using a variety of charts or cards which are manipulated by the screening personnel, and 3) photo screening.

1. Screening using a stereoscopic instrument

Two instruments are typically used for screening at optical distances; the Keystone Telebinocular and the Titmus Vision Tester. Each instrument includes appropriate cards for assessing near and distance acuity, fusion, muscle balance, depth perception, and color perception when appropriate. Instructions for conducting screening using the Keystone Telebinocular and the Titmus are provided with the machines. These instructions should be followed very carefully to ensure valid results. Screening personnel should keep in mind that the two stereoscopic instruments mentioned above tend to over-refer. The screener should select a quiet and private place to conduct the screening. The instrument should be placed on a table close to an electrical outlet. It may be necessary to have an electric adapter and a spare bulb. Forms for recording results should be next to the instrument. Chairs should be provided for the child and the screening personnel.

2. Screening at Physical Distances

Screening at physical distances involves the use of a variety of charts, cards, and other materials that are manipulated by the screening personnel. In this method, screening personnel actually measure the physical distance between the student being screened and the various charts or other instruments being used. The room selected for vision screening using the second method should be quiet and provide good lighting. If distance screening is to be conducted in the same room as the other areas to be screened, the room must be large enough to accommodate the screening distance indicated on the chart.

The Snellen Chart is considered to be the most reliable instrument for vision screening. Unlike the stereoscopic instruments, use of the Snellen Chart is less
likely to result in over referral due to failure on the screening. If a stereoscopic instrument is used in the initial screening and a child fails that screening, it would be beneficial to use the Snellen Chart or a similar instrument for the second screening.

The tests for distance vision will not detect the child with hyperopia or farsightedness. The Plus Lens Test is a more reliable test to detect hyperopia. The child’s vision is checked using the Snellen Chart or one of the binocular instruments while wearing plus lenses mounted in a small, inexpensive frame. The plus lenses are of 2.25 diopters for all ages. If the child can see the 20-foot line at twenty feet from the chart with both eyes while wearing these lenses, a referral should be made. Many of the stereoscopic instruments provide their own criteria for screening with the Plus Lens Test (Harley, Lawrence, Sanford, & Burnett, 2000).

**Screening Very Young Children or Children with Multiple Disabilities**

Other charts may screen children who are unable to respond to the Snellen Chart because of developmental level or multiple disabilities. The Snellen E Chart, the Apple, House, Umbrella Test or the Symbols for 10 Feet Chart (Lighthouse International) may be used. Other materials that may be appropriate are the Lea materials and the Home Eye Chart (Vision Associations) for screening preschool children. Vision Associates produces cards to assess the vision of young children or children with disabilities. Their information can be found at: http://www.visionkits.com/acuity.html.

SureSight is more accurate than the titmus machine and the photo screener. It is a portable and fast device that makes testing quick and painless. Some features of SureSight include:

- Five-second, automatic testing that is both fast and efficient
- SureSight's lights and sounds engage the patient's attention
- Minimal cooperation is required, making it ideal for use on young children, the disabled, and when there is a language barrier
- The hand-held, 2-pound (0.9 Kg) SureSight unit and printer can be carried easily from room to room, to your waiting area or off-site.
- SureSight refracts babies, children, and adults. You can even test patients while they're wearing glasses or contact lenses.
- As a result of using SureSight, one school system reduced vision rescreens by almost 50% among their kindergarten students.
- If a student fails the SureSight screen then a rescreen with the titmus is done to confirm the failure.

A checklist titled *Guide to Testing Distance Visual Acuity* (Prevent Blindness) is available in an easy-to-use format. It includes a diagram of room set-up, specific instructions for preparing the child, and interpretation of test results.

3. Photo screening

Photo screening is currently being used by various agencies such as the Lions Eye Center to detect potential vision problems in pre-literate children, ages six months to four years. The photo screener takes two black and white pictures of the eye which are later evaluated by eye care professionals.
Screening at Near Distance
Near vision screening is typically conducted by one of two methods: screening using stereoscopic instruments or screening using near vision test cards.

1. Screening using stereoscopic instruments
The same stereoscopic instruments used for distance screening may also be used to screen for near acuity. While these instruments do tend to over-refer, they do offer some advantages over a hand held chart in that they provide for a constant illumination and object distance (Harley, Lawrence, Sanford & Burnett, 2000, p. 126).

2. Screening using Near Vision Test Cards
Near vision is commonly tested using one of several reading cards which are available from a variety of sources. The reading card is ordinarily held at a distance of fourteen inches from the eye. The reading distance for low vision children and illumination should be recorded. Jaeger and point-print denote size which can be used in designing educational material. Jaeger thirteen to eighteen point type is largely used in books for first grade and low vision children (Harley, Lawrence, Sanford & Burnett, 2000, p. 126). Some examples of reading cards that may be used include the ETDRS Near Chart (Prevent Blindness America, 1996), Rosebaum Pocket Vision Screener and the Lighthouse Near Vision Acuity Test. Many of these cards may be obtained through Prevent Blindness America or Lighthouse International.

CHILDREN’S VISION SCREENING REFERRAL GUIDELINES
Refer the child who shows possible appearance, behavior, or complaint signs of a vision problem.

- Watering eye(s)
- Upper lid touching or partly covering pupil
- Presence of white pupil when looking directly at the child’s eyes, or in photo
- Rigid body when looking at distant objects
- Tilting head to one side
- Excessive blinking
- Headaches, nausea, or dizziness
- Burning, scratchy, or itching eyes
- Unusual sensitivity to light
- Eye(s) turning inward or outward
- Red-trimmed, encrusted or swollen lids
- Sty’s or infections
- Possible eye injury
- Thrusting head forward
- Squinting or frowning
- Closing or covering one eye
- Blurred or double vision
- Sees blur when looking up after work

GUIDELINES FOR THE DISTANCE ACUITY SCREENING (SNELEN CHART)
Age of Student  Starting Line  Refer the child who does not pass the line with one or both eyes when re-screened.

<table>
<thead>
<tr>
<th>Age of Student</th>
<th>Starting Line</th>
<th>Refer the child who does not pass the line with one or both eyes when re-screened.</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 years and younger</td>
<td>20/50</td>
<td>20/40</td>
</tr>
<tr>
<td>6 years and older</td>
<td>20/40</td>
<td>20/30</td>
</tr>
</tbody>
</table>

Source: Adapted and modified from Prevent Blindness
Source: ED – 4071 / 2003: Screening and Interventions in General Education, Department of Education
HEARING SCREENING

POLICY: At a minimum, all students in grades PreK, K, 2, 4, 6, and 8 shall receive a hearing screening once a year. Screening one year of high school is optional however whatever year of high school that is selected must be then screened year after year. For example, if the wellness classes were chosen then wellness classes should be screened every year thereafter. At any point a student can be referred for screening per local school district protocol.

RATIONALE: The objective of the hearing screening program is to identify students with possible hearing deficits at the earliest possible stage in order to refer for diagnosis and treatment, if required. Hearing deficits in children can interfere with normal speech and language development, communication, and with the ability to learn. It is estimated that one-third of children with minimal or unilateral hearing loss fail a grade. Loss of hearing is considered a “hidden handicap.” It is important to detect even mild hearing loss in order to treat the problem or compensate for the loss when possible. Children with mild to moderate hearing deficits may be at a disadvantage educationally, emotionally, and socially.

PURETONE AUDIOMETRIC SCREENING
The American Speech and Hearing Association recommends that screeners be trained by an audiologist. This screening assesses the ability to hear single tones, presented at varying levels of pitch. If the individual hears the tone, they indicate that they have heard the tone using a pre-arranged signal to the screener. The result is recorded as “Pass” or “Fail.”

1. Screening Equipment
   - Schedule a room that is as quiet as possible. Consider all noise; plumbing, heating/cooling systems, traffic, office machines, appliances, fluorescent light “buzz,” talking in adjoining rooms, music.
   - Have a desk or table that will provide space for the audiometer and recording materials. Two chairs will be needed for the screener and the individual to be screened.
   - Leave the audiometer on all day when screening.
   - Set all connections, dials, and switches on the audiometer in the correct position.
   - Screen yourself, or another person who is known to have good hearing, before doing any screening to be sure the audiometer is working properly.
   - Audiometers should be calibrated by a qualified technician, at least annually.
   - There should be a “standard precautions” policy and procedure in place to assure earphones are properly cleaned between children.

2. Preparing the Student for Testing
   Do not screen children with a known hearing loss who wear a hearing aid, or who are under the regular care of an ENT provider. Consider each student individually; some precocious children three years old can be screened audiometrically, but some children ten years old cannot.
Seat the student in a chair facing away from the examiner so the person whose hearing is being screened cannot watch the audiometer or the screener’s movements and expressions. Shy, and other difficult to screen children may need to be screened facing the examiner with their eyes closed.

Give test instructions before putting the earphones on the individual, and determine how they will indicate they have heard a sound.

Tell them they will hear some tones or “beeps” and that they should respond to the sound even if it is “very soft or tiny.” The individual could respond by one of the following ways:

- Raising hand
- Saying “yes” or “I hear it”
- Nodding head
- Holding block, chip, or bead close to ear then dropping it into a container when the sound is heard (use with young children)

INDIVIDUAL SWEEP SCREEN PROCEDURE
After the student has been instructed in the procedure, begin the screening:

1. Put the earphones in place.
2. Make sure hair is not under the earphone and that earrings are removed.
3. Adjust earphones so they fit snugly over the outer ear, with the speaker (center) of the earphone over the ear canal.
4. The RED earphone should be placed on the RIGHT ear, the BLUE on the LEFT ear.
5. Set the LOUDNESS dial to 20 decibels (dB). If you are in an environment with some ambient noise that cannot be eliminated, the screening should be rescheduled or relocated to a quieter environment.
6. Set control so that the tone or stimulus comes only after the examiner activates the switch.
7. Present stimulus twice as a short tone of approximately 1-2 seconds.
8. Do not present the stimulus in such a rhythm that the person being screened is given clues as to when to respond. Screen the frequencies in this order:
   
   1,000
   2,000
   4,000

9. When screening older students, you may wish to screen at 6,000 to detect noise-induced hearing losses.
10. Mark the results as Pass or Fail for each frequency
11. Screen the LEFT ear in the same manner. Tell the person being screened when you are changing to the other ear.

INTERPRETATION OF SCREENING RESULTS
Individuals who pass all frequencies in each ear are presumed to have normal hearing.

- Rescreen any individual who fails one or more frequencies in one or both ears.
- Rescreens also may be done on the basis of observations and/or symptoms.
If you are doubtful about the validity of screening results, indicate that on the recording form.

RESCREENING PROCEDURE
Rescreening may be done at the time of screening. Earphones should be removed and then repositioned, checking carefully to be sure the ear canal is not soft and collapsed due to placement of the earphones. If this appears to be a problem, the ear can be pulled up and back, or the skin in front of the ear gently pulled forward as the earphones are placed.

- Instructions should be repeated to be sure student understands the procedure.
- Rescreening may done up to two weeks later if the student has cold and allergy symptoms. This time period may allow symptoms to clear.
- Prepare screening site and equipment as for Individual Sweep Screen.
- Set loudness dial at 20 decibels.
- Screen the frequencies in the same order. Present each frequency twice. If the student fails to respond one of two times, it may be repeated to assure that it was not a lack of attention that caused the lack of response. If both presentations are missed, it should not be repeated. Screen hearing in each ear. Record as “P” those sounds heard at 20 dB, record as “F” those tones not heard at 20 dB.
- Refer for medical and/or audiological evaluation any individual who misses one or more frequencies in one or both ears. In schools, an audiologist may be asked to do an “individual threshold test” prior to referral. This information may be helpful to the professional doing the evaluation.
- It is estimated that about 3-9 percent of students will fail a hearing screen and warrant a referral.

USE OF VOLUNTEERS
Volunteers may be useful during the initial sweep screening to assist with the flow of students through the screening procedure. Some volunteers may be trained to conduct the initial sweep screen. Holding a volunteer instruction session is helpful for all new volunteers, and should be scheduled close to the day of the screening. During the training session, familiarize volunteers with the audiometers, screening forms and procedures. Having volunteers who feel comfortable with the equipment increases accuracy during the screening procedure. All volunteers should be counseled regarding confidentiality issues.

SCHOOL SCREENING PROCEDURE
1. Administer an initial sweep screen, presenting tones at 1,000, 2,000, and 4,000 Hz, in each ear, at 20 decibels.

2. Record as Pass or Fail at each level. If one or more frequencies are failed, in either or both ears, schedule for rescreening. It is sometimes helpful to wait for an interval of 10 days to two weeks for colds, allergies to resolve. However, knowing that a student has a hearing impairment when the child has allergic symptoms is important information, especially when the hearing impairment clears when the child is treated with medication. Make a note if the child is on medication and passes the rescreening.
3. Rescreen with the same procedure. If the student still fails one or more frequencies in one or both ears at 20 decibels, they should be referred for further evaluation.

4. If the school has an audiologist, they may be asked to perform an individual threshold test to determine the need for a referral.

5. If the school speech and hearing specialist does routine hearing screening, the nurse may collaborate to ensure adequate referral follow-up. It is not appropriate to make adjustment for a noisy environment, i.e., increasing the level of decibels above 25 for the screening. The range of normal hearing is – 10 to 20 decibels. Increasing the decibel level while screening could overlook children that should be referred for evaluation. Screening for hearing problems during “health fairs” is not productive unless the facility provides a quiet environment in which to screen, e.g., sound-treated van.

All failures on initial screen should be rescreened to confirm the need for further evaluation. There are a few obvious conditions that might warrant an immediate referral, but in most cases, the rescreening will eliminate some unnecessary referrals. Failure may be due to misunderstanding of directions, misinterpretation of information, poor placement of earphones, student fatigue or the inability to attend to testing. In addition, the student’s past health history, teacher observations and history of previous screening and outcome of referrals should be considered in making a referral decision.

TEACHER NOTIFICATION
The nurse should notify the child’s teacher(s) that the child has been referred for a possible hearing impairment. In addition to being alert to the possibility the child is having hearing difficulty, the school personnel are often in a position to reinforce the need to follow through on the referral. It is important to monitor the child closely; documenting the nurse and teacher concerns for the effect the suspected hearing impairment is having on the child’s education. These concerns need to be communicated to the parent/guardian. Trying to establish the reason for failure to have the child examined will often uncover the need for additional resources or information.

Source: GUIDELINES FOR HEARING SCREENING, Missouri Department of Health and Senior Services, September 2004.
HEARING LOSS SYMPTOM CHECKLIST

If a child has one or more of these symptoms, the child may have difficulty hearing and should have their hearing checked as soon as possible.

MEDICAL SYMPTOMS

• If a child has a bad odor or smell from his/her ear
• If a child has repeated bouts of upper respiratory infections, running nose, chronic cough or ear infections
• If a child pulls, rubs or digs his/her ears
• If a child's outer ear looks red or feels warm

LISTENING SYMPTOMS

• If a child is easily distracted or frustrated in a group
• If a child does not respond consistently to his/her name or live voice
• If a child cannot understand you if his/her back is turned
• If a child has difficulty finding the source of a sound
• If a child needs verbal instructions repeated several times before he/she understands
• If a child consistently turns the tape, CD, television or computer speaker up louder

BEHAVIORAL SYMPTOMS

• If a child does not particularly like listening to tapes, CDs, television or listening activities such as rhymes, sound games etc
• If a child is very inattentive during story time
• If a child watches your face and eyes for visual clues of meaning
• If a child depends on visual clues to successfully complete simple verbal tasks
• If a child has a short attention span for his or her age

SPEECH/LANGUAGE SYMPTOMS

• If a child has poor or delayed language development
• If a child has poor articulation of speech sounds
• If a child has poor sentence structure and speech patterns
• If a child talks in an extremely loud voice or extremely soft voice

Source: Janet Coscarelli, CCC-A, CCC-SL
Tennessee Head Start State Collaboration Office

Sample hearing screening forms can be found in Appendix C.
BODY MASS INDEX (BMI)
(Height and Weight)

BMI Law - TCA 49-6-1404
Nutrition and physical activity programs in schools where aggregate data suggests high rates of overweight children may be a problem are encouraged to expand existing or implement new school-based nutrition and physical activity programs designed to reduce those rates. The effectiveness of these results could be determined by completing a BMI on the schools’ students whose parents/guardians have not requested exclusion.

POLICY: At a minimum, all students in grades K, 2, 4, 6, 8 and one year of high school (usually wellness class) are screened annually. Whatever year of high school has been selected for screening must then be screened year after year. For example, if the wellness classes were chosen then wellness classes should be screened every year thereafter. Staff training for BMI screenings is required. Specific protocols must be used.

RATIONALE: The rapid increase in overweight among children and adolescents is generating widespread concern. Since the 1970s, the prevalence of overweight among children has more than doubled for preschoolers ages 2-5 and adolescents ages 12-19, and it has more than tripled for children 6-11 years. Nearly one-third of children and adolescents, of both sexes, aged 6-19 years (31.0%) are considered to be either at risk for overweight or overweight, defined as at or above the 85th percentile of the sex-specific BMI-for-age growth chart, and 16% are overweight or at or above the 95th percentile of the sex-specific BMI-for-age growth chart.

IMPLEMENT SIX SAFEGUARDS BEFORE CONDUCTING WEIGHT SCREENING*
Screening children to identify potential weight problems can contribute to positive health outcomes but, if done without sensitivity, can have negative effects on emotional well-being. On the positive side, students at both ends of the weight spectrum can be objectively identified and referred for additional evaluation and possible intervention. On the negative side, weight screening that results in labeling a child as “too fat” or “too thin” can damage self-esteem and may increase susceptibility to eating disorders. The decision to conduct weight screenings should be made by the local school board after careful review of proposed screening procedures. Schools should not initiate weight screening unless the following six safeguards are in place:

Safeguard 1: Learning Environment
Schools have fully implemented the recommendations for Creating A Safe and Supportive Learning Environment by implementing a Coordinated School Health Initiative.

Safeguard 2: Classroom Instruction
Teachers have instructed students in a way that counteracts social pressure for excessive slenderness and enhances the students' understanding of the healthy weight concept. Important concepts that need to be conveyed to students include:

- There are different body types; some body types are naturally associated with more body weight.
A range of weights is normal. People can be healthy at many weights and look very different from one another.

It is not normal and it is not possible for every person to be the same size and shape.

Students have the ability to make healthy food choices.

Daily physical activity contributes to overall health and healthy weight.

Sedentary behaviors can contribute to weight gain.

Normal growth and development patterns affect body shapes and sizes, especially at puberty.

Subtle media messages suggesting that only thin people are happy or attractive should be challenged.

Safeguard 3: Parental/Guardian Permission
A system is in place to notify parents/guardians of impending weight screening and to obtain parent/guardian permission for the weight screening through passive consent. Make sure that any form returned by a parent/guardian that indicates they do not want to have their child screened is on file. Parental/guardian involvement is critical. Invite parents/guardians to a meeting to discuss the screening if necessary. Preparation on the front end will ensure a minimum of problems later.

Safeguard 4: Referral System
A system is in place for referring students for further evaluation and help. It is inappropriate and possibly harmful to identify a child as having a potential problem with weight unless some source of referral for further assessment and help can be offered. If the parent/guardian does not respond to the referral suggestions then follow your school system’s protocol for follow-up. If such a protocol does not exist, it is strongly recommended that this be developed in partnership with School Nurses, Coordinated School Health Coordinator, and Family Resource Center Director.

Safeguard 5: Staff Training
All school staff participating in weight screenings have received training and have demonstrated proficiency in screening techniques and interpretation of screening results.

Safeguard 6: Respectful Screening
A screening process has been designed that protects the self-esteem of students and avoids labeling students. Whatever the results of the weight screening, school personnel should not label any child as overweight, obese, underweight, too thin or anorexic. For the purpose of school weight screening, if a child’s Body Mass Index for-Age (BMI) exceeds the 85th percentile or falls below the 5th percentile on the BMI-for-Age growth chart, the Healthy Weight Advisory Group recommends the wording, “weight which may place a child at health risk”. Maintain privacy in the assessment process. Only the person screening the student observes the results. For example, the screener can use an office or a screen to help maintain privacy. Height and weight should not be announced to the student or any other nearby adults.

The results of the screening should be kept confidential. For younger children in grades K-3, the teacher should not tell the students the results of the screening. Results should only be shared with the child’s parents/guardians. Younger students do not have the cognitive skills to process the results and use them to shape personal behavior.
A respectfully worded letter should be developed to notify parents/guardians if a child’s weight may present a health risk. The letter should not label the child but should request that the parents/guardians seek further assessment by a health care professional. Parents/guardians should be sent a letter when the student’s weight falls below the 5th percentile or above the 85th percentile on the BMI-for-Age charts published by the Centers for Disease Control and Prevention

No comments on weight should be offered during the measurement process. Neutral comments such as, “Thanks, you can get off the scale now,” are appropriate. Younger children and students who are anxious about the weighing process can be positioned with their backs to the scale during measurement. If a student makes a negative remark about his or her own weight, it is appropriate to respond with a supportive response such as, “Good bodies come in all shapes and sizes”. All students should undergo the same measurement procedures. No one child should be singled out for additional measurements because of physical appearance or weight. To minimize teasing, all students should line up in the screening area, even if their parents/guardians have excused them from the screening process.

* Implementation of Safeguards for measuring children is adapted from the Michigan State BMI measurement protocol.

GATHERING ESSENTIAL RESOURCES
Resources essential to this project fall into three categories: Community Involvement, Data Collection Personnel, and Equipment. Before any data is collected, the participation and enthusiasm of the community should be solicited to insure validation of the process and interest in the results. It is imperative that school system administrators are supportive of the system and willing to participate. The recommended partners are suggested resources for logistics of data collection and management, and are not limited to those listed.

RESOURCES
Recommended Partners

<table>
<thead>
<tr>
<th>Local Health Councils</th>
<th>HOSA Students</th>
</tr>
</thead>
<tbody>
<tr>
<td>School administration</td>
<td>PTA/PTO</td>
</tr>
<tr>
<td>Hospitals</td>
<td>Parent volunteers</td>
</tr>
<tr>
<td>Local health department</td>
<td>School psychologist/guidance counselor</td>
</tr>
<tr>
<td>Health Science Instructors</td>
<td>UT Extension</td>
</tr>
</tbody>
</table>

Local institutions of higher education
Data Collection Personnel

- Minimum of 2 people are needed with the cooperation of the classroom teacher (see Data Collection section for specific job assignments)
- Training (see training section)
- Personnel suggestions

Health Educators
Nutrition Staff
School Nurse

PE/Health/Wellness Teachers
College Students
Parent/Community volunteers

Equipment

1. Scale
2. Scale calibration weights
3. Stadiometer (measures height)
4. Data collection form
5. Privacy screen
6. Lock box for data storage
7. Parental/guardian permission request form (see Appendix A for samples)
8. Measurement follow-up parent/guardian letters (see Appendix B for samples)
9. Quality assurance notebook

WEBSITE RESOURCES

This website list was compiled for parents, school personnel and interested individuals. The websites listed are reliable sources of nutrition, physical activity and weight management.

American Dietetic Association
http://www.eatright.org

Arkansas BMI Project
http://www.achi.net/

Center for Health and Health Care in Schools – Parents Resource Center
http://www.healthinschools.org/parents/index.htm

Center for Health and Health Care in Schools – teen site
http://www.healthinschools.org/students/

The Center for Disease Control (CDC)
http://www.cdc.gov

The CDC site for Healthy Youth
http://www.cdc.gov/HealthyYouth/index.htm

Childhood Obesity: A Food and Nutrition Resource List for Educators and Researchers

Fruits and Veggies: More Matters
http://www.fruitsandveggiesmorematters.com
http://www.fruitsandveggiesmorematters.gov

4GirlsHealth
http://www.4girls.gov/index.htm
Institute of Medicine: Preventing Childhood Obesity
http://www.iom.edu/report.asp?id=22596

My Food Pyramid
http://www.mypyramid.gov

Tennessee Department of Education, Child Nutrition Programs
http://snp.state.tn.us

Tennessee Department of Education, Office of Coordinated School Health
www.tennessee.gov/education/schoolhealth

Tennessee Department of Health
http://health.state.tn.us/nutrition/index.html

UT Extension Service
http://www.utextension.utk.edu/topics/FoodNutrition/default.asp

United States Department of Health and Human Services – Child and Adolescent Health
http://www.ahrq.gov/child/

United States Department of Agriculture/Agriculture Research Service Children’s Nutrition Research Center at Baylor College of Medicine, Houston, Texas.
http://www.bcm.edu/cnrc/bodycomp/bmiz2.html

Weight Control Information Network: Helping Your Overweight Child

### EQUIPMENT CONSIDERED EFFICIENT AND “USER” FRIENDLY” FOR MEASUREMENT OF WEIGHT AND HEIGHT

<table>
<thead>
<tr>
<th>BRAND &amp; MODEL</th>
<th>TECHNOLOGY &amp; CAPACITY</th>
<th>MANUFACTURER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seca 770</td>
<td>Electronic, 440 pounds, digital</td>
<td>Seca Corporation 1352 Charwood Road Suite E Hanover MD 21076 1-800-542-7322</td>
</tr>
<tr>
<td>Seca 881</td>
<td>Electronic, 440 pounds, digital</td>
<td>Seca Corporation</td>
</tr>
<tr>
<td>Seca 881</td>
<td>Electronic, 440 pounds, digital</td>
<td>Seca Corporation</td>
</tr>
<tr>
<td>Seca 880</td>
<td>Electronic, 440 pounds, digital</td>
<td>Seca Corporation</td>
</tr>
<tr>
<td>Seca 841</td>
<td>Electronic, 330 pounds, digital</td>
<td>Seca Corporation</td>
</tr>
<tr>
<td>Seca 840</td>
<td>Electronic, 330 pounds, digital</td>
<td>Seca Corporation</td>
</tr>
<tr>
<td>Tanita BWB 800S</td>
<td>Electronic, 440 pounds, digital</td>
<td>Tanita Corp. of America 2625 S. Clearbrook Drive Arlington Heights, IL 60005 1-877-682-6482</td>
</tr>
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## STANDING MEASURING UNITS
### Portable Stadiometers

<table>
<thead>
<tr>
<th>BRAND &amp; MODEL</th>
<th>TECHNOLOGY &amp; CAPACITY</th>
<th>MANUFACTURER</th>
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<tr>
<td>Seca 214</td>
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<tr>
<td></td>
<td></td>
<td>1352 Charwood Road</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Suite E</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hanover MD 21076</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1-800-542-7322</td>
</tr>
<tr>
<td>Seca 225</td>
<td>Freestanding platform and transport castors</td>
<td>Seca Corporation</td>
</tr>
<tr>
<td>Perspective Enterprises PE-AIM-101</td>
<td>Portable</td>
<td>Perspective Enterprises</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Portage MI</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1-800-323-7452</td>
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## PRIVACY SCREENS

<table>
<thead>
<tr>
<th>BRAND &amp; MODEL</th>
<th>SPECIFICATIONS</th>
<th>MANUFACTURER</th>
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<tbody>
<tr>
<td>Portable Room Divider</td>
<td></td>
<td>Port-A-Wall 1053</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Home Run Lane</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Bedford, VA 24523</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1-866-802-0217</td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="http://www.portawall.com">www.portawall.com</a></td>
</tr>
<tr>
<td>Model 313</td>
<td>Overall Height 69&quot;</td>
<td>Pro-med Products</td>
</tr>
<tr>
<td>Model 363</td>
<td>Overall Height 69&quot;</td>
<td>Pro-med Products</td>
</tr>
<tr>
<td>Omnimed Beam Economy Folding Screen</td>
<td></td>
<td>Medical Resource USA</td>
</tr>
<tr>
<td>Winco 363 Folding Three-Panel Screen</td>
<td></td>
<td>Medical Resource USA</td>
</tr>
<tr>
<td>Winco 364 Folding Four-Panel</td>
<td></td>
<td>Medical Resource USA</td>
</tr>
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</table>
CALIBRATION WEIGHTS

<table>
<thead>
<tr>
<th>BRAND &amp; MODEL</th>
<th>SPECIFICATIONS</th>
<th>MANUFACTURER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calibration weights</td>
<td>Precision weights, magnetic susceptibility &gt;.01</td>
<td>Troemner 1-800-249-5554 <a href="http://www.troemner.com">www.troemner.com</a></td>
</tr>
<tr>
<td>Calibration weights</td>
<td>Meets ASTM specifications</td>
<td>Scientech 1-978-521-7095 <a href="mailto:sales@balances.com">sales@balances.com</a></td>
</tr>
<tr>
<td>Test Weights</td>
<td>Meets ASTM specifications</td>
<td>Seca Corporation 1352 Charwood Road Suite E Hanover, MD 21076 1-800-542-7322</td>
</tr>
</tbody>
</table>

LOCK BOX

Any type of lock box can be used. The only requirement is that it locks, in order to keep all measurements confidential.

\[
BMI = \frac{(\text{Weight in Pounds})}{((\text{Height in Inches} \times \text{Height in Inches}))} \times 703
\]

SUMMARY OF MEASUREMENT PROCEDURES

- Set up measurement stations with the appropriate equipment
- Privacy Screen to keep process confidential
- Stadiometer
- Scale
- Quality Assurance Notebook
- Calibration weights
- Lock Box
- Calibrate the scales and record data in the quality assurance notebook
- Prepare the child for measures
- Remove shoes, glasses, jewelry and any extra clothing such as jackets
- Empty pockets
- Measure the child
- Height in inches
- Weight in pounds
- Record data on data collection form
- Check that all data is recorded on data collection form and place form in lock box
- Instruct child to return to his/her teacher/classroom
SUMMARY OF WEIGHT MEASUREMENT

- "Zero" the scale (if digital)
- Child steps up on the center of the scale and stands in the direction as to not see their individual weight on the scale
- Body weight is evenly distributed between both feet
- Arms hang freely by the sides of the body, palms facing thighs
- Head is up and facing straight ahead
- Weight is recorded to the nearest 0.2 pounds (or appropriate unit for the scale)

TRAINING FOR RELIABLE RESULTS

The training section of the surveillance system is intended to provide for accurate, proficient, sensitive data collectors. These standardized training tools will assist system administrators in training new personnel. The objectives for training are: standardization of methods for measurement and sensitivity in addressing questions and comments from the student being measured.

Along with training, data collection personnel must sign a confidentiality statement that will be kept on file.

ACCURATELY WEIGHING AND MEASURING CHILDREN AND ADOLESCENTS

As you begin the process of collecting BMI data in schools, there are a few key concepts that need to be explored. In collecting data, the most important factors are to develop reliable techniques, to use calibrated equipment, and to perform accurate measurements.

1. Scales for weighing children and adolescents

Spring balance scales such as bathroom scales should not be used to weigh children or adolescents. These scales are not accurate over a variety of weights and the spring counter balance loses accuracy over time. Many spring balance scales can not be read accurately to less than one-half pound. The reading of bathroom scales is often distorted since the dial is on the floor rather than at eye level. A suitable scale is a quality beam balance or electronic scale that can be easily calibrated.

- Equipment must be used for the purpose for which it was designed.
- Do not use bathroom scales to weigh children or adolescents.
- If scales are moved from school to school they must be recalibrated each time.

It is desirable that the scale weigh in 100 gram or ¼ pound increments. Safety and accuracy dictate that the scale has a large enough platform for support of the individual being weighed.

The scale should have a function so that it can be “zeroed”. Standard weights should be available to calibrate the scale. Beam balance scales should have “screw type” provision for immobilizing the zeroing weight. Length devices attached to scales are notably inaccurate because they do not have a stable platform.

2. Stadiometers for measuring children and adolescents

Stadiometers are available in two types. The first type is permanently fixed to the wall. The second type is portable. The most common failing of a portable stadiometer is a base that is too small. When the base is too small, the stadiometer is not stable and entirely perpendicular to the floor.
➢ Equipment must be used for the purpose for which it was designed.
➢ No tapes, yardsticks or graphics should be attached to the wall.
➢ Do not have carpet under stadiometer.
➢ Stadiometer must be stable, calibrated and dedicated to the purpose.

An accurate stadiometer for stature/height measurements is designed for and dedicated to stature measurement. An appropriate stadiometer requires a vertical board with an attached metric rule and a horizontal headpiece that can be brought into contact with the most superior part, or top, of the head. The stadiometer should be able to read to 0.1 cm or 1/8 inch.

Although it would seem efficient to use a stature device attached to a scale, height attachments on scales are never used. They are inaccurate because they do not provide a firm platform for the measurement and they are relatively sharp, and thus pose a risk for harm to the person being measured.

3. Assuring accurate, reliable equipment
Maintenance is a regular, daily event.
➢ It requires that scales be checked and “zeroed” before each daily screening.
➢ It requires that stadiometers be checked and “zeroed” before each daily screening.

Calibration is a daily event.
➢ It requires that scales be “tested” with standard weights at least on a daily basis.
➢ It requires that movable scales be calibrated after each time the scale is moved.
➢ It requires that moveable stadiometers be checked with standard rods after each time the equipment is moved.

4. Critical components
The two most critical components of measuring are 1) accuracy and 2) reliability.

Accuracy is defined as the degree to which a measurement of an individual corresponds to his or her actual weight or stature.

Reliability is defined as the degree to which successive measurements of the same child agree within specified limits.

Both accuracy and reliability are to some degree a function of the quality of the equipment used for the measurements. Measurers are frequently expected to perform accurate and reliable measures on equipment which is not designed for performing accurate measurements. On the other hand, if appropriate equipment is available, it is often not properly maintained or is improperly used.

Often equipment is deemed to be expensive and is not purchased, or inferior or improvised equipment is used. Quality, easily calibrated and well maintained equipment is a good investment and will provide years of accurate and reliable service. Because quality equipment is durable, the seemingly high initial investment costs for quality equipment can be amortized over 20 or more years of service.
Using the same measuring instrument over time increases accuracy and reliability therefore, it is strongly recommended that the same equipment be used for subsequent screenings.

5. Gathering parameters of measurement accuracy

<table>
<thead>
<tr>
<th>Degree of refinement of a measure</th>
<th>Tolerance of a measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>The measurement is recorded to:</td>
<td>Two measures should agree within:</td>
</tr>
<tr>
<td>Child weight: 0.01 kg, 10 gm, or ½ oz</td>
<td>Child/adolescent weight: 0.1 kg, 100 gm, or ¼ oz</td>
</tr>
<tr>
<td>Child height: 0.1 cm or 1/8 inch</td>
<td>Child/adolescent height: 1 cm or ¼ inch</td>
</tr>
</tbody>
</table>

To address quality assurance issues, there are two sets of numbers of interest. The first set is the degree of refinement of a measure. That is, the degree to which a measure is recorded. For example, child weight is recorded to 0.01 kg, 10 grams, or ½ ounce. If a child was weighed to only 0.1 kg, 100 grams, or 3 ounces, a rate of weight gain of less than 100 grams would not be reflected in the measure.

The tolerance of a measure is the difference between two measures that is accepted as reasonable accuracy. The tolerance of a measure is generally larger than the degree of refinement of a measure. For example, the weight of a child is recorded as 3.12 kg and on re-measuring it is recorded as 3.13 kg. These measures are within an acceptable tolerance. If however, the child was weighed at 3.12 kg and a second measure was recorded as 3.11 kg, the average of the two closest measures would be recorded.

The tolerance of a measure is generally larger for measures of older children and adolescents because small changes are less critical for the interpretation of growth.

6. Weighing children and adolescents: Equipment and Calibration

It is assumed that the scale is appropriate for weighing a child or adolescent and is calibrated with a set of standard weights. It is important that the child or adolescent be weighed using procedures consistent with those by data collectors as other collection sites in order to establish accurate, reliable baseline data.

- A child older than 36 months is weighed standing on a scale.
- Use a calibrated beam balance or electronic scale.
- Child must be able to stand without assistance.

7. Weighing Children and Adolescents: Procedures

For all children, there is a need to respect privacy. Privacy includes where the measurements are taken, clothing removal, describing the measuring process, and interpreting the numbers.

- Child wears lightweight outer clothing.
- Child stands on center of platform scale, facing away from the scale.

8. Weighing Children and Adolescents: Quality of Measurements

The child is weighed wearing only lightweight clothing. The child stands on the center of the platform of the scale. For privacy, the child must be weighed facing in the direction so as not to see their individual weight on the scale.
The weight is recorded to the nearest 0.01kg or ½ oz.
- The weight is recorded on the data form. The individual is repositioned and the weight measure is repeated.
- The measures are compared; they should agree within 0.1 kg or ¼ lb.
- If the difference between the measures exceeds the tolerance limit, the child should be repositioned and re-measured a third time. The average of the two measures in closest agreement is recorded.

9. Measuring Child and Adolescent stature: Equipment and Preparation
Stature or height is measured for children over the age of 24 months who can stand unassisted. Accurate measurement of stature requires the use of a calibrated, vertical stadiometer with a movable headpiece, perpendicular to the vertical backboard.
- Measure stature for children over 24 months of age.
  - Use a calibrated vertical stadiometer with a right-angle headpiece.
  - The child is measured standing with heels, buttocks, shoulders and head touching a flat upright surface.

10. Measuring Child and Adolescent Stature: Procedures
The child or adolescent should stand on the footplate of the stadiometer without shoes. The person is positioned with heels close together, legs straight, arms at sides, shoulders relaxed. Ask the child to inhale deeply and to stand fully erect without altering the position of the heels. Make sure that the heels do not rise off the foot plate.

Lower the perpendicular headpiece snugly to the crown of the head with sufficient pressure to compress the hair. Hair ornaments, buns, braids, etc. may be removed to obtain an accurate measurement.

To ensure an accurate reading, the measurers’ eyes should be parallel with the headpiece.
- Child or adolescent stands against stadiometer without shoes, with heels together, legs straight, arms at sides, shoulders relaxed.
- Child should look straight ahead.
- Bring the perpendicular headpiece down to touch the crown of the head.
- Measurers’ eyes should be parallel with the headpiece.

11. Measuring Child and Adolescent Stature
- The measure is read to the nearest 0.1 cm or 1/8 inch and recorded on the data form.
- The person is repositioned and re-measured.
- The measures should agree within 1 cm or ¼ inch.

This website will calculate height percentile for you. It saves time to utilize this when determining blood pressure percentile:

http://pediatrics.about.com/cs/usefultools/l/bl_kids_centils.htm

Children with Physical Disabilities
Children with physical disabilities require specialized measuring equipment not appropriate for this type of screening. An example would be a child with a cast or a child in a wheelchair.
QUALITY ASSURANCE
The main points of measurer quality assurance are straightforward.

First, set a date to train new data collectors. Make sure there is documentation that all volunteers have been trained and that the documentation is on file with the school administrator.

Second, calibrate scales with standard weights.

The data collected that reflects attention to precision and accuracy of measurements by trained measurers will be very good documentation for assuring quality of data in reports and funding proposals.

For sample quality assurance forms, refer to the BMI manual that is distributed by the Tennessee Department of Health, Nutrition Services Division. A BMI manual and BMI instructional video are available by calling Tennessee Department of Health, Nutrition Services Division at 615-741-7218 or Tennessee Department of Education, Office of Coordinated School Health at 615-532-6300.

TOOLS TO CALCULATE BMI
The CDC has several tools to calculate BMI on their website.
http://www.cdc.gov/nccdphp/dnpa/growthcharts/resources/index.htm#interpretation

- BMI Percentile Calculator for Child and Teen provided in both English and Metric versions.
- CDC Table for Calculated Body Mass Index Values for Selected Heights and Weights for Ages 2 to 20 Years (PDF - 168K)
- Checkbook size BMI Table for Children and Adolescents (PDF-404K)
- Body Mass Index Measurement in Schools

Sources:
Assessing Body Mass Index (BMI) in Schools, Tennessee Department of Health Nutrition and Wellness, October 2007 (Revised), Special Thanks to the Coordinated School Health Program, This Manual was adapted from the Tennessee Coordinated School Health Program BMI Protocol Manual.


The Center for Health and Health Care in Schools, School of Public Health and Health Services, Graduate School of Education and Human Development, The George Washington University Medical Center, March 2005 www.healthinschools.org
**BLOOD PRESSURE SCREENING**

**POLICY:** At a minimum, all students in grades K, 2, 4, 6, 8, and one year of high school (usually the wellness classes) shall receive a blood pressure screening once a year. Whatever year of high school has been selected for screening must then be screened year after year. For example, if the wellness classes were chosen then wellness classes should be screened every year thereafter.

Additionally, all students who present with signs and symptoms that indicate a need should have their blood pressure (BP) status assessed and monitored. Education, counseling, and referral should be offered as indicated by the assessment.

**RATIONALE:**
- Mortality due to hypertension and heart disease in Tennessee is among the highest in the nation.
- Early identification followed by successful treatment may prevent heart disease, stroke and kidney failure.
- Elevated BP may be an early indication of the presence of other disease, stroke and kidney failure.
- Screening presents an excellent opportunity for health promotion related to cardiovascular health with a population of emerging adults.

**STANDARDS:**
In children and adolescents, the normal range of BP is determined by body size and age. BP standards that are based on gender, age, and height provide a more precise classification of BP according to body size. Normal BP in children and adolescents is defined as systolic BP and diastolic BP that is < the 90th BP percentile for gender, age, and height. Prehypertension in children and adolescents is defined as average systolic BP and/or diastolic BP levels that are > or = the 90th BP percentile but < the 95th BP percentile for gender, age, and height on three or more occasions. Prehypertension is an indication of heightened risk for developing hypertension. Children and adolescents with BP levels > or = 120/80 mm Hg but < the 95th BP percentile should be considered prehypertensive.

Hypertension in children and adolescents is defined as average systolic BP and/or diastolic BP that is > or = the 95th BP percentile for gender, age, and height on three or more occasions. When diagnosing hypertension, health care providers classify hypertension according to two stages – Stage 1 and Stage 2. Stage 1 hypertension is an average systolic BP and/or diastolic BP that is between the 95th BP percentile and the 99th BP percentile plus 5 mm Hg, inclusive. Stage 2 hypertension is an average systolic BP and/or diastolic BP that is > the 99th BP percentile plus 5 mm Hg. For the purpose of screening referral, hypertensive levels within the Stage 2 classification will warrant priority referral.

School nurses should organize and implement a BP assessment program, which includes screening and education of risk factors associated with hypertension and cardiovascular disease. Screening may be accomplished as a collaborative community effort with qualified staff from other agencies or with trained volunteers under the school nurse’s supervision. If volunteers are used, training regarding confidentiality should be a component of the training content.
Screening must be conducted in a quiet environment with necessary equipment. When measuring BP, use a stethoscope, sphygmomanometer and correct size cuffs (pediatric, adult or large adult). A manual or hospital grade BP cuff can be used. The preferred method of BP measurement is auscultation. Measures obtained by oscillometric devices that exceed the 90th BP percentile should be repeated by auscultation. When measuring the student’s height for use in assessing the student’s BP a vertical measurement board (stadiometer), metallic measuring tape or yardstick attached to a flat wall with no baseboard should be used. A movable right triangular headboard should be used to site the accurate height. This may be attached to the measurement board or separate if using a metallic measuring tape or yardstick. Do not use the measuring rod attached to the platform scale. The platform scale provides neither a steady standing base nor an adequate vertical surface for appropriately positioning children for accurate height measurements.

Equipment should be maintained and calibrated according to the manufacturer’s guidelines to assure accurate measurements. Some sources recommend calibration of aneroid manometers on a semi-annual basis. Equipment should be cleaned prior to each use and when necessary to minimize the spread of infection. Screening should be conducted in a manner congruent with infection control and standard precautions. Trained personnel should follow standard practices and procedures for measuring BP.

Parents/guardians should be notified of their child’s screening results and provided information regarding cardiovascular health maintenance. All students with a BP assessment that varies from the norm should receive a referral to their health care practitioner for evaluation and treatment as indicated. Each student’s BP screening results, referral, and follow-up should be documented in the student’s school health record.

PROCEDURE:
Preparation
1. Every effort should be made to ensure the students’ privacy during the screening process.

2. Locate a quiet room for conducting the BP screenings.

3. Work with the appropriate persons within the school to coordinate the screening activity. The process for coordination with teachers varies among schools. There may be preferred classes during which screenings are usually allowed (for an example, some schools prefer to schedule screenings during a related arts class).

4. Develop or obtain forms for recording the results of the screening for each student. Don’t forget to have the appropriate gender specific CDC stature-for-age growth charts available. These charts are available at: http://www.cdc.gov/nchs/about/major/nhanes/growthcharts/clinical_charts.htm.

5. Develop or obtain parent/guardian notification forms and educational brochures. See Appendix A for sample parent/guardian notification forms.
6. Check to be sure that the sphygmomanometer has been calibrated in accordance with the manufacturer’s suggestions.

7. Check the functionality of all equipment.

8. Prior to screening, students should be given an explanation of hypertension, ways to help maintain a normal BP, and an overview of the screening process. Advise students of the possibility that shoes will need to be removed and hairstyles may need to be adjusted in order to secure an accurate height measurement. Also advise students of clothing options that allow ease of baring the right arm for BP measurement. This may be done via a classroom instructional unit or if necessary, individually.

9. Prior to conducting the screening, set up the room for screening one student at a time or use a privacy partition if more than one screener will be working in the same room.

10. Preferably, the student being screened should not be able to see or hear other students.

11. The student should be able to be seated with feet flat on the floor with right arm supported at heart level on a table or desk.

12. The screener may choose to stand or be seated during the BP measurement phase of the procedure, thus a chair for the screener will be necessary.

13. The room should have an area without a baseboard for mounting the metallic yardstick or stadiometer that will be used for measuring height.

14. To assist with the flow of students, you may wish to have a teacher or staff assistant monitor students waiting to be screened in an adjacent room or hallway. Once a student has been screened, he/she can join his/her classmates and the next student to be screened can then enter the screening room.

15. Have supplies available to clean the equipment per the manufacturers’ suggestions between each student.

**BP SCREENING**

1. As appropriate, prior to checking a student’s BP, the examiner should ask the caretaker or the student about the student’s health history to determine if any risk factors exist that may cause BP readings to vary from the norm.

2. Screen for BP using an age and developmentally appropriate screening process. Talk with the student using age and developmentally appropriate terms. You may need to use words like “pressure” rather than blood pressure, and “arrow” rather than needle.

3. Explain to the student that you will be measuring his/her BP to determine if it is within a normal range or high range. Let the student know that a person’s BP changes during the day depending upon many factors (e.g., activity level, diet, medications). Advise the student that if the measurement is high, you will
recheck his/her BP and may want to check it again on another day to see if the BP measurement is still high. Help the student to understand that if his/her BP remains high after you have checked it several times, you will suggest that the student’s parents/guardians have a health care practitioner check to determine if the student has hypertension. The results of the BP screening do not mean that the student has hypertension; it means that the BP measurement was high during the screening activity.

4. Assess the BP.
   a. Prior to measuring BP, allow the student to rest at least 3-5 minutes.
   b. Explain the process to the student.
   c. Position student appropriately:
      (1) Student’s feet should be flat on floor.
      (2) Student should be leaning gently against back of chair, not on arm.
      (3) The entire arm in which the BP will be measured should be fully supported on a firm surface (table) with the brachial artery at heart level.
      (4) Upper arm should be bare – do not apply cuff over clothing.
   d. Choose appropriate cuff size:
      (1) The screener must ensure that the rubber bladder completely encircles the student’s arm and the width of the bladder covers approximately 75% of the upper arm. Most modern cuffs are marked with range lines to denote need to use larger or smaller cuff. Proper cuff size is essential for measuring BP accurately.
      (2) If there is a question between two cuffs, use the larger one. A cuff that is too small may result in an artificially elevated BP whereas a slightly larger cuff is unlikely to cause a falsely elevated BP level.
   e. Place the BP cuff on the upper right arm:
      (1) Leave enough room at the top of the cuff to prevent obstruction to the axilla and enough room at the bottom to place the stethoscope in the antecubital fossa.
      (2) Position the right arm so that the brachial artery is at heart level.
      (3) The right arm is preferred for consistency and comparison with standard tables for BP parameters and because of the possibility of coarctation of the aorta, which might result in false low readings in the left arm.
   f. To determine how far to inflate the cuff for measuring the student’s BP:
      (1) Palpate for the radial pulse.
      (2) Inflating the cuff while palpating the radial pulse.
      (3) Note the level at which the radial pulse disappears.
      (4) Release air from cuff rapidly and wait 15 minutes prior to measuring the student’s BP.
      (5) When measuring the BP, inflate the cuff 20 – 30 mm Hg above the point where the radial pulse disappeared.
   g. After the 15-second wait period, measure the student’s BP:
      (1) Palpate the brachial pulse.
      (2) Place the ear tips of the stethoscope in your ears with tips facing forward.
(3) Place the diaphragm of the stethoscope over the brachial artery. The diaphragm of the stethoscope should not touch the cuff.
(4) Rapidly inflate cuff 20 – 30 mm Hg above the point at which the radial pulse disappeared.
(5) Release cuff pressure at a rate of 2-3 mm Hg per second, while auscultating brachial artery.
(6) The systolic BP reading is taken at the onset of a clear tapping sound (1st Korotkoff sound).
(7) The diastolic BP reading is taken at the disappearance of 5th Korotkoff sounds. After the disappearance of Korotkoff sounds, continue to deflate the cuff slowly for another 10 mm Hg. If no further sounds are heard, rapidly release all air in the cuff and record the BP measurement.
(8) If the Korotkoff sounds continue to 0 mm Hg or is very low, repeat the BP measurement with less pressure on the head of the stethoscope.
(9) If the very low 5th Korotkoff sound persists record the 4th Korotkoff (muffling of the sounds) as the diastolic BP.

HEIGHT ASSESSMENT
1. If you do not already have a current height measurement for the student, measure the student’s height and plot it on the appropriate gender specific CDC stature-for-age growth chart. These charts are available at http://www.cdc.gov/nchs/about/major/nhanes/growthcharts/clinical_charts.htm.

2. School aged children able to stand on their own should be measured standing, without shoes, using a vertical measurement board (stadiometer) or a metallic measuring tape/yardstick attached to a flat wall with no baseboard. A movable right triangular headboard should be used when actually measuring height. Do not use the measuring rod attached to the platform scale. The platform scale does provide neither a steady standing base nor an adequate vertical surface for appropriately positioning children for accurate height measurements.

3. Prior to starting, check measurement board to ensure it is working correctly. The headboard should slide easily, but should not be so loose or worn that it slips when measuring the child’s height.

4. Remove the child’s shoes, hats, and bulky clothing, such as coats and sweaters. Undo or adjust hairstyles and remove hair accessories that interfere with measurement.

5. Have the student stand erect, with shoulders level, hands at sides, knees or thighs together and weight evenly distributed on both feet.

6. The student’s feet should be flat on the floor or foot piece, with both heels at base of the vertical board. When possible, all four contact points (i.e., the head, back, buttocks, and heels) should touch the vertical surface while maintaining a natural stance. Some students will not be able to maintain a natural stance with all four contact points touching the vertical surface. For these students, at a
minimum, two contact points - the head and buttocks, or the buttocks and heels should always touch the vertical surface.

7. Position the student’s head by placing a hand on the student’s chin to move the head into the Frankfort Plane. The Frankfort Plane is an imaginary line from the lower margin of the eye socket to the notch above the tragus of the ear. When aligned correctly, the Frankfort Plane is parallel to the horizontal headboard and perpendicular to the vertical measurement board. This is best viewed and aligned when the screener is directly to the side and at eye level with the child.

8. Lower the headpiece until it firmly touches the crown of the head and is at a right angle with the measurement surface.

9. Check contact points to ensure that the lower body stays in the proper position and heels remain flat. Some students may stand up on their toes, but verbal reminders are usually sufficient to get them in proper position.

10. Read the height measurement to the nearest 1/8 inch (or 1 cm) and record in the student’s school health record.

11. Follow procedural steps above as closely as possible if vertical measurement board is not available.

12. Plot the student’s height on the appropriate gender specific CDC stature-for-age growth chart. These charts are available at http://www.cdc.gov/nchs/about/major/nhanes/growthcharts/clinical_charts.htm

ASSESS BP STATUS

1. Determine height percentile of the student using the appropriate gender specific CDC growth chart (which follows in this section.). If the student’s height percentile is between two percentiles, use the higher height percentile.

2. Utilize the gender specific BP tables (that follow in this section) to determine if the student’s BP is normotensive, prehypertensive, hypertensive, or in the hypertensive priority referral range. This table was developed based on the BP percentile levels established by the National High BP Education Program Working Group on High BP in Children and Adolescents.

3. Compare the student’s systolic and diastolic BP measurements with the level provided in the BP tables for age and height percentile using the correct gender table to determine if the measurement falls in a normal or abnormal category.

4. For students or personnel over 18 years of age, use the following guidelines for determining if the BP measurement is normal, prehypertensive, hypertensive, or in the priority range.
   - Normotensive: systolic < 120 mm Hg; diastolic < 80 mm Hg
   - Prehypertensive: systolic > or = 120 – 139 mm Hg and/or diastolic > or = 80 – 89 mm Hg
   - Hypertensive: systolic > or = 140 mm Hg and/or diastolic > or = 90 mm Hg
5. Assessment & Referral Criteria:
   a. In presenting these guidelines we acknowledge that the school nurse may exercise her/his clinical judgment regarding referral decisions.
   b. Keep in mind that for all ages and heights a BP measurement that is > or = 120/80 (diastolic and/or systolic) is considered prehypertensive, unless the BP reading for the student’s height and age is in the hypertensive category.
   c. If the student’s BP (systolic and diastolic) is normotensive: provide educational material regarding healthy diet, sleep and physical activity for maintaining a healthy cardiovascular system.
   d. If the student’s BP (systolic and/or diastolic) is prehypertensive: provide educational material regarding healthy diet, sleep and physical activity and recheck the student’s BP again within two weeks, on two separate visits that are a few days apart. Average the three measurements. If averaged measurement is prehypertensive, recommend that the parent/legal guardian notify the student’s health care practitioner at the student’s next regularly scheduled visit.
   e. If student’s BP (systolic and/or diastolic) is hypertensive, but not in the priority referral range, assess for other symptoms of hypertension (e.g. headaches, blurred vision, feeling faint) and/or other activities that might explain a high BP (e.g., exercise prior to BP measurement, caffeine intake, medications).
      ➢ If symptomatic, ask the student to rest for 15 minutes; then recheck the student’s BP. Average the two measurements. Provide educational material regarding healthy diet, sleep and physical activity and refer for evaluation by the student’s health care practitioner.
      ➢ If not symptomatic, recheck the student’s BP again within one week, on two separate visits that are a few days apart. Average the three measurements. Refer for evaluation by the student’s health care practitioner if averaged measurement is elevated.
   f. If BP (systolic and/or diastolic) falls in the priority referral range on the gender specific BP tables, assess for other symptoms of hypertension (e.g. headaches, blurred vision, feeling faint) and/or other activities that might explain a high BP (e.g., exercise prior to BP measurement, caffeine intake, and medications). Ask the student to rest for 15 minutes and then recheck the student’s BP. Average the two measurements. Provide educational material regarding healthy diet, sleep and physical activity and refer for evaluation by the student’s health care practitioner. A telephone call to the student’s parent/guardian should be placed within 24 hours to discuss the BP screening results and to assist with referral completion.
   g. Referrals for assessment, treatment, and follow-up, may be made using an appropriate parent/notification form found in Appendix A.

6. Parents/guardians should be notified of their students’ screening results, whether normal or abnormal.

7. Education and counseling should be provided about normal findings, deviations from normal, and for any specific concerns identified during the visit.
8. Efforts should be made by the school nurse to assist parents/guardians with referral completion.

9. All findings, referrals, and follow-up should be documented in the student’s school health record.

**USING THE BLOOD PRESSURE TABLES**

1. Use the standard height charts to determine the height percentile.

2. Measure and record the child’s SBP and DBP.

3. Use the correct gender table for SBP and DBP.

4. Find the child’s age on the left side of the table. Follow the age row horizontally across the table to the intersection of the line for the height percentile (vertical column).

5. There, find the 50th, 90th, 95th, and 99th percentiles for SBP in the left columns and for DBP in the right columns.
   - BP less than the 90th percentile is normal.
   - BP between the 90th and 95th percentile is prehypertension. In adolescents, BP equal to or exceeding 120/80 mmHg is prehypertension, even if this figure is less than the 90th percentile.
   - BP greater than the 95th percentile may be hypertension.

6. If the BP is greater than the 90th percentile, the BP should be repeated twice at the same office visit, and an average SBP and DBP should be used.

7. If the BP is greater than the 95th percentile, BP should be staged. If Stage 1 (95th percentile to the 99th percentile plus 5 mmHg), BP measurements should be repeated on two more occasions. If hypertension is confirmed, evaluation should proceed as described. If BP is Stage 2 (>99th percentile plus 5 mmHg), prompt referral should be made for evaluation and therapy. If the patient is symptomatic, immediate referral and treatment are indicated. Those patients with a compelling indication and would be treated as the next higher category of hypertension.
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<td>139, 140, 141, 143, 145, 146, 147</td>
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</table>

BP: blood pressure

* The 90th percentile is 1.28 SD, 95th percentile is 1.645 SD, and the 90th percentile is 2.326 SD over the mean. For research purposes, the standard deviations in appendix table B-1 allow one to compute BP Z-scores and percentiles for boys with height percentiles given in table 3 (i.e., the 5th, 10th, 25th, 50th, 75th, 90th, and 95th percentiles). These height percentiles must be converted to height Z-scores given by (Z = -1.64; 1.28; 2.325; 0.67; 0.16; 0; 0.05; 0.04; 0.03; 0.02; 0.01; 0.00; 0.01; 0.02; 0.03; 0.04; 0.05; 0.16; 1.28; 2.326) and then computed according to the methodology in steps 2 to 4 described in appendix B. For children with height percentiles other than those, follow steps 1 to 4 as described in appendix B.
<table>
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<tr>
<th>Age (Year)</th>
<th>BP 50th Percentile</th>
<th>Systolic BP (mmHg)</th>
<th>Diastolic BP (mmHg)</th>
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*TABLE 4* Blood Pressure Levels for Girls by Age and Height Percentile.
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<th>Age (Year)</th>
<th>BP Percentile ↓</th>
<th>Systolic BP (mmHg) ← Percentile of Height →</th>
<th>Diastolic BP (mmHg) ← Percentile of Height →</th>
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Sources:
School Health/Blood Pressure Screening, South Carolina Department of Health and Environmental Control, April 4, 2006.

http://www.pediatrics hypertension.org/hypertension080104.pdf

References:

http://www.cdc.gov/nchs/about/major/nhanes/growthcharts/clinical_charts.htm


SCOLIOSIS SCREENING

POLICY: Schools are encouraged to screen all 6th graders for scoliosis once a year. Staff training for scoliosis screenings is required. Specific protocols must be used.

RATIONALE: Scoliosis is a physical condition characterized by an abnormal curvature of the spine. Its cause is unknown in most cases. The amount of curvature is measured in degrees after an X-ray and can vary from mild to severe. It is most often seen in the middle school age group, when rapid growth is occurring. Both girls and boys may be affected, but girls tend to progress eight times more frequently. Treatment ranges from observation to bracing to corrective surgery in severe cases. After scoliosis is identified or suspected, follow-up is essential to measure the degree of curvature and determine treatment options. Kyphosis, an accentuated spinal hump, and lordosis, or swayback, may occur independently or in conjunction with scoliosis.

Every student present will be screened, unless parents refuse by signing and returning a form that will be sent home. Screening consists of examining the student’s unclothed back. Female students can be screened wearing just a bra above the waist (preferred), or can wear a bathing suit under their clothes for the day of screening. The student will be asked to stand straight, and then bend forward while the examiner looks from the front, the back and the side. The screener looks for obvious curves, rib humps, uneven shoulders, waist or hips. Specially-trained PE teachers, clinic personnel, or volunteers can complete or assist school nurses with primary screening. Female examiners are preferable for female students. Refer students with questionable findings to the school nurse, public health nurse or other consultants for secondary screening. This can be done easily on the same day, if secondary screeners are available. If a curvature is seen or suspected on the secondary screening, notify the parents/guardians in writing. Offer assistance when access to healthcare is a barrier for the family. The child’s primary healthcare provider can complete a further examination or refer the child to a specialist.

TIPS FOR SETTING UP A SUCCESSFUL SCOLIOSIS SCREENING
1. Training for volunteers and new staff, and a refresher for experienced screeners should be done shortly before the screening date. A video and a training manual are available from Children’s Healthcare of Atlanta at 404.929.8397.

2. Schedule the screening so that there are no conflicts with testing, field trips, etc.

3. Schedule when secondary screeners can be available if possible.

4. Send letters/permission forms home one to two weeks before the screening is scheduled.

5. Have teachers collect and save the “Do Not Screen” letters.

6. Prepare students the day before screening, discussing the procedure that will be followed. A video for students “Scoli-What?” is available from Children’s Healthcare of Atlanta at 404.929.8397.
7. Remind female students the day before to wear bras or bathing suits under clothes.

8. Students or teachers should complete the personal information on the screening forms and the student should bring the completed form to the screening.

9. Many middle schools schedule screenings during PE or exploratory periods on one day and reschedule lunch periods if necessary to complete screenings.

10. It is very important to manage the screening area so that the student’s privacy is maintained i.e., utilizing boys’ and girls’ locker rooms, shower areas, screens, etc. This practice will make screening go more smoothly and quickly.

11. The setting chosen for screening should be checked for good lighting; the floor should be free of uneven areas; and the temperature of the room should be comfortable for students who will be undressing.

12. It is important to screen with the student’s entire back exposed (no T-shirts around the neck, bra is OK). An adequate exam cannot be done otherwise.

13. Volunteers will be helpful to control “traffic,” call classes down, get students to secondary screeners, etc.

Source: Georgia Department of Human Resources, Division of Public Health, Children’s Healthcare of Atlanta & Georgia Association of School Nurses 2004 Georgia School Health Resource Manual–Chapter 8 Screening Guidelines in the School Setting

SCOLIOSIS SCREENING PROTOCOLS
If your school system chooses to screen for scoliosis (6th grade only), it is recommended to partner with a local orthopedic doctor, osteopathy doctor or other trained professional to provide specific training for school staff and/or volunteers. A scoliosis training manual can be found at http://www.dshs.state.tx.us/spinal/pdf/spscrnprggd.pdf.

A sample scoliosis screening form can be found in Appendix C.
ORAL HEALTH SCREENING

Dental Screening Law – T.C.A. 49-6-5004.
Upon registration or as early as is otherwise possible and appropriate, public schools, nursery schools, kindergartens, preschools or child care facilities are encouraged to make reasonable efforts to apprise parents of the health benefits of obtaining appropriate eye and dental care for children.

POLICY: All schools are encouraged to screen students for oral health problems.

RATIONALE: Oral health is an important component of overall health and should be integrated into school health services. Because schools are where the majority of children and youth are, schools, and school nurses in particular, have an important role to play in promoting oral health by serving as a significant source of information and participating in prevention programs such as providing dental health education, intervening in dental emergencies and advocating the provision of well-balanced nutritious meals.

The goal of the school oral health program is to prevent oral disease and injury. The program should enable every child to maintain his or her own oral health. Dental health education combined with referral treatment programs has been shown to be effective in improving oral health. In addition, the school nurse can serve as an advocate for safe practices in all school settings (physical education, team sports, etc.) to prevent dental injuries.

Dental disease is a significant preventable debilitating disease. Nationally, diseases of the mouth, one of the most common health problems, affects about 98% of the entire U.S. population at some point in their lives. Health examination surveys conducted by the National Center for Health Statistics found that the most significant problems detected by an examination of children in the U.S. were “dental problems” in all age groups. Access to dental care is limited for a significant part of the population with 40% of Americans failing to receive any dental care each year.

Preventable oral disease is more common in children from underserved groups and in disabled children.

Screening for dental defects should be part of total health screening, and the personnel should be those involved with the overall responsibility for health defects. Screening for dental disease should require relatively little time. A set routine should be followed so as not to omit necessary aspects of the screening process. If one defect is found, the screening procedure should be terminated and the child referred to the family dentist or to the local health department dentist where available.

Source: Dr. E.J. Alderman, Former Director Oral Health Section, Office of Infant and Child Health, Georgia Department of Health
ORAL HEALTH SCREENING
A dental screening is an appraisal activity and identifies individuals with pain or imminent pain. It also creates awareness about the importance of good oral health. Please note, a dental screening does not replace a regular dental examination by a dentist. Routine dental screenings will assist in securing every child dental services and education to prevent pain, infection, premature loss of teeth and/or malocclusion.

A Dental Health Screening Program is designed to preserve the health of children and provides a procedure where a program in preventive dental hygiene is presented. The benefits of an oral health screening program include:

- Dental defects may be discovered early so they can be corrected with the least amount of discomfort to the child.
- Early symptoms of oral disease may be detected and corrected.
- Irregularity of tooth position may be observed and preventive measures instituted.
- Referral for early treatment before problems become magnified will keep the cost of dental care to a minimum.

AGE/GRADE FOR ORAL HEALTH SCREENING
The American Dental Association recommends annual oral health screenings for every student. The Tennessee Department of Health, Oral Health Services, provides a School Based Dental Prevention Program. This program is a statewide, school based preventive dental program targeting children in grades kindergarten through eighth in schools with 50% or more free and reduced lunch. Portable equipment is used by dental staff to provide dental screenings, referrals, and follow-up to dental providers to address unmet dental needs in this population. Health education and preventive sealants are provided to the target school population as well as information regarding TennCare eligibility and the application process. More information is available at http://health.state.tn.us/oralhealth/schoolbased.html. Also, contact your local health department to ascertain what types of oral health services are available for your community.

SCREENING
Oral health screening is performed using: a tongue depressor, disposable gloves, and flashlight. Gauze pads may be helpful if the tongue needs to be manipulated.

An overall visual inspection is performed in order to view the outer and inner aspects of the oral cavity, including the lips, outer cheeks, all inner tissues, floor of the mouth, tongue, palate, oropharynx, uvula, and teeth.

When viewing the student's face and neck prior to the oral health screening, swollen and tender lymph nodes may be noted in the neck and/or jaw. If breath is highly odiferous, seek the cause. Also, observe the quality of the voice.
SYMTOMS FOR REFERRAL (WITH OR WITHOUT SCREENING)

- Visibly decayed and/or fractured teeth, broken filling(s) and/or missing permanent teeth.
- Toothache, swelling and/or bleeding gums.
- Ulceration, lesions, inflammation or draining of oral mucosa, palate, tongue, gums.
- Malocclusion, mal-position or supernumerary teeth.
- Protrusion of upper/lower jaw; deviate swallowing (tongue thrust).
- Leukoplakia (on tongue or cheek) in known tobacco user.
- Broken or ill fitting orthodontic appliance.
- Difficulty in eating; e.g. chewing or swallowing of food.
- Swollen or tender lymph nodes in neck and jaw.
- Dental-related injuries obviously requiring treatment.
- Unusual lip conditions such as fissures, drooping, or color (e.g. pale or bluish).
- Nasal voice quality can suggest a health problem such as enlarged adenoids.

Source:
Answers4Families is a partnership of the Nebraska Health & Human Services System and the Center on Children, Families, and the Law at the University of Nebraska in Lincoln. The IFSPweb represents collaboration between the early intervention co-lead agencies of the Nebraska Department of Education and the Nebraska Health & Human Services System, and the University of Nebraska/Lincoln. The IFSPweb is funded through IDEA funds from the U.S. Department of Education Office of Special Programs.

Appendix A

SAMPLES

PARENT/GUARDIAN CONSENT FORMS FOR SCHOOL HEALTH SCREENINGS
SAMPLE
PARENT/GUARDIAN SCREENING CONSENT FORM

Dear Parent or Guardian,

Throughout the school year we will be providing several free health screenings for the students of ______________ school system. We routinely screen a variety of students in the appropriate grade levels. We also screen all transfer students, any student needing a screening for evaluation purposes, or any student referred by a teacher. For example, a teacher may notice that a student is having difficulty seeing the board or hearing his/her instructions and request a screening of the child. This information is shared only on a need to know basis. Following the example above, if your child did have difficulty with his/her vision or hearing test, we would ask the teacher to move the student to the front of the classroom so they could see or hear the classroom information until you were notified and able to follow-up on the screening.

We will be screening for the following throughout the school year. The ________ County Health Department, or other community health care providers may be assisting with these screenings. Again, this information is only shared on a need to know basis.

<table>
<thead>
<tr>
<th>Vision</th>
<th>Dental</th>
<th>Speech/Hearing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Height/Weight</td>
<td>Scoliosis</td>
<td>Blood Pressure</td>
</tr>
</tbody>
</table>

If we screen your child and find any alterations from a normal screening we will contact you concerning this manner. There are no charges for these services.

PLEASE NOTIFY YOUR CHILD’S TEACHER AT THIS TIME IF YOU WISH FOR HIM/HER NOT TO BE INCLUDED IN THESE SCREENINGS. Please feel free to contact your school nurse if you have any questions.

Thank you,

(name)_________________________________
SAMPLE
PASSIVE PARENTAL/GUARDIAN CONSENT FORM
FOR SCHOOL HEALTH SCREENINGS
(Stewart County Sample)

STUDENT HEALTH SCREENING NOTIFICATION

Free student health screenings will be conducted at your child’s school before November 1st of this year. The high school students will be screened in their Wellness classes. Austin Peay State University (APSU) Nursing Department, Lions Club and various other trained volunteers will be assisting with screening. Data does not include any identifying information. All information is private and confidential.

We will be screening to determine if your child has a health risk that:
1) needs medical attention, and/or
2) might affect his/her classroom work.

The screenings that will be conducted are as follows:

- Vision – Grades PreK, K, 2, 4, 6, and 8.
- Hearing – Grades PreK, K, 2, 4, 6 and 8.
- Scoliosis – Grade 6 only – (include only if your school system is providing this optional screening)
- Dental – Grades K, 2, 4, 6 and 8 (include only if your school system is providing this optional screening)
- Blood Pressure – Grades K, 2, 4, 6, 8 and one year of high school
- Height and Weight – Grades K, 2, 4, 6, 8, and one year of high school

You will be mailed a report with the results of your child’s screenings after review by the school nurse. If there is a need for further evaluation by a physician a referral will be indicated. These screenings do not qualify as an examination and parents are encouraged to make sure your child has annual medical check ups as well as bi-annual dental check ups.

If you have any questions regarding this free service, or if you wish your child excluded from any part of the Health screenings, please contact the School Nurse at your child’s school:

______________________________________________________________________
SCHOOL   NURSE   PHONE NUMBER
SAMPLE
PARENT/GUARDIAN SCREENING DENIAL FORM

If you wish to decline any of the following services/survey listed below please check the appropriate box, sign and date this form and return to the school nurse by ____________.

I, ____________________________________________, parent/guardian of ________________________________________ student decline the following services:

[ ] Health Screenings
[ ] Youth Risk Behavior Survey
[ ] Other: ___________________________

Date: _________________   Sign: _________________________________
Appendix B

SAMPLES

PARENT/GUARDIAN NOTIFICATION FORMS FOR SCHOOL HEALTH SCREENING RESULTS
SAMPLE
PARENT/GUARDIAN SCREENING RESULTS NOTIFICATION FORM

__________________________ COUNTY DEPARTMENT OF EDUCATION
____________________________ COORDINATED SCHOOL HEALTH
Address
Phone numbers

Date:________________________
Name:____________________________________
Teacher:_________________________ Grade:_____
School:_______________________________________

Dear Parent/Guardian:
Your child recently participated in a vision, hearing, dental and body mass index, blood pressure and pulse screening mandated by the State of Tennessee. They are effective in revealing common vision and hearing deficiencies, dental problems and developmental trends. It does not substitute for a professional examination.

YOUR CHILD SCREENED WITHIN NORMAL LIMITS

THE FOLLOWING:

□ Vision □ Hearing □ Dental □ Blood Pressure □ BMI □ PULSE

A RESCREEN WILL BE PERFORMED BY NURSING SERVICES FOR:

□ Vision □ Hearing □ Dental □ BP □ BMI □ PULSE

WE HAVE ISSUED A PHYSICIAN REFERRAL FOR:

□ Vision □ Hearing □ Dental □ BP □ BMI □ PULSE

Our observations, for your child, are listed below. If your child is not under the care of a physician, we strongly encourage you to make an appointment for a complete examination and any needed treatment; if your child has already been seen please ask them to fax a report to ___________. If your child does not have a physician or if you need financial assistance, please call our office. Thank you for your prompt attention to this matter.

Please have the physician complete the form below and mail or fax to the address above. Thank you.

VISION REFERRAL Results: Far Acuity: 20/20 20/20 Near Acuity: 20/20 20/20

Failed Muscle Balance

We recommend your child receive an examination from an eye doctor.

To be completed by physician:
This student was seen by me on ____________________ as per your referral. The following diagnosis/recommendations were made:

Glasses prescribed:________________________ Comments:__________________________________________________________

Physician Signature and Phone Number

HEARING REFERRAL Results: □ Failed Audiometry □ Failed Tympanometry

Signs of Infection: □ Pain □ Discharge □ Wax □

Erythema

1. Immediate Care is recommended for the acute symptoms circled above

2. As soon as possible for a suspected hearing problem

We recommend your child receive an examination from a physician or audiologist.

To be completed by physician:
This student was seen by me on ____________________ as per your referral. The following diagnosis/recommendations were made:

_________________________
Medication/PE Tubes/Hearing Aids prescribed: _______Comments: ____________________________________________

Physician Signature and Phone Number

DENTAL REFERRAL

Immediate Care is recommended for: □ Pain □ Extensive Decay □ 
Severe Gum Inflammation

As soon as possible for: □ Obvious Decay □ Gum Inflammation □ 
Damaged Filling

When possible for: □ Symptoms of Early Decay □ Routine Cleaning / Exam

Needed □ We recommend your child receive an examination from a dentist.

To be completed by dentist:
This student was seen by me on ____________________ as per your referral. The following diagnosis/recommendations were made:
Filling/Extraction: _______Comments: ______________________________________________________________

Physician Signature and Phone Number

BMI (BODY MASS INDEX) (Do not send specific results) BLOOD PRESSURE REFERRAL

PULSE REFERRAL

Call the Coordinated School Health Office _____________ for your Blood Pressure Reading Today: _____/_____
PULSE Today:__________
Child’s results

We recommend your child receive an examination from a physician.

To be completed by physician:
This student was seen by me on ____________________ as per your referral. The following diagnosis/recommendations were made:
Comments:

Physician Signature and Phone Number

_________________________ __________________________
Signature Date

_________________________ __________________________
Signature Date
SAMPLE
PARENT/GUARDIAN SCREENING RESULTS NOTIFICATION
FORM

Student Name:____________________________________
School:____________________________________________________________________
Grade:______________________ Date:_____________
Teacher:______________________________________

Dear Parent:
Your child recently participated in free health screenings that included scoliosis, body mass index,
hearing, vision, blood pressure and pulse screenings.

All screenings are within normal limits: _______       Your child does not
require further follow up.

Your child was given a posture check to screen for scoliosis (curvature of the spine) by the
Nursing Supervisors as one of the health services provided by the school system. The results
are below. It is advised that you have your child further checked by your family doctor or
pediatrician. Early treatment can often prevent a progressive spine deformity. Please take this
form with you when you take your child for the evaluation and return it to your school nurse or the
address above. We need the physician’s recommendations in order to close out the referral in
our records. If you need assistance obtaining an appointment or have questions, please call the
number above.

Greater than 10 degree curvature measured:_______________ Your child does require further follow up.

Accentuated kyphosis (roundness in upper back) observed:_______________ Your child does
require further follow up.

Extreme lordosis (swaying of the lower back) observed:_______________ Your child does
require further follow up.

Obvious Leg Length Discrepancy observed:_______________ Your child does require
further follow up.

Blood Pressure Reading Today:_____/_____               Pulse:_________

We recommend your child receive an examination from a physician.
_______ BMI (BODY MASS INDEX)

Call the Coordinated School Health Office at _________ for your child’s results

_____ We recommend your child receive an examination from a physician.

-------------------------------------------------------------

TO BE COMPLETED BY PHYSICIAN

I examined this patient and make the following observations and recommendations:

_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

_____ Physician Signature           _____ Physician Phone Number
Date: __________________

Dear Parent or Guardian,
Now through the end of the _______________ school year, the Monroe County
School System, in conjunction with the state office of Coordinated School Health,
will be performing the health screenings listed below to all students in the
appropriate grade levels. All screenings will maintain strict adherence to the
confidentiality of each child and adolescent screened.

- Blood Pressure
- Height/Weight
- Vision
- Hearing
- Scoliosis
- Dental

If you want your child’s results in any of the above screenings, please complete
and sign the form below and return to your child’s teacher.
If you have any questions or concerns, please feel free to contact me at the
number listed below.

Thank you.

Contact Person and Phone Number and Hours Person Is Available

I want my child’s results of the free screenings.

Parent/Guardian’s signature: _______________________________________

Child’s Name: ________________________________ Date: __________________

Child’s School: _____________________ Teacher’s Name: _____________________

Check the screening that you want your child’s results:

- Blood Pressure  - Height/Weight
- Vision  - Hearing
- Scoliosis  - Dental
Appendix C

SAMPLES

SCREENING RESULTS FORMS FOR SCHOOL RECORDS
SAMPLE
SCREENING RESULTS FORM FOR SCHOOL RECORDS

SCREENING RESULTS

School:_________________________ Birth date:_________________________

Last Name:____________________ First Name:__________________________

Teacher:________________________ Grade:____ Date:____________________

☐ Routine Screening  ☐ Special Ed Request
☐ Teacher/Parent Request  ☐ Rescreening

****************************************************************************************************

***********

Vision: ☐ Glasses  ☐ Contacts  Last Exam: ☐ > One Year  ☐ < One Year

Glasses: ☐ Broken  ☐ Lost  ☐ Not Wearing  ☐ Refuses to Wear

R FAR: Acuity 20/_____ L FAR: Acuity 20/_____

R NEAR: Acuity 20/_____ L NEAR: Acuity 20/_____

Muscle Balance: ☐ Passed  ☐ Failed

Comment:________________________________________________________

Hearing: ☐ Hx. of hearing loss/surgery  ☐ PE Tubes

☐ Hearing Aid(s)  ☐ Rescreening

Audiometry: ☐ Pass  ☐ Fail  Tymanometry: ☐ Pass  ☐ Fail

Otoscope: ☐ Cerumen  ☐ Drainage  ☐ Erythema  ☐ Infected/Ruptured Eardrum

R Hz Freq 1000______  R Hz Freq 2000______  RHz Freq 4000_____

L Hz Freq 1000______ L Hz Freq 2000______ LHz Freq 4000_____

Comment:________________________________________________________

Dental: 1. Immediate Care is recommended for:

☐ Pain  ☐ Extensive Decay  ☐ Severe Gum Inflammation

2. Care is recommended as soon as possible for:

☐ Obvious Decay  ☐ Gum Inflammation  ☐ Damaged Filling

3. Care is recommended when possible for:

☐ Symptoms of Early Decay  ☐ Routine Cleaning/Exam needed

Comment: ________________________________________________________

Vital Statistics:

Blood Pressure: _____/_______  Ht: ________ inches  Wt: _________ lbs.

Pulse: ________  BMI: _____________

<table>
<thead>
<tr>
<th>Vision</th>
<th>Hearing</th>
<th>Dental</th>
<th>Blood Pressure</th>
<th>BMI</th>
<th>PULSE</th>
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<td>Passed</td>
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</tbody>
</table>
Sample
Scoliosis Medical Screening Form

Shoulder Elevated

Shoulder Blade Prominence

Unequal Distance Between Arm and Body

Uneven Hips

Rib Prominence

Lumbar Prominence

Kyphosis Increased

Date of screening:

Negative Referred for 2° screening

Screener's name (print):

Check one: __Volunteer  __Teacher  __Clinic Asst.  __School Nurse  __Health Dept. Employee  __Other (Specify)

Comments of screener:

Date of screening

Negative Referred

Screener's name (print):

Check one: __School Nurse  __Health Dept. Employee  __Other (Specify)

Comments of screener:
Elevated Shoulder blade (scapular) prominence ____________
Unequal distance between arm and body ____________
Uneven hips Rib Prominence (Upper back) ____________
Lumbar Prominence (Lower back) ____________
More than normal roundness (kyphosis) ____________

Source: Georgia Department of Human Resources, Division of Public Health, Children’s Healthcare of Atlanta & Georgia Association of School Nurses, Georgia School Health Resource Manual–Chapter 8 Screening Guidelines in the School Setting, 2004
SAMPLE
Hearing Screening Form

Student Name __________________________________________________________

Last       First

Teacher ________________________ Grade ____ School _______________________

School System _______________________________________ Date ______________

Pure Tone Screening
1000 Hz 2000 Hz 4000 Hz

RIGHT EAR:  _______ ________ ________

LEFT EAR:  _______ ________ ________

(20 db HL)(20db HL) (20 db HL) (Screening Level)

√ = Pass

______ Pass  _____ Could not screen

______ Rescreen  _____ Absent

(Screener’s Signature)

****************************************************************************************************

Rescreen Date _________________

Pure Tone Screening
1000 Hz 2000 Hz 4000 Hz

RIGHT EAR:  _______ ________ ________

LEFT EAR:  _______ ________ ________

(20 db HL)(20db HL) (20 db HL) (Screening Level)

√ = Pass

______ Pass

______ Further testing indicated

(Screener’s Signature)

Source: ED – 4071 / 2003: Screening and Interventions in General Education, Department of Education
HEARING SCREENING PROGRAM
Re-screening Worksheet

Name ___________________________ Age ______ Grade ______ Teacher ________

Parents __________________________ Address __________________________

Phone ____________________________ Health Care Provider ________________

Conditions Indicative of Possible Hearing Loss: (teacher observations and health history)

_____ Repeated colds
_____ Cold today
_____ Sore throat today
_____ Discharge from ear more than once
_____ Discharge from ear today

Frequent earaches:
R _____ L _____ Both _____

_____ Complains of loud, constant ringing in the ears

_____ Hearing problems or deafness in family

_____ Inattentive
_____ Slow responding
_____ Repeating grade
_____ Says “huh?” or “what” often
_____ Speech defect “baby talk”
_____ Omitts letters
_____ Substitutes letters
_____ Garbled speech
_____ Distorted speech
_____ Too soft
_____ Too loud
_____ Too high pitched
_____ Too low pitched

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<td>---</td>
</tr>
<tr>
<td>2,000</td>
<td>---</td>
</tr>
<tr>
<td>4,000</td>
<td>---</td>
</tr>
<tr>
<td>6,000 (optional)</td>
<td>---</td>
</tr>
</tbody>
</table>

| Tympanometry       |                |                |
|---------------------|-----------------|
| R Ear               | P | F | Type Curve |
| L Ear               | P | F | Type Curve |

Referred by nurse to:

_____ Family
_____ Primary Care Provider
_____ ENT Specialist
_____ Speech/Language Pathologist
_____ Audiologist
_____ Other
Appendix D

SAMPLES

CONFIDENTIALITY AGREEMENT FORMS
Sample
Confidentiality Agreement Form
(STAFF)

Definition: Disclosing health information only to the people who are authorized to know it.

Purpose: To safeguard the privacy of students and staff regarding personal health information and to maintain the nurse/patient relationship in compliance with the nurse practice act while facilitating accurate nursing assessment and safe intervention. To allow student, staff and parent to feel secure in sharing appropriate information and to observe statutes and rules governing confidentiality.

Steps and/or Points:

1. Nursing assessment and intervention shall be provided in such a way as to protect student privacy and confidentiality.
2. Nursing feedback to school personnel who refer a student is essential and shall always occur. Share only information that is necessary and that impacts the student’s educational experience, health care of safety.
3. Sharing student health information in staffing committees may require written permission for release of confidential information.
4. A “Health Concerns List” is distributed to all school personnel for whom the student’s health information might possibly impact the student’s educational experience and safety. This information is not sent to anyone whom the parent/guardian checked on the Health History as NOT wanting the information shared with. This Health Concerns List contains all students (listing conditions) who have a moderate to high risk of a major health problem exacerbation while at school.
5. There are situations when confidentiality must not be maintained. If at any time, information has been shared with you that indicates a student or staff member is at imminent risk of harm or is a danger to himself or others, that information must be shared with those who need to intervene in order to protect the student or staff member (school administrators, parent, child protective agency, police, health care provider, etc.).
   a. It is recommended that your discussion with students or staff include something like, “What you tell me, I will keep in confidence, unless I feel it is necessary to share it with someone to protect you or others.”
   b. In those situations where nursing judgment determines it is necessary to reveal information regarding the student’s health without a release from student/parent, it is prudent to share only those details that are essential to achieve resolution of the problem. It is also recommended that the information be shared with as few people as possible.
6. Records of student/nurse communications regarding the personal affairs of the student or his/her family are confidential and may be shared only as the student or parent authorizes except in life-threatening situations. All information is confidential by virtue of nurse/client relationship and under student records law.
   a. Only the school nurse, back-up, and the Director of Nursing may have access to nursing records without written release by student/parent.
b. Nursing records may be viewed by the involved and, with some exceptions, his parent.

(1) A student, particularly a student under age 18, can't limit the parent’s access to nursing records in most cases. There are some health-related items that are confidential from parents, but such items are the exception.

**A parent does NOT have the right to inspect that part of the nurse’s record that the state law requires to be kept confidential, even from parents. This pertains to sexually transmitted diseases, contraceptives and family planning issues. To respond to these parental requests, follow the direction of your legal counsel/district policy (consult the Director of Schools).**

(2) The student may view records immediately upon his/her request unless the nurse feels such viewing would be counterproductive to the student’s health management.

7. Anytime nurse/health records are released to someone, the bottom part of the Release of Information form is to be completed and filed in the student's or staff’s nursing file.

8. Nursing records may not be released to another agency/individual unless the parent has signed a “Release of Information” document or the nursing record is subpoenaed by court action.

**The non-custodial parent has the right to inspect nursing records but not to sign an authorization to release them.**

9. When a record is subpoenaed:
   a. The original of the records will be maintained by the school and a copy will be submitted to court.
   b. The exception to this would be health records obtained from other clinics/physicians that are stamped, “Do not release for third party access.” For these unreleased records, make note in the released copy that a medical report from a specific clinic exists in your nursing record. The receiving party may wish to obtain a release for this same source document.

10. Information may be shared with protective services caseworkers without a subpoena when the caseworker is conducting an assessment or planning intervention/court hearing.

**Information to be shared will be summative in nature; a subpoena is necessary to release the nursing record.**

11. Exercise caution in discussing confidential issues on the telephone. Efforts should be taken to establish the identity of the caller and his/her right to confidential information.

12. Documents released by our department should be stamped, “Confidential; Not To Be Forwarded Without Parental Permission.”

13. When uncertain who has legal custody of a student, consult with the school administrator and when necessary, the student’s Child Protective Service Case Manager.

14. Use the FAX ONLY when there is not sufficient time for mailing records.
   a. Confirm recipient's FAX number before pushing the "send" button.
   b. Use a cover sheet to facilitate confidentiality and to give directions for destruction of misrepresented information.
c. Always call the receiver when you suspect a FAX was sent to a wrong place, to confirm the information was destroyed.

15. All health records containing staff or student’s names should be kept in a locked location where no one but the school nurse, back-up, or nursing supervisor has access.

16. All discarded health records containing staff or student names should be shredded before being discarded.

17. Never discuss health information about a student or staff member with anyone who is not authorized to know it. The only people authorized to know it are as follows:
   a. School Nurse
   b. Back-up
   c. Director of Nursing
   d. Staff listed on the Health History whom the parent authorized to know the health information
   e. EMT personnel, if an ambulance has to be called
   f. Physicians, as listed on the Health History, if the Health History is signed.
   g. Persons/agencies authorized by the parent on the Release of Information
   h. Coordinated School Health (CSH) personnel
   i. Health screening workers/volunteers

**The above listed authorized people only need to be informed of the health information if, and when, it becomes “need-to-know” to them. This means if and when the particular information would affect that person or agency by impacting the student’s or staff’s educational experience, health care or safety.

18. All school nurses, backups, CSH personnel, teachers, teaching assistants, and health screening workers/volunteers must sign a copy of this policy/procedure.
Tennessee Department of Education Confidentiality Statement
By signing below, I am acknowledging my awareness of the requirements of the Health Insurance Portability and Accountability Act (HIPPA) and acknowledging and understand that, as a volunteer for the Department of Education’s interests I am prohibited from releasing to any unauthorized persons any protected health information which may come to my attention in the course of my duties and that all data is the property of the school system and State of Tennessee and must be sent to the state CSH evaluator and is not the property of the screener. School systems are expected to follow the Family Educational Rights and Privacy Act (FERPA) requirements that cover health information privacy concerns in the educational setting. For information on FERPA visit the National Association of School Nurses website: http://www.nasn.org/Default.aspx?tabid=277.

__________________________________________________
Signature

__________________________________________________
Date

__________________________________________________
Print Name
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