

**- C -**

# **Documentation**

## **Maintenance of Health Records**

According to Florida Administrative Code 64F-6.005, cumulative health records on each student shall be maintained in the school by personnel authorized by school board policy and governing authority of non-public schools. Such records may include information regarding:

- Immunization status and certification (required for attendance);
- Health history, including any chronic conditions and treatment plan;
- Screening tests results, follow-up and corrective action;
- Health examination report (school entry physical);
- Documentation of injuries and/or episodes of sudden illness referred for emergency health care
- Documentation of any nursing assessments done, written plans of care, counseling in regards to health care matters and results;
- Documentation of any consultations with school personnel, students, parents, guardians, or service providers about a student's health problem, recommendations made and results; and
- Documentation of physician's orders and parental permission to administer medication or medical treatments given in school

Records for documented confidential health information that are not part of the student cumulative health record shall be maintained in the private professional's office or the office of the school health nurse and shall be used only in connection with the provision of treatment to the student and be available only to persons providing such treatment as defined in Section 228.093(2)(e)4., F.S.

Confidential health information shall include such information as notes taken during a counseling session, and mental health assessments and evaluations. It should be noted in the student cumulative health record that a separate record of health information exists.

It is the responsibility of DCPS staff to input into the student's electronic record their immunization history and update the immunization code or exemption date as appropriate. The DOH School Nurse will help to answer compliance questions.

It is the responsibility of DCPS staff to input into the student's electronic record their health examination date and compliance code. The DOH School Nurse will help to answer compliance questions.

### **Documentation of Care Provided to Sick or Injured Student**

Each time care is provided to a sick or injured student, the staff member providing care should document the care given on the Daily Visit Log located in a confidential binder in the school health room (see Daily Visit Log, attachment C-1) or into the student's electronic record.

The purpose of this documentation is to have a legal record of the care provided. The care provider needs to document at the time that care is provided to ensure accuracy. Make sure that the following information is included in the documentation:

- Reason student came to the health room
- Your observations relating to student's illness or injury
- Action(s) taken in response to the student's problem (first aid, medication administered, rest in health room, call to parent, etc.)
- Student response to action(s)
- Disposition of student (home, back to class, etc.)
- Time student left health room

### **How to Document**

- Write legibly using blue or black ink.
- Entries should have a date, time, and signature. Note time of student entering and leaving the health room.
- Use complete sentences and proper punctuation.
- Be accurate, objective (facts only), concise, thorough and timely.
- Organize content, include only essential information.
- Document in compliance with national and professional standards.

### **When Documenting, DO NOT:**

- Do not skip lines
- Do not leave blank spaces
- Do not erase, scratch out, or use correction fluid/tape
- Do not use assumptions, value judgments, or conjecture
- Do not label behavior or attempt to diagnose

### **Errors**

When an error is made, one single line should be drawn through the error; the word "error" and the initials of the person writing the information and the date should be written directly above it. The correct entry should then follow. (NASN Guidelines for School Nursing Documentation)

When an entry is made in the wrong student's record, one single line should be drawn through the error; the words "mistake in entry" and the initials of the person writing the information and the date should be written directly above it. (NASN Guidelines for School Nursing Documentation)

Late entries should be avoided. When necessary, a late entry may be added, but in the correct date and time sequence. (NASN Guidelines for School Nursing Documentation)

### **Release of Information**

An “Authorization to Disclose Confidential Information” form (see Attachment C-II A or B) must be signed by the parent/guardian of a student when:

- Records from another agency are needed by the School Nurse
- Records are requested by another agency

The nurse will explain to the parent/guardian what he/she is signing and the reason for the request.

A copy of the signed Release of Information form will be attached to the Nurse’s Referral/Report Form.

Note: Written information obtained through the signed Release of Information form is to be filed in the DOH School Health office. **Do not file this information in the student’s cumulative folder.**

### **Confidentiality**

Family Educational Rights and Privacy Act (FERPA) is a Federal law that protects the privacy of students’ “education records.” FERPA applies to educational agencies and institutions that receive funds under any program administered by the U.S. Department of Education. This includes virtually all public schools and school districts and most private and public postsecondary institutions. The term “education records” is broadly defined to mean those records that are: (1) directly related to a student, and (2) maintained by an educational agency or institution or by a party acting for the agency or institution. At the elementary or secondary school level, students’ immunization and other health records that are maintained by a school district or individual school, including a school-operated health clinic, that receives funds under any program administered by the U.S. Department of Education are “education records” subject to FERPA, including health and medical records maintained by a school nurse who is employed by a school district. Therefore, if the nurse is hired as a school official, the records maintained by the nurse or clinic are “education records” subject to *FERPA*. Education records in public schools are covered by FERPA and are specifically exempted from the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

If publicly funded schools transmit personally identifiable student health information electronically to Medicaid or an insurance company for health services, they must comply with applicable requirements of the HIPAA Transaction Rule.

The HIPAA Privacy Rule allows covered health care providers to disclose protected health information about students to school nurses, physicians, or other health care providers for treatment purposes, without the authorization of the student or student’s parent.

Any information placed in a student's cumulative health record is confidential and should not be released without written consent of the parent or guardian. Confidential information shall include notes taken during a counseling session or mental health assessment and evaluation. Access to the cumulative health record should be limited to those with a genuine need to know and as per School Board Policy. Health records may be kept inside the student's cumulative folder in the records vault or in a locked cabinet inside the health room.