pennsylvania
DEPARTMENT OF HEALTH

Bureau of Community Health Systems
Division of School Health

SCHOOL HEALTH
ANNUAL REIMBURSEMENT REQUEST

This hard copy form is for data consolidation only; submit all information electronically in the annual SHARRS report

When completing this report, please refer to SHARRS instruction manual, accessible on the SHARRS Main Menu page, on each page of the electronic report, as well as on the School Health webpage: www.health.state.pa.us/schoolhealth then select the "School Health Annual Reimbursement Request System (SHARRS)" link
http://www.health.pa.gov/My%20Health/School%20Health/Pages/Reimbursement-SHARRS.aspx#.VaPS-mTD9D8

SCHOOL YEAR: _____

HEALTH DISTRICT	COUNTY	VENDOR NUMBER AND AUN	DENTAL PROGRAM
DOH USE ONLY ☐ NW ☐ SW ☐ NC ☐ SC ☐ NE ☐ SE		DOH USE ONLY	☐ Mandated Program ☐ Dental Hygiene Services Program

SCHOOL ENTITY NAME & ADDRESS	INSTITUTION TYPE
	☐ School District ☐ Charter School - or - ☐ Cyber Charter School ☐ Comprehensive Career and Technology Center (CTC)

PHONE	PHONE EXTN.	PENN*LINK E-MAIL ADDRESS

At least one of the following contact persons* must *be a Certified School Nurse.

PRIMARY CONTACT PERSON REGARDING REPORT			
NAME (First and Last):			
TITLE:	☐ Business Manager ☐ CSN ☐ School Dental Hygienist ☐ Superintendent/CEO ☐ Support Staff ☐ Other		
PHONE NUMBER (000-000-0000):		**EXTN.**	
E-MAIL ADDRESS:			

SECONDARY CONTACT PERSON REGARDING REPORT			
NAME (First and Last):			
TITLE:	☐ Business Manager ☐ CSN ☐ School Dental Hygienist ☐ Superintendent/CEO ☐ Support Staff ☐ Other		
PHONE NUMBER (000-000-0000):		**EXTN.**	
E-MAIL ADDRESS:			

ITEMIZED EXPENDITURES

(1) INCLUDE expenses for medical/dental reasons (NOT related to academic placement)
(2) INCLUDE fee-for-service costs (NOT salaries, health, or other fringe benefits)
(3) Do NOT INCLUDE expenses related to sports/athletic programs or expenses reimbursed by any other source

01. SPECIAL MEDICAL, DIAGNOSTIC & TREATMENT SERVICES	TOTAL COST
ENT (Ear/Nose/Throat) Specialist / Audiologist	$
Occupational / Physical Therapist	$
Ophthalmologist / Optometrist	$
Psychiatrist / Psychologist	$
OTHER (specify)	$
TOTAL	$

(Enter total on ADM/Cost of Services page, section 02, line C. "Special Medical, Diagnostic & Treatment Services")

02. MEDICAL SUPPLIES, EQUIPMENT, LAB SERVICES & EDUCATIONAL MATERIALS	TOTAL COST
A. Administrative Supplies	$
B. General Supplies	$
C. Medical Exam / Health Screening Supplies and Equipment	$
D. Reference and Educational Materials	$
TOTAL	$

(Enter total on ADM/Cost of Services page, section 02, line D, "Medical Supplies, Equipment, Lab Services & Educational Materials")

03. SPECIAL DENTAL PREVENTATIVE, DIAGNOSTIC & TREATMENT SERVICES	TOTAL COST
A. Preventative	$
B. Diagnostic	$
C. Treatment	$
TOTAL	$

(Enter total on ADM/Cost of Services page, section 03, line D "Special Dental Preventative, Diagnostic & Treatment Services")

04. DENTAL SUPPLIES, EQUIPMENT, FLUORIDE & EDUCATIONAL MATERIALS	TOTAL COST
A. Administrative Supplies	$
B. Dental Exam / Screening Supplies & Equipment / Fluoride Supplies	$
C. Reference and Educational Materials	$
TOTAL	$

(Enter total on ADM/Cost of Services page, section 03, line E, "Dental Supplies, Equipment, Fluoride & Educational Materials")

AVERAGE DAILY MEMBERSHIP (ADM) AND COST OF SERVICES

The ADM is calculated for each grade in the same manner as ADMs reported to the PA Department of Education. ADMs are not enrollment figures; they are calculated by dividing the total aggregate days' membership by the number of days school is actually in session. Private/non-public schools should complete the tally form, *Determination of Average Daily Membership (ADM)*, to calculate the ADM per grade and report this data to the School District that provided school health services.

Report ADMs to the third decimal point; enter 0.000 for grades with no ADMs

01. ADM BY GRADE:

GRADE	PUBLIC STUDENTS	PRIVATE / NON-PUBLIC STUDENTS
K4		
K		
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
UNGRADED SPEC ED		
OTHER*		
TOTAL ADM	A.	B.
GRAND TOTAL ADM (Total of Columns A+B above)		

* The **"OTHER"** category is limited to home-schooled and alternative education students ONLY when a grade cannot be identified.

An explanation is required in the comment box:

Comments:

NOTE: Include students attending part-time Career & Technology Centers (Vo-Techs) in the ADM of each applicable grade; NOT in the "OTHER" category.

02. COST OF MEDICAL SERVICES:

NOTE: Do not include health or other fringe benefits**.**

A. School Physicians $_____

B. Supplemental Staff $_____

C. Special Medical, Diagnostic & Treatment Services
(Total from Itemized Expenditure page, Section 01) $_____

D. Medical Supplies, Equipment, Lab Services & Educational Materials
(Total from Itemized Expenditure page, Section 02) $_____

TOTAL $_____

03. COST OF DENTAL SERVICES:

NOTE: Do not include health or other fringe benefits**.**

A. School Dentists $_____

B. Dental Hygienists $_____

C. Dental Assistants $_____

D. Special Dental Preventative, Diagnostic & Treatment Services
(Total from Itemized Expenditure page, Section 03) $_____

E. Dental Supplies, Equipment, Fluoride & Educational Materials
(Total from Itemized Expenditure page , Section 04) $_____

TOTAL $_____

04. COST OF CERTIFIED SCHOOL NURSING SERVICES:

NOTE: Do not include health or other fringe benefits**.**

A. Certified School Nurses (CSN) $_____

B. Travel: Costs paid for travel by CSNs directly related to routine and emergency school health services or on behalf of students. Do not include travel to continuing education $_____

TOTAL $_____

CERTIFIED SCHOOL NURSES (CSN)

CSN Credentials Professional Personnel ID number (PPID#): https://www.perms.ed.state.pa.us/Screens/wfPublicAccess.aspx Pa RN License Number: http://www.licensepa.state.pa.us/	**CSN Assigned School Building(s)** Identify School Building Type: Public (P) or Private/Non-Public (NP)		**Days per Cycle in Bldg**	**OR**	**Other* Comment Required**	**Students in Building (not ADMs)**	**Students per CSN (not ADMs)**
NAME (as appears on RN license): PA License #:_____ Expiration Date:___/__/___ ☐ PDE Certified School Nurse (CSN) *PPID #:_____ ☐ PDE Emergency Certification (requires annual renewal) ☐ CPR Certified. CPR Expiration Date: ___/___/____ Name of CPR Course completed: _____ Other Licensed Credential(s): ☐ CRNP ☐ PA ☐ SNP	1.	☐ P ☐ NP	___/___				
	2.	☐ P ☐ NP	___/___				
	3.	☐ P ☐ NP	___/___				
	4.	☐ P ☐ NP	___/___				
Employment Details: _____ Hours/week worked **Check all that apply:** ☐ Job Share ☐ Float Pool ☐ Administrative duties only (does not carry a caseload).	**Total number of students assigned to the CSN at <u>all</u> buildings (Caseload):** _____ *Check **Other** <u>only</u> when CSN's building assignment varies significantly from week-to-week & cannot be averaged; list # of hours per day/week/month CSN is typically present in the school building. Comment required below explaining schedule. Refer to Instruction Manual for further detail						
Comment:							

CSN Credentials Professional Personnel ID number (PPID#): https://www.perms.ed.state.pa.us/Screens/wfPublicAccess.aspx Pa RN License Number: http://www.licensepa.state.pa.us/	**CSN Assigned School Building(s)** Identify School Building Type: Public (P) or Private/Non-Public (NP)		**Days per Cycle in Bldg**	**OR**	**Other* Comment Required**	**Students in Building (not ADMs)**	**Students per CSN (not ADMs)**
NAME (as appears on RN license): PA License #:_____ Expiration Date:___/__/___ ☐ PDE Certified School Nurse (CSN) *PPID #:_____ ☐ PDE Emergency Certification (requires annual renewal) ☐ CPR Certified. CPR Expiration Date: ___/___/____ Name of CPR Course completed: _____ Other Licensed Credential(s): ☐ CRNP ☐ PA ☐ SNP	1.	☐ P ☐ NP	___/___				
	2.	☐ P ☐ NP	___/___				
	3.	☐ P ☐ NP	___/___				
	4.	☐ P ☐ NP	___/___				
Employment Details: _____ Hours/week worked **Check all that apply:** ☐ Job Share ☐ Float Pool ☐ Administrative duties only (no caseload).	**Total number of students assigned to the CSN at <u>all</u> buildings (Caseload):** _____ *Check **Other** <u>only</u> when CSN's building assignment varies significantly from week-to-week & cannot be averaged; list # of hours per day/week/month CSN is typically present in the school building. Comment required below explaining schedule. Refer to Instruction Manual for further detail						
Comments:							

SUPPLEMENTAL STAFF ASSISTING CSN

Supplemental Staff Credentials Pa RN/LPN License Number: http://www.licensepa.state.pa.us/ Include: CSNs hired as supplemental staff; Do NOT include: 1:1 staff; short-term subs, staff hired to assist with screenings, etc.	**Supplemental Staff Assigned School Building(s)**	**CSN Assigned to Students in Building**	**Function(s)**	
			Health Care	Clerical
NAME as appears on license (if applicable)**:**	1.		☐	☐
Licensed: ☐ RN; ☐ LPN Unlicensed: ☐ Hours/week worked _____	2.		☐	☐
PA License #_____ Expiration date___/__/___	3.		☐	☐
	4.		☐	☐
☐ **FLOATING:** A building assignment that changes from day-to-day/week-to-week rather than having an established schedule. **(**Comment required below explaining schedule)	5.		☐	☐
Comments:				

Supplemental Staff Credentials Pa RN/LPN License Number: http://www.licensepa.state.pa.us/ Include: CSNs hired as supplemental staff; Do NOT include: 1:1 staff; short-term subs, staff hired to assist with screenings, etc.	**Supplemental Staff Assigned School Building(s)**	**CSN Assigned to Students in Building**	**Function(s)**	
			Health Care	Clerical
NAME as appears on license (if applicable)**:**	1.		☐	☐
Licensed: ☐ RN; ☐ LPN Unlicensed: ☐ Hours/week worked _____	2.		☐	☐
PA License #_____ Expiration date___/__/___	3.		☐	☐
	4.		☐	☐
☐ **FLOATING:** A building assignment that changes from day-to-day/week-to-week rather than having an established schedule. **(**Comment required below explaining schedule)	5.		☐	☐
Comments:				

OTHER HEALTH PROFESSIONALS

School Physician: Only an MD (Doctor of Medicine) or a DO (Doctor of Osteopathic Medicine) may serve as the School Physician. They may not charge a fee to the students to perform the mandated exams. If a group practice, identify the name of the group and the name/credentials of the Pa licensed physician who assumes medical responsibility for the school.

School Dentist: Only a DDS (Doctor of Dental Surgery) or a DMD (Doctor of Dental Medicine) may serve as the School Dentist. They may not charge a fee to the students to perform the mandated exams. If a group practice, identify the name of the group and the name/credentials of the Pa licensed dentist who assumes medical responsibility for the school entity.

Mobile Dentist: A mobile dentist may serve as the **School Dentist.** They may not charge a fee to the students to perform the mandated exams. If a group practice, identify the name of the group and the name/credentials of the Pa licensed dentist who assumes medical responsibility for the school.
A mobile dentist may provide dental services to students in the capacity of a **Family Dentist** when the mobile dentist does not assume dental responsibility for the school. They may charge a fee to the students to perform the mandated exams.

School Dental Hygienist (SDH): ONLY identify a hygienist employed by the school with a Mandated Dental Program. Hygienists employed by the school in a DOH approved Dental Hygiene Services Program are reported on the "Dental Hygiene Services Program" page

Professional License Number: http://www.licensepa.state.pa.us/

SCHOOL PHYSICIAN	
NAME as appears on MD/DO license	
PENNSYLVANIA LICENSE	License Number:_____ Expiration date:_____
GROUP PRACTICE as the SCHOOL Physician?	☐ No ☐ Yes, Name of Group Practice:_____
☐ **No Physician**. Comments required (See Chapter 10 of instructions)	

SCHOOL DENTIST	
NAME as appears on DMD/DDS license	
PENNSYLVANIA LICENSE	License Number:_____ Expiration date:_____
GROUP PRACTICE / MOBILE DENTIST as the SCHOOL Dentist?	☐ No ☐ Yes, Group Practice: Name_____ ☐ Yes, Mobile Dentist Group: Name_____
MOBILE DENTIST GROUP as a FAMILY Dentist?	☐ No ☐ Yes, Name of Mobile Dentist Group:_____
☐ **No Dentist**. Comments required (See Chapter 10 of instructions)	

SCHOOL DENTAL HYGIENIST (SDH) employed by the school Do **NOT** Include SDHs in a DOH approved Dental Hygiene Services Program. Include them on the "Dental Hygiene Services Program" page	
NAME as appears on DH license	
PENNSYLVANIA LICENSE	License Number:_____ Expiration date:_____
CERTIFICATION Professional Personnel ID number (PPID#): https://www.perms.ed.state.pa.us/Screens/wfPublicAccess.aspx	☐ Not certificated ☐ PDE Certified School Dental Hygienist *****PPID #_____ ☐ PDE Emergency Certification (requires annual renewal)
Additional Pennsylvania Licensure	☐ PHDHP (Public Health Dental Hygiene Practitioner) ☐ Other:_____ License Number:_____ Expiration date:_____

MANDATED DENTAL SERVICES PROGRAM

Dental Examinations by FAMILY Dentist Include dental exams performed by: (1) Family Dentist (2) Mobile Dentist Group NOT in the position of a SCHOOL Dentist (Refer to definitions on the "Other Health Professionals page of this report)	**PUBLIC Students**	**PRIVATE/ NON-PUBLIC Students**	**TOTAL Students**
A. Grades K or 1, 3, 7			

Dental Examinations by SCHOOL Dentist Include dental exams performed by: (1) School Dentist (2) Mobile Dentist in the capacity of SCHOOL Dentist (Refer to definitions on the "Other Health Professionals page of this report)	**PUBLIC Students**	**PRIVATE/ NON-PUBLIC Students**	**TOTAL Students**
A. Grades K or 1, 3, 7			
B. OTHER Grades			
C. Referred for Dental Evaluation / Treatment			
D. Completed Referrals Reported			

Complete this section only if the school entity participated in a fluoride program.

FLUORIDE PROGRAM	**PUBLIC Students**	**PRIVATE/ NON-PUBLIC Students**	**TOTAL Students**
A. Fluoride MOUTH RINSE Program			
B. Fluoride TABLET Program			
C. TOPICAL Fluoride Program			

DENTAL HYGIENE SERVICES PROGRAM (DHSP)

Only schools that received written approval from the Department of Health for a Dental Hygiene Services Program (DHSP) should enter information in this section of the report.

All other schools should enter dental information on the "Mandated Dental Services Program" page; include the School Dental Hygienists employed by the school on the "Other Health Professionals" page

School Dental Hygienist	
NAME as appears on DH license	
PHONE/EXTN	
EMAIL ADDRESS	
PENNSYLVANIA LICENSE Professional License Number: http://www.licensepa.state.pa.us/	License Number:_____ Expiration date:_____
CERTIFICATION Professional Personnel ID number (PPID#): https://www.perms.ed.state.pa.us/Screens/wfPublicAccess.aspx	☐ Not certificated ☐ PDE Certified School Dental Hygienist *****PPID #:_____ ☐ PDE Emergency Certification (requires annual renewal)
Additional Pennsylvania Licensure	☐ PHDHP (Public Health Dental Hygiene Practitioner) ☐ Other:_____ License Number:_____ Expiration date:_____
DAYS per School Year Worked	Days per School Year Worked_____

School Dental Hygienist	
NAME as appears on DH license	
PHONE/EXTN	
EMAIL ADDRESS	
PENNSYLVANIA LICENSE Professional License Number: http://www.licensepa.state.pa.us/	License Number:_____ Expiration date:_____
CERTIFICATION Professional Personnel ID number (PPID#): https://www.perms.ed.state.pa.us/Screens/wfPublicAccess.aspx	☐ Not certificated ☐ PDE Certified School Dental Hygienist *****PPID #:_____ ☐ PDE Emergency Certification (requires annual renewal)
Additional Pennsylvania Licensure	☐ PHDHP (Public Health Dental Hygiene Practitioner) ☐ Other:_____ License Number:_____ Expiration date:_____
DAYS per School Year Worked	Days per School Year Worked_____

DENTAL HYGIENE SERVICES PROGRAM (DHSP)

Dental Hygiene Services Program (DHSP) Plan		
1	Was the DHSP plan amended since the authorization for this school year was submitted/approved by the Department of Health?	☐ Yes ☐ No
2	List the number of **public** schools that received dental hygiene services through the DHSP plan.	
3	List the number of **private/non-public** schools that received dental hygiene services through the DHSP plan.	

Dental Hygiene Services PROVIDED (Public and Private / Non-Public Students Combined)

(1) Enter the number of students in each grade who actually received Dental Hygiene Services in Columns 01B, 02B, 03B, and 04B. (Count the student once in each respective column, as applicable.)

00	01		02		03		04	
GRADE	Exams Family Dentist		Exams / Screens School Dental Provider		Prophylaxis / Preventative Treatment		Dental Health Education/Activities	
	01 A Check grade(s)	01 B Total Students (Count each student once)	02 A Check grade(s)	02 B Total Students (Count each student once)	03 A Check grade(s)	03 B Total Students (Count each student once)	04 A Check grade(s)	04 B Total Students (Count each student once)
K4								
K								
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
Ungraded Spec Ed								
*Other								
TOTAL								

***NOTE: The "Other" category is limited to home-schooled and alternative education students when a grade cannot be identified. Students attending part-time CTCs (Vo-Techs) are included in the applicable grades; NOT in the "OTHER" category**

05	**Follow-up Exams / Screens by School Dental Provider (ALL grades)**	**TOTAL Students**
05 A	**Referred for Further Evaluation/Treatment**	
05 B	**Completed Referrals Reported**	
06	**Fluoride Application Program:** number of students who actually received fluoride	**TOTAL Students**
06 A	**Fluoride MOUTH RINSE Program**	
06 B	**Fluoride TABLET Program**	
06 C	**TOPICAL Fluoride Program**	
07	**Sealant Application Program:** number of students who actually received sealants	**TOTAL Students**
07 A	**Sealant Application by School Dental Provider (School Dentist, Certified School Dental Hygienist, CSDH /PHDHP)**	
07 B	**Sealant Application coordinated through school entity or DHSP plan but services provided by other than the School Dental Provider**	

HEALTH EXAMS, SCREENS & SELECT SERVICES

	HEALTH SERVICES FOR STAFF / OTHER ADULTS	Public Staff / Other Adults	Private / Non-Public Staff / Other Adults	TOTAL Staff / Other Adults
01	Staff / Other Adult Contacts for Acute / Chronic ILLNESS			
02	Staff / Other Adult Contacts for Acute / Chronic INJURY			
03	Staff / Other Adult Emergencies Requiring Activation of Emergency Medical Services (EMS)			
04	Staff / Other Adult Emergencies Requiring Use of an Automated External Defibrillator (AED)			

	HEALTH SERVICES FOR STUDENTS	Public Students	Private / Non-Public Students	Total Students
01	Student Contacts for Acute/Chronic ILLNESS			
02	Student Contacts for Acute/Chronic INJURY			
03	Students REQUIRING SKILLED NURSING Count the number of students who required skilled nursing procedures as ordered by a licensed provider or deemed necessary by a CSN. Only count each student once (do not include the student contacts here)			
04	Students (count each student once) with a Plan of Care (IHP, ECP, 504 or IEP with a medical component)			
05	Students Sent from School for Health Reasons			
06	Student Emergencies Requiring Activation of Emergency Medical Services (EMS)			
07	Student Emergencies Requiring Use of an Automated External Defibrillator (AED)			

HEALTH EXAMS, SCREENS & SELECT SERVICES

	STUDENT PHYSICAL EXAMINATIONS NOTE: Athletic & driver's permit physicals are acceptable as a mandated exam when completed by a medical health care provider other than a chiropractor.	Public Students	Private / Non-Public Students	Total Students
08	**Examined by FAMILY Health Care Provider**			
	A. Grades K or 1, 6, 11			
09	**Examined by SCHOOL Health Care Provider**			
	A. Grades K or 1, 6, 11			
	B. OTHER Grades			
	C. Referred for Further Evaluation / Treatment			
	D. Completed Referrals Reported			

	STUDENT HEALTH SCREENS	Public Students	Private / Non-Public Students	Total Students
10	**Vision Screens** (K – 12 & Ungraded)			
	A. Referred for Further Evaluation / Treatment			
	B. Completed Referrals Reported			
11	**Hearing Screens (**K,1, 2, 3, 7, 11 & Ungraded)			
	A. Referred for Further Evaluation / Treatment			
	B. Completed Referrals Reported			
12	**Scoliosis Screens** (6, 7) Students who had a 6th grade physical meet this requirement, do not need screened by the nurse and should be included in the count. Students currently under the care of a healthcare provider for scoliosis do not need screened and are counted as if the screening was performed			
	A. Referred for Further Evaluation / Treatment			
	B. Completed Referrals Reported			
13	**Growth Screens – BMI** (coincides with the CDC percentile) **TOTAL for Grades K – 6** (A+B+C+D)			
	A. Underweight – Less than 5TH Percentile			
	B. Healthy Weight – 5 TH Percentile to Less than 85TH Percentile			
	C. Overweight – 85TH Percentile to Less than 95TH Percentile			
	D. Obese – Equal To or Greater than 95TH Percentile			
14	**Growth Screens – BMI** (coincides with the CDC percentile) **TOTAL for Grades 7 – 12** (A+B+C+D)			
	A. Underweight – Less than 5TH Percentile			
	B. Healthy Weight – 5 TH Percentile to Less than 85TH Percentile			
	C. Overweight – 85TH Percentile to Less than 95TH Percentile			
	D. Obese – Equal To or Greater than 95TH Percentile			
	GRAND TOTAL for Grades K – 12 (13+14)			

SELECT CHRONIC CONDITIONS – STUDENT HEALTH

CHRONIC CONDITIONS		Public Students	Private / Non-Public Students	Total Students
01	Arthritis / Rheumatic Disease			
02	Asthma			
03	Attention Deficit Disorder / Hyperactivity			
04	Bleeding Disorders / Cooley's Anemia			
05	Cardiovascular Condition			
06	Cerebral Palsy			
07	Cystic Fibrosis			
08	Diabetes Type I			
09	Diabetes Type II			
10	Epilepsy / Other Seizure Disorders			
11	Life-Threatening Allergies			
11 A	Food Related Life-Threatening Allergies			
11 B	Other Life-Threatening Allergies (Example: Bee stings, Latex, etc)			
12	Sickle Cell Disease			
13	Spina Bifida			
14	Tourette's Syndrome			
	TOTAL			

SERIOUS SCHOOL INJURIES – STUDENTS

Count each serious school injury to students in public / private schools (combined).

When multiple serious injuries occur to a student, count the primary injury category only.

To be considered a serious school injury, the student must be:

(1) Under school jurisdiction (excluding summer school, band/other camps, sports injuries that occur during approved PA Interscholastic Athletic Association [PIAA] activities) and

(2) Meet <u>at least one</u> of the following criteria:

- Emergency Medical Services (EMS) response;
- Immediate care by a physician or dentist, such as, a family health provider, an emergency room physician, a medical or dental specialist, etc.
- The loss of one-half or more days of school.

The total of EACH subsection (Nature of Injury, Time Period, and Location) must equal one another

NATURE OF INJURY					
01 Burn		05 Dental Injury		09 Sprain / Strain / Tear (Possible)	
02 Concussion (Possible)		06 Dislocation (Possible)		10 Other	
03 Contusion		07 Eye Injury		**TOTAL OF SUBSECTION: NATURE OF INJURY**	
04 Cut / Laceration / Puncture		08 Fracture (Possible)			

TIME PERIOD					
01 After School		05 Field Trip		09 Sci Lab / Fam & Consumer Sci & Tech Ed Class	
02 Before School		06 Lunch Period		10 Other	
03 Class Change		07 P. E. Class		**TOTAL OF SUBSECTION: TIME PERIOD**	
04 Class Time		08 Recess			

LOCATION					
01 Athletic Field / Play Field		07 Field Trip		13 Sidewalk	
02 Auditorium / Multipurpose		08 Gymnasium / Pool		14 Stairs / Ramp / Elevator	
03 Bus Loading Area		09 Playground		15 Street / Driveway / Parking	
04 Cafeteria		10 Restroom		16 Other	
05 Classroom		11 School Bus / Public Bus		**TOTAL OF SUBSECTION: LOCATION**	
06 Corridor / Hall		12 Sci Lab / Fam & Consumer Sci & Tech Ed Class			

MEDICATION ADMINISTRATION – STUDENTS ONLY

MEDICATION by Category of Use See Chapter 15 Instructions for assistance		NUMBER OF DOSES ADMINISTERED (Public & Private/Non-public Students Combined)	
		Doses by Individual Order (Primary Care Provider)	Doses by Standing Order (School Physician)
01	Analgesic		
02	Antibiotic		TOPICAL ANTIBIOTICS ONLY
03	Anticonvulsants		
	A. Diastat		
	B. Versed		
	C. Other than Diastat or Versed		
04	Antihistamine / Decongestant		
	A. Epinephrine (include auto-injector)		
	B. Other than Epinephrine		
05	Anti-Inflammatory		
06	Asthma (inhaler, nebulizer, oral, IV)		INHALER AND NEBULIZER ONLY
07	Diabetes		
	A. Oral		
	B. Insulin (include bolus/adjustment to insulin pump)		
	C. Glucagon		
	D. Other Glucose Medication (glucose gel / tablet)		
08	Gastrointestinal		
	A. Enzymes		
	B. Other than Enzymes		
09	Reversal Agents: Naloxone/Narcan		
10	Psychotropics		
	A. ADD / ADHD		
	B. Other than ADD / ADHD		
11	OTHER (**EXCLUDE:** cough drops/lozenges, fluoride supplements, saline, hydrogen peroxide, alcohol, products to treat head lice, oxygen, etc.)		
	TOTAL		