



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](http://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
<b>DOH USE ONLY</b> <input type="checkbox"/> NW <input type="checkbox"/> SW <input type="checkbox"/> NC <input type="checkbox"/> SC <input type="checkbox"/> NE <input type="checkbox"/> SE		<b>DOH USE ONLY</b>	<input type="checkbox"/> Mandated Program <input type="checkbox"/> Dental Hygiene Services Program
SCHOOL ENTITY NAME & ADDRESS		INSTITUTION TYPE	
		<input type="checkbox"/> School District <input type="checkbox"/> Charter School - or - <input type="checkbox"/> Cyber Charter School <input type="checkbox"/> 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:	<input type="checkbox"/> Business Manager <input type="checkbox"/> CSN <input type="checkbox"/> School Dental Hygienist <input type="checkbox"/> Superintendent/CEO <input type="checkbox"/> Support Staff <input type="checkbox"/> Other		
PHONE NUMBER (000-000-0000):		EXTN.	
E-MAIL ADDRESS:			

SECONDARY CONTACT PERSON REGARDING REPORT			
NAME (First and Last):			
TITLE:	<input type="checkbox"/> Business Manager <input type="checkbox"/> CSN <input type="checkbox"/> School Dental Hygienist <input type="checkbox"/> Superintendent/CEO <input type="checkbox"/> Support Staff <input type="checkbox"/> 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)	\$
<b>TOTAL</b>	<b>\$</b>
(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	\$
<b>TOTAL</b>	<b>\$</b>
(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	\$
<b>TOTAL</b>	<b>\$</b>
(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	\$
<b>TOTAL</b>	<b>\$</b>
(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*		
<b>TOTAL ADM</b>	A.	B.
<b>GRAND TOTAL ADM</b> (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	CSN Assigned School Building(s)	Days per Cycle in Bldg	OR	Other* Comment Required	Students in Building (not ADMs)	Students per CSN (not ADMs)
Professional Personnel ID number (PPID#): <a href="https://www.perms.ed.state.pa.us/Screens/wfPublicAccess.aspx">https://www.perms.ed.state.pa.us/Screens/wfPublicAccess.aspx</a> Pa RN License Number: <a href="http://www.licensepa.state.pa.us/">http://www.licensepa.state.pa.us/</a>	Identify School Building Type: Public (P) or Private/Non-Public (NP)					
<b>NAME</b> (as appears on RN license): PA License #: _____ Expiration Date: ___ / ___ / ___ <input type="checkbox"/> PDE Certified School Nurse (CSN) *PPID #: _____ <input type="checkbox"/> PDE Emergency Certification (requires annual renewal) <input type="checkbox"/> CPR Certified. CPR Expiration Date: ___ / ___ / ___ Name of CPR Course completed: _____ Other Licensed Credential(s): <input type="checkbox"/> CRNP <input type="checkbox"/> PA <input type="checkbox"/> SNP	1.	<input type="checkbox"/> P <input type="checkbox"/> NP	/			
	2.	<input type="checkbox"/> P <input type="checkbox"/> NP	/			
	3.	<input type="checkbox"/> P <input type="checkbox"/> NP	/			
	4.	<input type="checkbox"/> P <input type="checkbox"/> NP	/			
<b>Employment Details:</b> _____ Hours/week worked <b>Check all that apply:</b> <input type="checkbox"/> Job Share <input type="checkbox"/> Float Pool <input type="checkbox"/> Administrative duties only (does not carry a caseload). <b>Comment:</b>		<b>Total number of students assigned to the CSN at all buildings (Caseload):</b> _____ * Check <b>Other only</b> 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				

CSN Credentials	CSN Assigned School Building(s)	Days per Cycle in Bldg	OR	Other* Comment Required	Students in Building (not ADMs)	Students per CSN (not ADMs)
Professional Personnel ID number (PPID#): <a href="https://www.perms.ed.state.pa.us/Screens/wfPublicAccess.aspx">https://www.perms.ed.state.pa.us/Screens/wfPublicAccess.aspx</a> Pa RN License Number: <a href="http://www.licensepa.state.pa.us/">http://www.licensepa.state.pa.us/</a>	Identify School Building Type: Public (P) or Private/Non-Public (NP)					
<b>NAME</b> (as appears on RN license): PA License #: _____ Expiration Date: ___ / ___ / ___ <input type="checkbox"/> PDE Certified School Nurse (CSN) *PPID #: _____ <input type="checkbox"/> PDE Emergency Certification (requires annual renewal) <input type="checkbox"/> CPR Certified. CPR Expiration Date: ___ / ___ / ___ Name of CPR Course completed: _____ Other Licensed Credential(s): <input type="checkbox"/> CRNP <input type="checkbox"/> PA <input type="checkbox"/> SNP	1.	<input type="checkbox"/> P <input type="checkbox"/> NP	/			
	2.	<input type="checkbox"/> P <input type="checkbox"/> NP	/			
	3.	<input type="checkbox"/> P <input type="checkbox"/> NP	/			
	4.	<input type="checkbox"/> P <input type="checkbox"/> NP	/			
<b>Employment Details:</b> _____ Hours/week worked <b>Check all that apply:</b> <input type="checkbox"/> Job Share <input type="checkbox"/> Float Pool <input type="checkbox"/> Administrative duties only (no caseload). <b>Comments:</b>		<b>Total number of students assigned to the CSN at all buildings (Caseload):</b> _____ * Check <b>Other only</b> 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				

**SUPPLEMENTAL STAFF ASSISTING CSN**

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

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

**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/>

<b>SCHOOL PHYSICIAN</b>	
<b>NAME</b> as appears on MD/DO license	
<b>PENNSYLVANIA LICENSE</b>	License Number: _____ Expiration date: _____
<b>GROUP PRACTICE</b> as the SCHOOL Physician?	<input type="checkbox"/> No <input type="checkbox"/> Yes, Name of Group Practice: _____
<input type="checkbox"/> <b>No Physician.</b> Comments required (See Chapter 10 of instructions)	

<b>SCHOOL DENTIST</b>	
<b>NAME</b> as appears on DMD/DDS license	
<b>PENNSYLVANIA LICENSE</b>	License Number: _____ Expiration date: _____
<b>GROUP PRACTICE / MOBILE DENTIST</b> as the SCHOOL Dentist?	<input type="checkbox"/> No <input type="checkbox"/> Yes, Group Practice: Name _____ <input type="checkbox"/> Yes, Mobile Dentist Group: Name _____
<b>MOBILE DENTIST GROUP</b> as a FAMILY Dentist?	<input type="checkbox"/> No <input type="checkbox"/> Yes, Name of Mobile Dentist Group: _____
<input type="checkbox"/> <b>No Dentist.</b> Comments required (See Chapter 10 of instructions)	

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

### MANDATED DENTAL SERVICES PROGRAM

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

<b>Dental Examinations by SCHOOL Dentist</b>	<b>PUBLIC Students</b>	<b>PRIVATE/ NON-PUBLIC Students</b>	<b>TOTAL Students</b>
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)			
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.**

<b>FLUORIDE PROGRAM</b>	<b>PUBLIC Students</b>	<b>PRIVATE/ NON-PUBLIC Students</b>	<b>TOTAL Students</b>
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	
<p style="text-align: center;"><b>NAME</b></p> <p style="text-align: center;">as appears on DH license</p>	
<p style="text-align: center;"><b>PHONE/EXTN</b></p>	
<p style="text-align: center;"><b>EMAIL ADDRESS</b></p>	
<p style="text-align: center;"><b>PENNSYLVANIA LICENSE</b></p> <p>Professional License Number: <a href="http://www.licensepa.state.pa.us/">http://www.licensepa.state.pa.us/</a></p>	<p>License Number: _____ Expiration date: _____</p>
<p style="text-align: center;"><b>CERTIFICATION</b></p> <p>Professional Personnel ID number (PPID#): <a href="https://www.perms.ed.state.pa.us/Screens/wfPublicAccess.aspx">https://www.perms.ed.state.pa.us/Screens/wfPublicAccess.aspx</a></p>	<p><input type="checkbox"/> Not certified</p> <p><input type="checkbox"/> PDE Certified School Dental Hygienist *PPID #: _____</p> <p><input type="checkbox"/> PDE Emergency Certification (requires annual renewal)</p>
<p style="text-align: center;">Additional Pennsylvania Licensure</p>	<p><input type="checkbox"/> PHDHP (Public Health Dental Hygiene Practitioner) <input type="checkbox"/> Other: _____</p> <p>License Number: _____ Expiration date: _____</p>
<p style="text-align: center;"><b>DAYS</b></p> <p style="text-align: center;">per School Year Worked</p>	<p>Days per School Year Worked _____</p>

School Dental Hygienist	
<p style="text-align: center;"><b>NAME</b></p> <p style="text-align: center;">as appears on DH license</p>	
<p style="text-align: center;"><b>PHONE/EXTN</b></p>	
<p style="text-align: center;"><b>EMAIL ADDRESS</b></p>	
<p style="text-align: center;"><b>PENNSYLVANIA LICENSE</b></p> <p>Professional License Number: <a href="http://www.licensepa.state.pa.us/">http://www.licensepa.state.pa.us/</a></p>	<p>License Number: _____ Expiration date: _____</p>
<p style="text-align: center;"><b>CERTIFICATION</b></p> <p>Professional Personnel ID number (PPID#): <a href="https://www.perms.ed.state.pa.us/Screens/wfPublicAccess.aspx">https://www.perms.ed.state.pa.us/Screens/wfPublicAccess.aspx</a></p>	<p><input type="checkbox"/> Not certified</p> <p><input type="checkbox"/> PDE Certified School Dental Hygienist *PPID #: _____</p> <p><input type="checkbox"/> PDE Emergency Certification (requires annual renewal)</p>
<p style="text-align: center;">Additional Pennsylvania Licensure</p>	<p><input type="checkbox"/> PHDHP (Public Health Dental Hygiene Practitioner) <input type="checkbox"/> Other: _____</p> <p>License Number: _____ Expiration date: _____</p>
<p style="text-align: center;"><b>DAYS</b></p> <p style="text-align: center;">per School Year Worked</p>	<p>Days per School Year Worked _____</p>

## 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2	List the number of <b>public</b> schools that <u>received</u> dental hygiene services through the DHSP plan.	
3	List the number of <b>private/non-public</b> schools that <u>received</u> 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								
<b>TOTAL</b>								

\*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 <u>actually received</u> 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 <u>actually received</u> 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 <u>other than</u> 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 <u>Contacts</u> for Acute / Chronic ILLNESS			
02	Staff / Other Adult <u>Contacts</u> for Acute / Chronic INJURY			
03	Staff / Other Adult <u>Emergencies</u> Requiring Activation of Emergency Medical Services (EMS)			
04	Staff / Other Adult <u>Emergencies</u> Requiring Use of an Automated External Defibrillator (AED)			

	HEALTH SERVICES FOR STUDENTS	Public Students	Private / Non-Public Students	Total Students
01	Student <u>Contacts</u> for Acute/Chronic ILLNESS			
02	Student <u>Contacts</u> for Acute/Chronic INJURY			
03	<p><u>Students</u> REQUIRING SKILLED NURSING</p> <p style="background-color: #fce4d6;">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)</p>			
04	<u>Students</u> (count each student once) with a Plan of Care (IHP, ECP, 504 or IEP with a medical component)			
05	<u>Students</u> Sent from School for Health Reasons			
06	Student <u>Emergencies</u> Requiring Activation of Emergency Medical Services (EMS)			
07	Student <u>Emergencies</u> Requiring Use of an Automated External Defibrillator (AED)			

## HEALTH EXAMS, SCREENS & SELECT SERVICES

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

<b>STUDENT HEALTH SCREENS</b>		Public Students	Private / Non-Public Students	Total Students
10	<b>Vision Screens (K – 12 &amp; Ungraded)</b>			
	A. Referred for Further Evaluation / Treatment			
	B. Completed Referrals Reported			
11	<b>Hearing Screens (K,1, 2, 3, 7, 11 &amp; Ungraded)</b>			
	A. Referred for Further Evaluation / Treatment			
	B. Completed Referrals Reported			
12	<b>Scoliosis Screens (6, 7)</b> 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	<b>Growth Screens – BMI (coincides with the CDC percentile) TOTAL for Grades K – 6 (A+B+C+D)</b>			
	A. Underweight – Less than 5 <sup>TH</sup> Percentile			
	B. Healthy Weight – 5 <sup>TH</sup> Percentile to Less than 85 <sup>TH</sup> Percentile			
	C. Overweight – 85 <sup>TH</sup> Percentile to Less than 95 <sup>TH</sup> Percentile			
	D. Obese – Equal To or Greater than 95 <sup>TH</sup> Percentile			
14	<b>Growth Screens – BMI (coincides with the CDC percentile) TOTAL for Grades 7 – 12 (A+B+C+D)</b>			
	A. Underweight – Less than 5 <sup>TH</sup> Percentile			
	B. Healthy Weight – 5 <sup>TH</sup> Percentile to Less than 85 <sup>TH</sup> Percentile			
	C. Overweight – 85 <sup>TH</sup> Percentile to Less than 95 <sup>TH</sup> Percentile			
	D. Obese – Equal To or Greater than 95 <sup>TH</sup> Percentile			
<b>GRAND TOTAL for Grades K – 12 (13+14)</b>				

## 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			
<b>TOTAL</b>				

## 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 at least one 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		<b>TOTAL OF SUBSECTION: NATURE OF INJURY</b>	
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		<b>TOTAL OF SUBSECTION: TIME PERIOD</b>	
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		<b>TOTAL OF SUBSECTION: LOCATION</b>	
06 Corridor / Hall		12 Sci Lab / Fam & Consumer Sci & Tech Ed Class			

### MEDICATION ADMINISTRATION – STUDENTS ONLY

<b>MEDICATION by <u>Category of Use</u></b> <b>See Chapter 15 Instructions for assistance</b>		<b>NUMBER OF DOSES ADMINISTERED</b> <b>(Public &amp; Private/Non-public Students Combined)</b>	
		<b>Doses by Individual Order</b> <b>(Primary Care Provider)</b>	<b>Doses by Standing Order</b> <b>(School Physician)</b>
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.)		
<b>TOTAL</b>			