eSchoolPlus+

Medical Training Guide

Version 4.0

August 2019

Arkansas Public School Computer Network
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**Note:**

This page contains a table of contents for medical reports and trainings, including sections on immunizations, vision screening, and medical cards. It also lists utilities and alerts, along with details on medical tables and Cognos medical table listings. The guide covers the school year 2019-2020.
Student Medical Records Overview

The Student Medical Records application allows maintenance of medical records for every student. If the user has security access to all buildings, records can be maintained for all students. If the user has limited building access, only records for students registered within the user’s building group will be accessible.

Each student MUST have a record in Demographics before he or she can be processed in any other eSchoolPlus application. Medical records can be maintained for both active and inactive students.

The Student Medical Records application contains data entry windows for the following:

- Dental
- Emergency
- Growth
- Hearing (SIS Cycle 7/June)
- Immunizations (SIS Cycle 3/November)
- Office Visits
- Other Exams
- Physicals
- Medication Log
- Medication Requirements
- Scoliosis (SIS Cycle 7/June)
- Vision (SIS Cycle 3/November & Cycle 6/April)

Notes: Entries in Medical Records that are past the building's limit on prior days to update are display only. This is determined by the building’s Medical Configuration.

Medical Tables are listed at the back of this document. The Location Table is the only table where additions are allowed. Do NOT edit any medical tables other than Location.

There are specific rules in Arkansas for Referral and Follow-ups when pertaining to Vision, Hearing, and Scoliosis. See those areas of the training guide for specifics.

Supported screen sizes are: small (tablet), medium, large, and extra-large. Extra-small (phone) is not supported. The size of the screen determines the fields displayed. Example below:

Smaller screen size versus full size display. Note more fields display as screen enlarges.
Medical Menu

General Features

- The Medical Records System allows school personnel to maintain a comprehensive medical record for each student.
- The Medical Records System accesses demographic, guardian, and emergency contact information drawn from Student Demographics. When updated in one area, the updated information is reflected automatically in the other.
- Medical records may be maintained for both active and inactive students.
- Whenever a medical record is updated, a time stamp that includes the name of the user who made the update, the date of the update, and the time of the update is added to the record.
- Validation table maintenance enables school personnel to define district-specific codes used by the Medical Records System. This excludes any state defined tables.
- The Daily Log option allows entry of basic information about medical office visits for multiple students on one page. The following information can be entered by building/date by student: office visit date and time, reason, treatment, room, any medications administered, and dose.
- The Office Visits option can be used to enter Reason, Intervention, and Outcome codes, Blood Pressure, Pulse, Temperature, Respiration, Room, Initials, and Comments for a single student.
Student Search

The Navigational Bar

Returns the user to their Home page from anywhere in eSchoolPlus.

Click to open the Menu listing.

Quick Search is used to enter a search for an active student or a page. The magnifying glass icon is used to open the Student Search.

Tasks and Reports are accessible from all pages.

The School Year drop down is used to set your Environment or Change School Year.

Mega Menu

Clicking on the 'Menu' item drop down will display all applications a user has security access to view. Selecting one of the menu items will display the related application items.

Shown below is the Registration > Entry & Reports items.
Quick Search

Quick Search, located on the toolbar below the system’s banner, provides a fast, convenient way to navigate to pages and locate active students. Because the Quick Search feature is available on all of the main pages in eSchoolPLUS, it is not necessary to leave the page being worked on to search for and select a student. The feature also enables the user to find and select menu options without using the main menu and its sub-menus.

Searching for Menu Options and Students

To initiate a search, simply type a few characters in the Quick Search field. A drop-down list displays showing menu items and active students that matches the entry. For example, typing emer will display three menu options and a list of students whose names include these characters. Only the first 10 records will display. Use the Student Search for further records or to narrow the search.

Note: Quick Search searches only for students whose current status is Active. Students with other statuses, including Graduated, Inactive, and Pre-Registered, are filtered out. To find students with other statuses, click on the magnifying glass (Search) in the Quick Search field to display the Student Search page.

Quick Search is a faster way to navigate than using the main menu. While most options can be reached on the menu with no more than 3-4 clicks, it is usually needed to scan lists of options to locate the one wanted. With Quick Search, most options can be found within 3-4 keystrokes and with no more effort than glancing at a short list of possible choices.

The same is true about using Quick Search to locate a student. You can find most students in your database by typing the first name and just part of the second. The process is even faster when you start to apply different strategies; for example, if a student has a unique last name, you can skip the first name.
Tasks and Reports

Tasks and Reports Dropdown Window

As shown above, by clicking the Tasks/Reports drop-down on the Navigation bar, any Running Tasks information and Recent Reports can quickly be accessed from any eSchoolPLUS option without leaving the current page. When reports are selected they open in a new tab.

Tasks and Reports Page

Click Tasks/Reports button on the Navigation bar

Use this page to view tasks and retrieve reports. The page includes three panels:

- **Reports**: Displays reports and logs previously generated.
- **Running Tasks**: Displays reports and calculations that are in progress.
- **Scheduled Tasks**: Displays reports and calculations that are scheduled to run.

Retrieve, Print, and Save Reports

1. On the Navigation bar, click the Tasks/Reports bar. The system displays the Tasks and Reports page.
2. On the Reports panel, click the File Name link of the report to retrieve.
3. A new tab opens on the browser displaying the report in a PDF report viewer.
4. As needed, click the report viewer's Save icon to save the report to another location, or click the Print icon to print the report.
5. Click the close button on the browser tab to close the PDF report viewer and return to the Tasks and Reports page.
Delete Reports and Tasks

- To delete individual items, select the check box in the (Delete) column for each report or task to delete and then click the Delete icon in the upper right of the page.
- To check all visible items in a panel, select (Delete) in the Column Header of a panel and then select Delete in the upper right of the page to delete all selected items.

Reports Panel - This section displays reports and logs that have been run and the date and time. Reports sort descending by date and time.

Running Tasks Panel - This section displays any task(s) currently running, including the Description, Start Time, and Progress.

Note - A task in progress cannot be deleted unless an error occurs.

Scheduled Tasks Panel - Items that are scheduled to run at a set time will display here. Users have the ability to schedule reports and tasks to run at a specific time. The Scheduled Time, Status, and whether the task has been enabled or disabled will display.
Student Notes

Menu Access: Student Information Bar Notes icon OR Registration > Entry & Reports > Student Notes

The Student Information Bar displays important student notes so users (for instance office personnel) will have access to this key information on all student pages. It also includes an icon to indicate if the student has any notes and allows the user to click the ‘cloud’ icon to display the Student Notes page. When student notes are added, they can be designated as a personal or critical alert. If an alert is coded as critical, then the student's information is displayed in a red background on a pink header to alert users.

One of two icons will display:

- Student has at least one note.
- Student does not have any notes.

To edit an existing comment, click the icon. To enter a new Personal or Critical Note for a student, click View/Edit Notes.

Viewing/Updating Student Notes

This page allows the user to view and update notes for which the user has access, and to add a note for a student. The Student Notes page displays a list of any existing notes for the student. By default only the first two lines of each note display in the Note column of the Student Notes page. To view the note as it was originally formatted click the Entry Date link.

The Note column includes Expand All and Collapse All icon. The user can expand all notes or only selected notes to display the full content by use of the Expand/Collapse icon.

To add a note for a student:

1. Select Registration > Entry & Reports > Student Demographics > Student Notes.
2. Select (Add).
3. On the Student Note page, enter the appropriate information. See Field Descriptions below for detail on setting a note as Critical, Sensitive, or Private.
4. When note information is complete, click the (Save) icon.
Field Descriptions: (*Asterisk notes a required field)

**Entry Date** - Today's date defaults when adding a new note; however, a different date can be entered.

**Entry Time** - The time defaults when New is selected to add a new note; however, a different time can be entered in HH:MM AM or HH:MM PM format.

**Note Type** - The type of note to enter. The district determines the types of notes available.

**Note** – Enter the note text, up to 7500 characters. The first 40 characters display on the Student Notes page which lists the notes for the student.

**Alert Type** – Select the Alert Type:

- **C** - *Critical Alert* - to display the note as a critical alert in the Student Information Bar.
- **P** - *Personal Alert* - to display the note as a personal alert that can be viewed from eSchoolPLUS and TAC.

**Sensitive** – Checked if the note contains sensitive information and should only be viewed by users with the appropriate security. Certain Note Types may be defined by the District to default as Sensitive when a note is added. A user's security resources determine if the user can add and view Sensitive notes. This box is inaccessible if the user does not have the appropriate security (REG-PRIVATE-FLDNOTE).

**Private** - Checked if the note should display only for the user adding the note and other users with the appropriate security to view other people's notes. (REG-MAINT-OTHERNOTE)

**To Delete a Student Note:**
Enter a check in the box in the Delete column, and then click the Save icon.
Emergency

Menu Access: Medical > All > Student > Emergency

Use this page to add or change student information for emergencies. This page lists the phone numbers for guardians and contacts; insurance and hospital information; and medical alerts and disabilities.

Items that can be performed from this page:

- Access the contact record by clicking on the contact's name.
- Add a new contact by clicking New Contact. User must have the proper security resources. Refer to the eSchoolPlus Registration Training Guide for instructions on adding new contacts for a student.
- Medical alerts and disabilities can be maintained.
- Delete medical alerts or disability records by checking the Delete box, then clicking Save. Click the (Delete) icon in the column header to select all rows for deletion.

Field Descriptions: (*Asterisk notes a required field)

**Emergency - Contact Information**

Add Emergency Contacts by clicking the Add icon in the upper right of the Contact panel. See the Adding a new contact for a student section of this document for instructions.

**Medical Alerts Panel**

Medical Alert Code* - List of allergies or special medical conditions for the student. For example, a student may be listed as having asthma and an allergy to bee stings. Displays the description of the Medical Alert Code, for example, ASTHMA.

Comments - Detailed information on the alert. For example, if there is an alert code of Food Allergy, this could specify the foods to avoid. [Character/255]

**Disabilities Panel**

Priority* - Number used to specify the order for listing the disability. Order number 1 would be considered the student's primary disability. If a user enters multiple disability codes and close one of the lines, they must update the Disability Order to display a 1 for the first open disability record.
**Disability Code and Description** - Code identifying the student's disability and displays the description of the disability.

**Physician, Hospital, and Insurance Information Panel**

Enter data as desired by the district. The fields on this panel are optional by district. If the Hospital field is used, the Hospital Code table must be populated in Validation Tables.
Exams

Menu Access: Medical > All > Student > Exams

Use this page to view and record student medical exam data, such as dental, hearing, and physical exams. For each type of exam, the user can quickly see the history of when the exam was administered including the student's grade and exam date.

- To view the exam details, click (Expand) for an individual exam.
- To add exam results, click (Add) on the exam's panel.

Entries that are past the building's limit on prior days to update are display only. This is determined by the building’s Medical Configuration. For existing referrals, the user can always add referrals and enter follow up information. The user may be able to edit existing notes, comments, and referral comments if the configuration is defined to allow editing of notes for locked office visits.

Student Medical Exam Procedures

View medical exam results

1. Select Medical > All > Student > Exams.
2. If the Student Search Page displays, search for the appropriate student, then click the student’s name link.
3. To view exams that are not currently displayed, select the appropriate checkboxes in the Selections panel. Then click (Load). See Detail Items on Exam Pages below. This selection will hold for future accessing of the page.
4. To display an exam's detailed results, click (Expand) for the exam.

Details Items on Exam Pages

- In the Selections panel, check which Exams to display for the student and click (Load Records). In 4.0 there are no longer separate exam pages for each exam.
- Alerts and Disabilities display in a panel at the top of the page.
- Panels are closed by default upon access. Panels and subpanels may be expanded/collapsed by use of the icons. Once expanded, except for re-accessing, the panels must be manually collapsed.
- The most recent record displays as the top row. The header of each row displays the grade, date, and screening referral information.
➢ Click to add a record to an exam panel. Enter the screening date and test detail in the detail panels. Note the Referral Detail is now visible from the screening data page.

➢ Validated fields now provide drop-downs instead of tooltips to select a valid code.

Add medical exam results

1. Select Medical > All > Student > Exams.
2. If the Student Search Page displays, search for the appropriate student, then click the student's name link.
3. To add results for an exam that is not currently displayed, select the appropriate checkboxes on the Selections panel. Then click (Load).
4. Click (Add) on the exam's panel.
5. Enter the exam date and other prompt values, and click **OK**.

6. Complete fields in the exam detail fields.
7. Click **(Save)**.

**Change medical exam results**

Entries that are past the building's limit on prior days to update are display only. This is determined by the building's Medical Configuration. For existing referrals, the user can always add referrals and enter follow up information. The user may be able to edit existing notes, comments, and referral comments if the configuration is defined to allow editing of notes for locked office visits.

1. Select **Medical > All > Student > Exams**.
2. If the **Student Search Page** displays, search for the appropriate student, then click the student's name link.
3. To change results for an exam that is not currently displayed, select the appropriate checkbox in the Selections panel. Then click **(Load)**.
4. To display an exam's detailed results, click **(Expand)** for the exam.
5. Change values as needed.
6. Click **(Save)**.

**Note:** The time stamp on the Exam page is updated each time an area is changed and Save is selected. The most recent change is reflected as the time stamp record.

**Delete medical exam results**

Entries that are past the building's limit on prior days to update are displayed only. This is determined by the building's Medical Configuration.

1. Select **Medical > All > Student > Exams**.
2. If the Student Search Page displays, search for the appropriate student, then click the student's name link.
3. Click **(Delete)** for each exam record to delete. **Deleting the Exam deletes any Referral data.**
4. Click **(Save)**.
Referral Detail

Example Referrals panel

<table>
<thead>
<tr>
<th>Referral Code*</th>
<th>Referral Date*</th>
<th>Followup Code</th>
<th>Followup Date</th>
<th>Doctor Name</th>
<th>Referral Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>S - School Nurse</td>
<td>11/08/2017</td>
<td>I - In-Process</td>
<td>11/08/2017</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

General information displays in the header identifying the student and record accessed.

Field Descriptions: (* Asterisk notes a required field)

Referral Code* – The code describing the type of referral. Select from drop down values.

Referral Date* – The date on which the referral was made.

Followup Code – The code indicating what kind of follow-up was made. Select from drop down values.

Followup Date – The date on which the follow-up information was received. Follow-up date is required when a Follow-up code is entered.

Doctor Name – The name of the doctor who provided care. [Character/255]

Referral Comments – Any additional text to describe the referral or follow-up. [Character/255]

Delete – Can be used to remove a record by checking the Delete box and selecting Save.

Note: There are specific rules in Arkansas for Referral and Follow-ups when pertaining to Vision, Hearing, and Scoliosis. See those areas of the training guide for specifics.
Dental

Menu Access: Medical > All > Student > Exams > Dental Panel

The Dental Exam window allows maintenance of a student’s dental examination results.

Sample Dental Exam Window

Field Descriptions: (*Asterisk notes a required field)

Grade - Holds the grade level of the student at the time of the examination.

Date - Holds the date of the student’s dental screening. To be valid the dates must be after the student’s date of birth.

Location - Holds a code to identify where the dental screening was performed.

Status - The result of the exam. [Character/1]

Notes - Unlimited free text about the exam. [Character/Unlimited]

Referral Detail – Expand the Referral Detail panel to enter or view referrals for the student for the exam.
Growth

Menu Access: Medical > All > Student > Exams > Growth Panel

Use this page to add or view growth exam results for a student. After saving a record for the student, referrals or notes can be entered or viewed for the student, as well.

Growth panel

Field Descriptions: (*Asterisk notes a required field)

Grade* - The student’s grade on the exam date.

Date* – The date of the exam. Location – Holds a code to identify where the dental screening was performed. Mouse-over field

Age – The student’s age on the exam date. The system calculates the student’s age based on the student’s birth date and the date of the exam.

Height – The student’s height measured in full and fractional inches. Enter the measurement in decimal format. For example, to indicate 5 feet, 2 1/4 inches tall, the entry would be 62.25. [Decimal (5,2)]

Percent (%) – The student’s height percentile (from 1 to 100) based on the student’s age (from ages 24 months to 240 months) and gender.

The system calculates the student’s age, based on the student’s birth date and the date of the exam, and then pulls the appropriate percentile value from a table maintained by SunGard. If the student is older than the highest age in the table, the system will use the percentile for the highest age. If the student’s percentile exceeds the established range, 1 or 100 may display.

Weight – The student's weight measured in full and fractional pounds. Enter the measurement in decimal format. For example, to indicate 95 and ½ pounds, the entry would be 95.50. [Decimal (5,2)]

Percent (%) - The student’s weight percentile (from 1 to 100), based on the student's age (from ages 24 months to 240 months) and gender.

The system calculates the student’s age, based on the student’s birth date and the date of the exam, and then pulls the appropriate percentile value from a table maintained by SunGard. If the student is
older than the highest age in the table, the system will use the percentile for the highest age. If the student's percentile exceeds the established range, 1 or 100 may display.

**BMI** - The body mass index for the student. The formula is weight/height\(^2\) multiplied by 703 (conversion factor for pounds/inches). This does not show the difference between fat and muscle. Sample guidelines:

Less than 18.5 is underweight / 18.5 to 24.9 is healthy / 25 to 29.9 is overweight.

**Percent (%)** – The percentile range for this body mass index value, based on the student's age (from ages 24 months to 240 months) and gender.

The system calculates the student’s age, based on the student’s birth date and the date of the exam, and then pulls the appropriate percentile value from a table maintained by SunGard. If the student is older than the highest age in the table, the system will use the percentile for the highest age. If the student's percentile exceeds the established range, 1 or 100 may display.

**Status** – Indicates the district-defined status of the calculated percentile range for the body mass index value. For example, the status could indicate whether the student's BMI percentile falls within or outside the average range established for the age and gender.

**AN Reading** – Indicates the AN (Acanthosis Nigricans) Reading result.

**BP Sys/Dia** – Indicates the Systolic/Diastolic reading for two sets of blood pressure checks. One set is for blood pressure taken before the AN Reading; the other set is for blood pressure taken after the AN Reading. [Number/3]

**Notes** - Unlimited free text about the exam. [Character/Unlimited]

**Referral Detail** – Expand the Referral Detail panel to enter or view referrals for the student for the exam. See *Referral Detail* section of this guide.
Hearing

Menu Access: Medical > All > Student > Exams > Hearing Panel

Use this page to add or view hearing exam results for a student. Both general and detailed results can be entered. The hearing data pulls in state reporting and should be followed as described. Each new screening requires a line entry with all state required fields.

Hearing Exam Panel

Field Descriptions: (*Asterisk notes a required field)

Grade* - The student's grade on the exam date.

Date* – The date of the exam.

Location – Holds a code to identify where the dental screening was performed.

Right Ear – The result of the exam for the right ear. Valid entries are P - Pass/F - Fail.

Left Ear – The result of the exam for the left ear. Valid entries are P - Pass/F - Fail.

Decibel/Frequency Test – After a record has been saved for a student, decibel/frequency test details can be entered for the exam. Those instructions are listed below.

Referral Detail – Expand the Referral Detail panel to enter or view referrals for the student for the exam. See Referral Details section of this document. Arkansas State Reporting Guidelines are listed below:
Arkansas State Reporting Guidelines

- If a student fails any portion of the screening a valid state referral and follow-up **MUST** be entered.
- To meet Arkansas guidelines if a referral is entered, a follow-up value must be entered.
- Hearing data pulls in State Reporting Cycle 7/June.

<table>
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<tr>
<th>Valid Referral Codes</th>
<th>Valid Follow-up Codes for Referral of S:</th>
<th>Valid Follow-up Codes for Referral U or P:</th>
</tr>
</thead>
<tbody>
<tr>
<td>U – Audiologist</td>
<td>I – In Process</td>
<td>R – Refused Referral</td>
</tr>
<tr>
<td>P – Family Physician</td>
<td>T – Re-Screened</td>
<td>N – Normal Exam</td>
</tr>
<tr>
<td>S – School Nurse</td>
<td>X – Left District</td>
<td>J – Treatment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>X – Left District</td>
</tr>
<tr>
<td></td>
<td></td>
<td>I – In Process</td>
</tr>
</tbody>
</table>

Reminder: Each screening requires an additional row (record) on the Screening Exam page.

Add decibel and frequency ranges for hearing exam results

1. After adding and completing fields in the Hearing exam detail fields that display.
2. Click (Expand) on the Decibel/Frequency Test section.
3. To fill in default results for ranges, click (Additional options) at the far right of the section, and then select Set Default. Select the default value, such as Pass, and click OK.
   - To fill a column with the default result, select the checkbox at the top of the column.
   - To fill a row with the default result, select the checkbox at the left of the row.
4. As needed, change the value for a decibel/range to record the student's status.
5. Click (Save).
Other Exams

Menu Access: Medical > All > Student > Exams > Other Exams

Use this page to add or view other exams results for a student. Screenings entered under the Other Exams do not print on the Medical Card.

Note: Head Lice is currently the only Other Exam available. Converted Comments may also display in this area.

Other Exams screen

Field Descriptions: (* Asterisk notes a required field)

Exam* – Select the screening type for which the student was examined. The district defines the available screenings. For example, a district may have a screening to track the results of a head lice exam.

Grade* - The student's grade on the exam date.

Date* – The date of the exam.

Location – Holds a code to identify where the dental screening was performed. Mouse-over field

Status - The result of the exam. [Character/1]

Notes - Unlimited free text about the exam. [Character/Unlimited]

Referral Detail – Expand the Referral Detail panel to enter or view referrals for the student for the exam. See Referral Details section of this document.
Physicals

Menu Access: Medical > All > Student > Exams > Physical Panel

Use this page to add or view physical exam results for a single student. After a record is entered for the student, referrals or notes can be entered or view for the student, as well.

The assessments available depend on what the district has defined in the Examinations table. When adding, select the Exam Type to enter from the choices below:

- **Normal** - includes all assessments that have been defined for a normal exam in the Examinations table.
- **Athletic** - includes all assessments that have been defined for an athletic exam in the Examinations table.

Physical Exam screen

Field Descriptions: (*Asterisk notes a required field)

**Date** – The date of the exam.

**Grade** - The student's grade on the exam date.

**Location** – Holds a code to identify where the dental screening was performed. *Mouse-over field*

**Pulse** – The student's pulse at the time of the examination. [Small Integer]

**Blood Pressure** – The student’s blood pressure at the time of the examination. Systolic pressure is entered in the first field and diastolic pressure in the second. [Character/3; Character/3]

**Exam(s)** - When adding a new exam, select: **Normal** - to add a normal exam OR **Athletic** - to add an athletic exam. The tests available depend on the district’s setup.

**Exam Status Fields** – For each assessment included, enter the result of the exam. Move the mouse pointer over the exam name to see its description. Move the mouse pointer over the entry field to see possible statuses.

**Referral Detail** - Expand the Referral Detail panel to enter or view referrals for the student for the exam. See **Referral Detail** section of this guide.

**Notes** - Unlimited free text about the exam. [Character/Unlimited]
Scoliosis

Menu Access: Medical > All > Student > Exams > Scoliosis Panel

Use this page to add or view scoliosis exam results for a student. The scoliosis data pulls in state reporting and should be followed as described. Each new screening requires a line entry with all state required fields.

Scoliosis Exam panel

Field Descriptions: (*Asterisk notes a required field)

Grade* - The student's grade on the exam date.

Date* – The date of the exam.

Location – Holds a code to identify where the scoliosis screening was performed.

Status - The result of the exam. [Character/1] Valid entries are P - Pass/F – Fail.

Note: If a student fails any portion of the screening a valid state referral MUST be entered. More information follows.

Referral Detail - Expand the Referral Detail pane to enter or view referrals for the student for the exam. Arkansas State Reporting Guidelines are listed below:

<table>
<thead>
<tr>
<th>Arkansas State Reporting Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>If a student fails any portion of the screening a valid state referral and follow-up MUST be entered.</td>
</tr>
<tr>
<td>To meet Arkansas guidelines if a referral is entered, a follow-up value must be entered.</td>
</tr>
<tr>
<td>Scoliosis data pulls in State Reporting Cycle 7/June.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Valid Referral Codes</th>
<th>Valid Follow-up Codes for Referral of S</th>
<th>Valid Follow-up Codes for Referral O or P:</th>
</tr>
</thead>
<tbody>
<tr>
<td>O – Orthopedic Physician</td>
<td>I – In Process</td>
<td>R – Refused Referral</td>
</tr>
<tr>
<td>P – Family Physician</td>
<td>T – Re-Screened</td>
<td>N – Normal Exam</td>
</tr>
<tr>
<td>S – School Nurse</td>
<td>X – Left District</td>
<td>J – Treatment</td>
</tr>
</tbody>
</table>

Reminder: Each screening requires an additional row (record) on the Screening Exam page.
Vision

Menu Access: Medical > All > Student > Exams > Vision Panel

The Vision Screening Window allows the maintenance of information about the student’s vision examinations. The vision data pulls in state reporting and should be followed as described. Each new screening requires a line entry with all state required fields.

Sample Vision Screening Window

Field Descriptions: (*Asterisk notes a required field)

**Grade** - Holds the grade level of the student at the time of the examination.

**Date** - Holds the date of the student’s vision screening.

**Exam Time** - The time of the exam.

**Location** – For state reporting purposes, a Value of ‘Y’ in the Location field will indicate an Auto Refractor was used. Leave the Location field blank/NUL to pull as ‘No’. Other values are not valid for SIS.

**External Exam** - The external exam is any obvious anomaly of the eye. Valid entries are P - Pass/F - Fail.

**Right w/Glasses** – If the student is wearing glasses on the right eye when vision screened. Valid entries are Y - Yes/N - No.

**Left w/Glasses** – If the student is wearing glasses on the left eye when vision screened. Valid entries are Y - Yes/N - No.

**Vision 20** – Enter the results of the distance visual acuity screening using Snellen Eye Chart at twenty feet (20') or an age or developmentally appropriate chart at ten feet (10’). Valid entries are P - Pass/F - Fail.

**+2.0 test 20’ (Plus 2 Lens)** - Enter the results of the plus lenses visual acuity screening using a Snellen Eye Chart at twenty feet (20') or an age or developmentally appropriate chart at ten feet (10’). Valid entries are P - Pass/F - Fail.

**LAT MB(far)** - Enter the results of the Lateral muscle balance exam at far. Valid entries are P - Pass/F - Fail.
VERT MB(far) - Enter the results of the Vertical muscle balance at far only. Valid entries are P - Pass/F - Fail.

Fusion(far) – Eye’s ability to unite the images from both eyes into a single image. Valid entries are P - Pass/F - Fail.

LAT MB(near) – Lateral Muscle Balance at near. Valid entries are P - Pass/F - Fail.

Fusion(near) - Eye’s ability to unite the images from both eyes into a single image. Valid entries are P - Pass/F - Fail.

Color – The color perception of the eyes. Valid entries are P - Pass/F - Fail.

Referral Detail - Expand the Referral Detail panel to enter or view referrals for the student for the exam. Arkansas State Reporting Guidelines are listed below:

Note: To meet state reporting guidelines, if a student fails any of the state required items, except for color blindness, a referral is required. The state required items are Date, External Exam, Vision 20', +2.0 test 20', Lat MB(far), Vert MB(far), Fusion(far), Lat MB(near), Fusion(near) and Color Blind.

Note: See table below for further referral/follow-up state reporting requirements.

<table>
<thead>
<tr>
<th>Arkansas State Reporting Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>If a student fails any portion of the screening a valid state referral and follow-up MUST be entered.</td>
</tr>
<tr>
<td>To meet Arkansas guidelines if a referral is entered, a follow-up value must be entered.</td>
</tr>
<tr>
<td>Location field is used to indicate if an Auto Refractor was used in the screening. Value = Y</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Valid Referral Codes</th>
<th>Valid Follow-up Codes for Referral of S</th>
<th>Valid Follow-up Codes for Referral of P or E</th>
</tr>
</thead>
<tbody>
<tr>
<td>P – Family Physician</td>
<td>I – In Process</td>
<td>R – Refused Referral</td>
</tr>
<tr>
<td>E – Eye Doctor</td>
<td>T – Re-Screened</td>
<td>L – Lens Prescribed</td>
</tr>
<tr>
<td>S – School Nurse</td>
<td>X – Left District</td>
<td>N – Normal Exam</td>
</tr>
<tr>
<td>G – Guardian can ONLY be used when Colorblind is the only failure</td>
<td></td>
<td>J – Treatment</td>
</tr>
<tr>
<td>A – Abex No Lens (Abnormal Exam No Lens Prescribed)</td>
<td></td>
<td>X – Left District</td>
</tr>
<tr>
<td>I – In Process</td>
<td></td>
<td>I – In Process</td>
</tr>
</tbody>
</table>

Vision Referral example screen:

Reminder: Each screening requires an additional row (record) on the Screening Exam page.
Immunizations

Use this page to add or view vaccinations for a student. ADE/APSCN sets up the vaccination names used and the requirements for students. Initially, this page displays the vaccinations that are defined to auto generate for all students.

Menu Access: Medical > All > Student > Immunizations

The page includes two modes:

Summary Displays a grid of vaccination information including fields to record doses.

Detail Displays a panel for each vaccination to view detailed information. Use this option to record source documents, indicate the student had the disease associated with the vaccination, or enter referrals.

Summary example

The Student Immunizations page is divided into three panels:

Save Options Panel - This panel only displays if the Medical Configuration is set up to allow the option to run Validate Immunizations on save. The panel displays in both Summary and Detail modes.

- Run immunization calculation on save - Checked if the Validate Immunizations option should be run when you save the page. The calculation validates the student's immunizations to determine their status.
  
  This field only displays if the Medical Building Configuration Allow Option to Validate Immunizations on Save box is checked.

- Generate grace period alert - Checked if the Validate Immunizations option should generate email alerts for a student who is overdue for immunizations after the student's grace period has expired. The Medical Configuration determines whether the email is sent to an internal user and/or the student's guardians.
This field only displays if the Medical Building Configuration Use Immunization Records Alerts box is checked.

- **Overall Immunization Status Panel** - The student's overall status, based on all vaccinations received, is displayed in the title of the panel to provide you with a quick way to see the status. More detail follows.

- **Vaccination Summary or Detail Panel** - The bottom section contains information about each vaccination the student received. Some vaccinations may be defined as a series; while others may be vaccinations that can fill a series requirement (state defined). A series can be used to validate that students have received all scheduled doses of an immunization. Field details follow.

### Overall Immunization Status

**Status subpanel**

- **Status Calculated** - Holds the date on which the status was last calculated by the Validate Immunizations program.

- **Override** - Check the box to insert a check mark to manually update the Overall Immunization Status and to prevent updates. This prevents the Validate Immunizations program from updating the student’s status.

- **Student Status** - Holds the overall immunization status of the student as calculated by the Validate Immunizations program. Status can also be updated manually by clicking on the Override checkbox in this subpanel. Checking the Override box can prevent future updates of the status field.

**Note:** APSCN recommends that the Overall Immunization Status NOT BE manually maintained.

Valid statuses are as follows:

- **CO (Complete):** If all immunizations selected by the criteria have a status of CO or DS, then the student’s status is CO. No further vaccinations are needed.

- **DS (Had Disease):** Indicates the student had the disease for every series included in the criteria.

- **EX (Exempt):** If the immunization status of any specified immunization is marked EX, then the student’s overall status is EX.

- **IP (In Process):** If there are no immunizations with a status of EX, NR or OV, but one or more with IP, then the student is considered in process of completing vaccination requirements.

- **IS (Insufficient Information):** If any series has a status of IS, indicating a warning status was set, and no series has a status of EX, the overall status is IS.

- **MR (Meets Requirements):** If, for the immunizations selected by the criteria, at least one series has a status of MR, and the rest have a status of CO, or DS, the student’s status is MR.

**Note:** If a student has no dosages but it is too soon for an immunization, based on the **Time From Event** field in the immunization schedule, the system will assign a code of MR. This is necessary to avoid students receiving letters for immunizations which they do not have, but do not need.

- **NA (Not Applicable):** If no dates have been entered and the criteria applied to a student does not include the immunization; the status is set to NA.

- **NR (No Record):** If all immunizations have a status of NR, then the student’s status is NR.
OV (Overdue): If there are any immunizations with a status of OV, then the student’s status is OV. If the student has a combination of any of the following, the student’s status is also OV:

NR + OV
NR + IP
NR + MR
NR + CO
NR +DS

Student Exemption - An overall exemption reason for the student, such as for a student who is exempt for religious reasons or for medical reasons.

To enter an exemption, check the Override box and set the Student Status to EX - Exempt. Then, the Student Exemption field is accessible.

Grade Period subpanel

District Entry Date - Holds the date on which the student entered the district. This date is entered automatically by the system, based on the student's first entry vector in Demographics. The date is used by the Validate Immunizations program to determine the grace period, if any, for the student for each vaccination.

Grace Period Alert - Checked if the student is overdue for immunizations. The Validate Immunizations calculation will set this field to checked if the student's overall immunization status is Overdue.

Expiration Date – Date that the student's grace period for immunizations expires. If the Validate Immunizations calculation has set this field, the expiration date is calculated based on the grace period settings in the Medical Building Setup. The expiration date is calculated based on the student's first entry date for the district or the current year's first entry date.

Immunization records alerts are sent when the student's grace period has expired because the student still has time to meet immunization requirements.

The Medical Building Setup determines whether the student's expiration date is automatically cleared when removing the check from the Grace Period Alert field or when the Validate Immunizations calculates the student to be compliant with immunization requirements.

Override – Checked if the student's Grace Period Alert and Expiration Date values should not be updated by the Validate Immunizations calculation.

Comments Subpanel

Comments - Free text about the vaccinations. [Character/255]

Vaccination Summary Panel

Vaccination - Identifies the type of vaccination being recorded for the student.

A warning code may display in front of the vaccination if one of the shot dates entered is a date before the student's date of birth (BB, for Before Birthdate) or before the licensing date (BL, for Before Licensing Date). To remove warning code, the record must be corrected.

This column will never display if the Medical Building Setup does not have the Force Warning on Invalid Dates box checked. If that box is not checked, data cannot be saved when entering a date that is before the birthdate or before the licensing date.

Series Status - If a vaccination is a series, this column will display the current status of the immunization series. Series status may be entered manually in the Series Detail window or updated by the Immunization Validation program.

To permanently override system calculations of the series status click the Override box in the Series Detail window. This is NOT recommended and is only used where the Validate Immunizations cannot calculate an exception.
Valid Series Status codes:

- **CO** = Completed
- **DS** = Had Disease
- **EX** = Exempt
- **IP** = In Process
- **IS** = Insufficient
- **MR** = Meets Requirements
- **NA** = Not Applicable
- **NR** = No Record
- **OV** = Overdue

**Series Total** - If this vaccination is also a series, this field displays the number of doses that have been applied to the series. For example, if you have a series of DTaP, this may be fulfilled by a DTaP vaccination, a DT vaccination, or a Tetanus booster. If the vaccination is not a series, "N/A" displays in this field.

If shots are added for the series, this total is updated when Save is selected.

**Shots Total** - Displays the total number of doses the student has received of this type of vaccination. If dates are added for the shots, this total is updated when Save is selected.

**Dose 1-5** - Each date field holds a date on which the student received a vaccination of this immunization type.

- The first five immunization dates display in the window. Use the left/right scroll bar to display additional date fields, referral, and status information.
- To be valid, each date must be after the student’s date of birth.
- If vaccination date #1 is deleted and there is a date entered in field #2, the system will move the date #2 to the date #1 field.
- Dates entered out of sequence will be reordered in sequence.
- Additional vaccination dates can be entered by clicking the **Detail** mode and adding the remaining dose dates for the vaccination.
- If multiple vaccinations are given together to fulfill a dose of a series, for example, if a Measles vaccination, a Mumps vaccination, and a Rubella vaccination can equate to one dose of MMR, the vaccinations must all be entered under the same date field number to be counted together. The latest dose date in that date number is used for the series date.

**Exemption** - Holds an exemption reason for the vaccination that identifies the reason a student is excused from the immunization vaccination. Select the Exemption code from the table verified field. The exemption will be carried up to the series if the series has the same name as the vaccination. If the exemption is for a vaccination that is not a series, it will be handled as follows:

- If it is a single alternate to a series, it will not affect the series calculation. For example, if TD is marked as an alternate to DTP, and the student has an exemption entered for TD, the student would not be considered exempt from the DTP vaccination.
- If a student is exempt from a vaccination, and the vaccination is one part of multiple vaccinations required to fulfill a dose for a series, the vaccination is considered to meet requirements when other doses are given. For example, if the Measles, Mumps, and Rubella vaccinations are given separately to fulfill one dose of MMR, and a student is exempt for the Rubella portion of the vaccination, if the student has the appropriate doses of Measles and Mumps, the student would meet the requirements for the MMR series.

**Referrals** – Count of referrals for the vaccination. To view referrals, select the Detail mode.
Vaccination Detail Page

In Detail mode, a panel displays for each vaccinations that have been defined to auto generate, as well as any vaccinations that were added for the student in the Vaccination Summary panel. The code and description of the vaccination displays in the panel's title. If the vaccination is a series, the series status also displays in the panel's title.

If you need to add a vaccination for which a panel does not display, switch to Summary mode, and then add the vaccination in the blank row of the Vaccination Summary panel. After you save, the Detail mode will include a panel for the vaccination.

Use this page to add additional doses of a vaccination, to indicate the student had the disease, or to view series information.

The Vaccination Detail page is divided into multiple sections. The sections that display are based on the definition of the vaccination.

Tip: Click (Collapse) next to the Student Immunizations page title to collapse all panels. The collapsed view allows to quickly see the vaccinations and series status information. Then the user can expand the vaccination panel for which you want to enter information.

Vaccination Detail

Doses Section

Vaccination Date – Each date field holds a date on which the student received a dose of this vaccination. The first five dates will display on the Immunizations page.
Source Document – The type of source document provided by the parent or guardian for each shot the student received.

Signed Document – Checked if the source document was signed by the appropriate person for state purposes.

Warning Status – This column may display with a code if the Configuration is set to Force Warning and a vaccination was entered with a date before the student's date of birth (BB, for Before Birthdate) or before the licensing date (BL, for Before Licensing Date). To remove warning code, the record (such as DOB in Registration) must be corrected and then save the Immunization record.

Override – If checked, the Validate Immunizations program will not recalculate the status of this vaccination.

Series Section
Dates - The dates of doses that can be applied to this series. If a series dose is fulfilled by an alternate dose that includes multiple vaccinations, the dose date for the series will be the date of the vaccination that was given last.

Series Status – The Validate Immunizations program sets the status for each vaccination for the student that is part of the requirements for that student.

Override – Checking this box will allow manual entry/override of the Validate Immunizations program. This is NOT recommended and is only used where the Validate Immunizations cannot calculate an exception.

Details Section
Exemption – An exemption reason for having not received the vaccination.

Had Disease – Checked if the student had the disease, rather than a shot. When checked, the student's status is set to display the district-defined code to indicate the student has had the disease. For example, DS - Had Disease.

Date – The date on which the student had the disease.

Comments – Free text about the vaccination. [Character/255]

Alternate Dose Section
This section contains data only if other vaccinations can fulfill the requirement for this vaccination as defined in the alternate dose table. A separate section displays for each alternate dose.

Vaccination Code – The alternate vaccination that the student received, if applicable.

Vaccination Dates – The dates on which the student received doses of this alternate vaccination.

Referral Section
This section displays if a referral has been entered for the vaccination. To add a referral, click (Additional options) in the Vaccination panel header, and then select Add Referral to display the Referral Detail section. Enter the referral information in the blank row.

Referral Code* – The code describing the type of referral. Select from drop down values.

Referral Date* – The date on which the referral was made.

Followup Code– The code indicating what kind of follow-up was made. Select from drop down values.

Followup Date – The date on which the follow-up information was received.

Doctor Name – The name of the doctor who provided care. [Character/255]

Comments – Any additional text to describe the referral or follow-up. [Character/255]

Delete – Can be used to remove a record by checking the Delete box and selecting Save.
Medication Requirements

Menu Access: Medical > All > Student > Medication Requirements

Use this page to add or view medications or treatments that a student may receive. Medications/treatments are divided into two groups:

- **Scheduled Medications** - for medications/treatments that are given on a set schedule, such as prescription medicines or a scheduled diabetic sugar check. Enter the start and end dates, number of doses, and, optionally, time. Doses with times display in the default Day Sheet. Doses with no time display if the *Show Entries without Times* box is checked. If a student may sometimes require an additional dose, for example, for an inhaler, include all possible doses, but leave the time blank for the additional doses.

- **PRN Medications** - for medications/treatments that are not given on a set schedule. For example, the district might allow certain common non-prescription medications to be given if a parent has signed a general permission slip.

### Example Medication Requirements

#### Scheduled Medications Panel

- **Rx/Tx** – The medication or treatment to be given to the student.
- **Start Date** – The first date that the medication or treatment can be given
- **End Date** – The last date that the medication or treatment can be given
- **Add Dose**
- **Time**
- **Comment**
- **Physician**

#### PRN Medications Panel

- **Start Date** – The date the medication or treatment can be given
- **End Date** – The last date that the medication or treatment can be given
- **Comment**
- **Physician**

### Scheduled Medications

#### Field Descriptions: (*Asterisk notes a required field)

- **Rx/Tx** – The medication or treatment to be given to the student.
- **Start Date** – The first date that the medication or treatment can be given
- **End Date** – The last date that the medication or treatment can be given
- **Add** – To add multiple times for giving a medicine on a single date, click on the box, then enter the time in the Time column. If a dose is optional, but may sometimes be required, add an additional line, but do not enter a time.
Time – The time the medication or treatment should be given. Options:
- Enter the time in the format HH:MM or click to enter the current system time. Medications with a time indicated are automatically displayed in the Medication Day Sheet in the Daily Log.
- To add additional times for giving a medicine, click in the Add Dose column.
- If a dose is optional, but may sometimes be required, add an additional line, but do not enter a time.

Comment – Text about the medicine given or the dosage. [Character/255]

Physician – The physician prescribing the medicine. [Character/255]

PRN Medications

This panel is collapsed upon accessing. Expand by clicking icon.

Example PRN Medications Panel

Field Descriptions: (*Asterisk notes a required field)

Rx/Tx* – The medication or treatment to be given to the student.

Start Date* – The first date that the medication or treatment can be given

End Date* – The last date that the medication or treatment can be given

Comments – Text about the medicine given or the dosage. [Character/255]

Physician – The physician prescribing the medicine. [Character/255]

Delete - Delete a medication requirement for a student by checking the Delete box and clicking Save.
Medication Log

Menu Access: Medical > All > Student > Medication Log

Use this page to add or view medications or treatments that have been given for a student. This page also displays the medications that are issued based on entries on the Day Sheets page or the RX/TX field on the Daily Log page.

The Medical Building Configuration (Administration > Medical Setup > Setup > Medical Configuration) determines the number of days prior to the current date for which medical records can be updated. The page initially displays the records that have been given within this timeframe. Use the Selections panel's Prior to Current Period option to view medications or treatments that are past the building's limit on days.

Note: Previous date data can be entered at any time, even if there is not the ability to update and delete.

Selections Panel - Use the fields on this panel to select the medication records to display. After the selection(s) is chosen, click Load (Load) to display the records.

Display Medications Issued - Select to display the current period (records that can be edited) or prior records. On this page, current period is determined based on the number of prior days of medical records that allow edits as defined in the Medical Configuration.

Current Period (past #) days - to display the student's records that can be edited. The number of days included in the current period is indicated in parenthesis. For example, if this label displays as "Current Period (past 365) days", then records for the last year are displayed.

Prior to Current Period - to display prior records past the building's limit on days to update that cannot be edited.

Issued Date - To filter medication records to a specific date, enter the date.

Rx/Tx - To filter medication records to a specific medication, select the medication.

Dosage - To filter medication records to a specific dose number, enter the dose number.

Initials - To filter medication records to those issued by a specific person based on initials, enter the initials.

Medication Log example

Select Load after making Selections.
Medication Log Panel

This panel displays the student's medication records as specified in the Selections panel.

Field Descriptions: (*Asterisk notes a required field)

Date* – The date that the medicine was given.

Time* – The time the medicine was given. Enter the time in the format HH:MM AM or HH:MM PM or click (time icon) to enter the current system time.

Rx/Tx* – The medicine or treatment given to the student. Medicines can only be entered that have been added in the Rx/Tx Requirements for the student. To be entered here, medications must be within the start and end dates given on the Rx/Tx Requirements page or be marked PRN (take as needed).

Dose* – The number of the dose given, if multiples can be given in a day. If only one dose can be given, enter 1.

Comment – Text about the medicine given or the dosage, for example, if only a partial dosage was given. [Character/255]

Initial – The initials of the person making the entry. [Character/20]

Delete – Delete a medication record for a student by checking the Delete checkbox and clicking Save.
Office Visits

Menu Access: Medical > All > Student > Office Visits

Use this page to add or view office visits for a student. The most current record displays at the top of the page. Entries that are past the building's limit on days to update (as specified in the "Allow Update on Prior Office Visit" field in the Medical Building Setup page) are display only.

Viewing a Student’s Office Visits

Office Visit Dates Panel

Use this panel to change the date range to display. Only visits that occurred within the range will be shown.

Date Range - Upon access, the Date Range will default to 30 days as shown in page example below. Specify the range of dates to view and select (Load).

Office Visits Panel

Upon accessing the page, existing office visits display collapsed. The fields of Visit Date, Time In/Time Out, and Reasons for visit display in the collapsed row.

- To view visit information, such as reason, treatment, comments, and vitals, click (Expand) for the visit.

- To display the Office Visit Details page for the visit, click (Edit).

Office Visits expanded panel:
Adding a Student’s Office Visit

To add a new record, click ☞ (Add) at the top right of the page. After saving a record for the student, referrals or notes can be entered or viewed for the student.

1. Select Medical > All > Student > Office Visits.
2. If the Student Search Page displays, search for the appropriate student, then click the student’s name link.
3. Click ☞ (Add).
4. On the Office Visit Details page, complete fields as needed. See screen shot and field definitions below.
5. To add or edit a student’s note, click ☟ (Add Comment) or ☞ (View/Edit Comments). On the Notes dialog, enter the note text. If a note was entered for a previous visit for the same date, add your text below that note. Then click Save.

Office Visit Note: One note record is stored per date for office visits, but multiple visits may be recorded per day for a student. For students who have multiple visits in day, include the time in the note text. If multiple staff are involved, you may want to record staff initials as well.

When you add a subsequent office visit, the Note window shows the text that was entered for the previous visits.

6. Click ☞ (Save).
7. To return to the Office Visits page, click ☚ (Back).

Field Descriptions: (*Asterisk notes a required field)

Visit Details Panel

Date In* – Date of the office visit.

Time In* - The time the student came to the nurse’s office. Enter the time in the format HH:MM AM or
HH:MM PM or click (time icon) to enter the current system time.

**Time Out** - The time the student left the nurse’s office. Enter the time in the format HH:MM AM or HH:MM PM or click (time icon) to enter the current system time.

**BP Sys/Dia** – The student’s blood pressure at the time of the office visit. Systolic pressure is entered in the first field and diastolic pressure in the second. Valid values are in the range 30-300.

**Pulse** – The student’s pulse at the time of the office visit. Valid values are in the range 30-200.

**Temp** – The student’s temperature at the time of the office visit.

**Respiration** – The student’s respiratory rate at the time of the office visit.

**Room** - The classroom that the student was in before coming to the nurse’s office. The Medical Building Setup can be defined to use the student’s homeroom as a default for this field.

**Initials** – The initials of the person making the entry.

**Reasons, Interventions, and Outcomes Panel**

**Reason** - The reason why the student came to the nurse’s office. Additional reasons can be added on the Office Visit Detail page. If the additional reasons are needed, add new information on an additional row.

**Intervention** - The treatment given to the student, if any. Additional intervention codes can be added on the Office Visit Detail page. Even if multiple Reason codes may exist, it is not necessary to enter multiple Intervention codes unless needed.

**Outcome** - The outcome of the office visit. Even if multiple Reason and Intervention codes may exist, it is not necessary to enter multiple Outcome codes unless needed. For example, indicates if the student’s parent was contacted; the student was sent home; or the student was taken to a hospital. Additional outcome codes can be added on the Office Visit Detail page. The Medical Building Setup determines whether this field displays.

**Comments Panel** - Free text about the office visit.

**Rx/Tx Panel** - Enter or view medicine or treatment given to the student.

**Referrals Panel** - Enter or view referrals for the student for the exam.

**TAC Medical Notifications Message**

If using Teacher Access Center and the building is configured to send Medical Notification messages, when a student is admitted to the nurse’s office the student’s teachers for this period of time will be notified that the student is in the nurse’s office.

**Sample TAC screen with Medical Notification message**
Dyslexia

Menu Access: Medical > All > Student District Defined > Dyslexia

The Dyslexia Screening Window allows the maintenance of information about the student’s dyslexia evaluations. The dyslexia data pulls in state reporting cycle 7.

Field Descriptions: (*Asterisk notes a required field)

Receiving Dyslexia Intervention – Check this box to signify the student is receiving Dyslexia intervention services.

Do Not Use (Evaluation Date) – Not used at this time. The evaluation date was previously defined as the date of administration of the Level II Dyslexia Evaluation as defined in the Dyslexia Resource Guide.

Do Not Use (Exit Date) – Not used at this time. The exit date was previously defined as the date the student stopped receiving therapy, if applicable.
Building Medical Summary

Menu Access: Medical > All > Office > Building Medical Summary

Use this page to display counts of students in a building who have received medical services during a specified date range. Depending on what data exists, available statistics may include exams, medication, reasons for visits, intervention/treatment, alerts, and disabilities.

For each building, the counts shown reflect services provided to students currently enrolled in the building or inactive students who were last active in the building.

What is seen when first accessing the report depends on what was last accessed by the user and what building(s) a user has access.

Note: Screen shown below is example of when user has access to multiple buildings and all buildings are collapsed.

1. Select building(s) and the date range to display summary data for medical services received by students.
2. Click (Load).
3. To display the counts for a building, click (Expand) on the building’s panel. Click again to Collapse.

Show below is the Vision Exam section of the page:

<table>
<thead>
<tr>
<th>Vision Exam Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grade</td>
</tr>
<tr>
<td>-------</td>
</tr>
<tr>
<td>01</td>
</tr>
<tr>
<td>03</td>
</tr>
<tr>
<td>04</td>
</tr>
<tr>
<td>05</td>
</tr>
<tr>
<td>06</td>
</tr>
<tr>
<td>07</td>
</tr>
</tbody>
</table>
Summary subpanels:

<table>
<thead>
<tr>
<th>Medication Summary</th>
<th>Visit Reason Summary</th>
<th>Intervention Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AD</strong> Adwell (Dextroamphetamine &amp; Amphetamines)</td>
<td><strong>Visit Reason</strong></td>
<td><strong>Treatment Code</strong></td>
</tr>
<tr>
<td>PR</td>
<td>Desc</td>
<td>Count</td>
</tr>
<tr>
<td>4</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong> 4</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td><strong>Alert Summary</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Code</strong></td>
<td><strong>Description</strong></td>
<td><strong>Student Count</strong></td>
</tr>
<tr>
<td><strong>AB</strong> Allergy-Bee/Wasp</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td><strong>AL</strong> Allergy-Peanut/Treenuts/Nuts</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td><strong>AS</strong> Asthma</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td><strong>ASTH</strong> Asthma</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td><strong>IN</strong> Incontinence</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td><strong>LTAG</strong> Life-Threatening Allergy</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td><strong>ST</strong> Stroke</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong> 13</td>
<td></td>
<td>23</td>
</tr>
</tbody>
</table>

**Disability Summary**

| **Code** | **Description** | **Count** |
| AU | Autism | 1 |
| CR | Cerebral/Cane | 2 |
| OD | Orthopedic Disability | 1 |
| WC | Wheelchair | 1 |
| **Total** 5 | | |

**Tip:** If entered into eSchool, information from this report could be used for Acuity counts that are entered in state reporting cycle 2, due October 15.
Using Medical Office Pages

The Medical > Office options allow entry and updating of office visit and medical exam results for multiple students. For example, general information for vision exams could be mass loaded for a grade or a homeroom and then update individual students as needed.

This option will add information for a student provided the student does not have existing information for the selected date with the exception of Vision. (See Vision Screening Mass Load section.) If the student does have information entered for the selected date, the Mass Load will not update the information. Mass Load information will only default into a new, blank record.

The Daily Log (Office Visit) page contains a link to the detail page where additional information related to the exam may be entered or updated. For Exams, Medical Notes and Referral information may be entered on the mass load page.

Daily Log

Use this page to add or view office visits by day. The Daily Log allows entry on Daily Log, Office Visit Details Page, and Note Dialog.

Menu Access: Medical > All > Office > Daily Log

Viewing Office Visits Daily Log

The Daily Log default is for the user’s default building and current date. To view the log for another building or a prior date, enter the values to view. Then click (Load).

- Entries that are past the building’s limit on days to update (as specified in the “Allow Update on Prior Office Visit” field in the Medical Building Setup page) are display only.
- Changes made on the Daily Log page are saved automatically. A green indicator displays on the far left of each row after it has been saved to verify that the data has been saved.
- Office Visit Note: One note record is stored per date for office visits, but multiple visits may be recorded per day for a student. For students who have multiple visits in day, include the time in the note text. If multiple staff are involved, the user may want to record staff initials as well. When you add a subsequent office visit, the Note window shows the text that was entered for the previous visits.

Add Office Visits using the Daily Log

1. Select Medical > All > Office > Daily Log.
2. To record visits for another building or a prior date, enter the values you want to add in the Selections panel. Then click (Load).
3. To default your initials for the office visits as blank rows are added, enter the initials in the Selection panel.

4. In the blank row at the top of the Daily Log panel, enter student's arrival and departure times in the Time In and Time Out fields using the format HH:MM AM or HH:MM PM.

5. In the Student Name, enter all or part of the student name. Then click  (Search) to display the Student Search window. Click the student's row, and click OK.

6. Enter office visit information as needed.

7. If needed, record more information for the visit use the below options. For detail of the panels and field information, see the Exams > Office Visits area of this document.
   - To enter additional details, such as more reasons and treatments, vital signs, comments, and referrals, click  (Detail Page). On the Office Visit Details page, enter information as needed and click  (Save). To return to the Daily Log page, click  (Back).
   - To enter notes for the office visit, click  (Notes). On the Notes dialog, enter the note text. If a note was entered for a previous visit, add your text below that note. Then click Save.

Change office visits using the Daily Log

1. Select Medical > All > Office > Daily Log.

2. To view visits for another building or a prior date, enter the appropriate values on the Selections panel. Then click (Load).

3. Enter office visit information as needed.

4. If needed, record more information for the visit:
   - To enter additional details, such as more reasons and treatments, vital signs, comments, and referrals, click (Detail Page). On the Office Visit Details page, enter information as needed, and click (Save). To return to the Daily Log page, click (Back).
   - To enter notes for the office visit, click (Add Comment) or (View/Edit Comments). On the Notes dialog, enter the note text. If a note was entered for a previous visit, add your text below that note. Then click Save.

Delete an office visit using the Daily Log

1. Select Medical > All > Office > Daily Log.

2. To view visits for another building or a prior date, enter the values you want to add in the Selections panel. Then click (Load).

3. To delete an office visit, click (Delete).

4. Click Yes.
Day Sheet

Menu Access: Medical > All > Office > Day Sheet

Use this page to view a list of students who are scheduled to receive medications or treatments on the Log Date which default to current date which creates a Medication Log record. **Note:** If no Medications are scheduled for the Log Date, the page will hold no records.

Issue medications based on today's day sheet

1. Verify the building for which to view the Day Sheet. If the building is changed, select (Load).
2. To record your initials when you click Issue, enter your initials in the Initials field.
3. To indicate a medication has been issued, click Issue. The current system time is recorded as the time issued. This creates a Medication Log entry for the student.

Displaying medication doses that do not have a time specified in the Medication Requirements page for a student

1. Select the Show Entries Without Times checkbox.
2. Click (Load).

---

**Day Sheet Panel**

The current date is indicated in the panel's title. When the Issue button is selected for a medication, this date is saved in the student medication log.

**Time** – The time the medicine should be given, as entered in the Medications Requirements page (Medical > All > Student > Medication Requirements).

If the Show entries without times box is checked, medications/treatments that were entered without a specific time also display.

**Student** – Student's full name. Click the Student link to open the Medications Log page for the student.

**Rx/Tx** – The medicine or treatment to be given to the student.

**Comment** – Text about the medicine given or the dosage. This information was entered on the Medications Requirements page (Medical > All > Student > Medication Requirements) by can be changed or add more comments.

**Issued** – If the medication has not yet been given to the student, the column displays the Issue button. To administer the medication to the selected student, click Issue. A green check mark displays in the column to indicate the medication has been given to the student.
Medical Exam Procedures

Overview

On each of the Daily Log exam pages (Dental, Growth, Hearing, Other Exams, Physical, Scoliosis, and Vision), exam results can be added for selected students. A default location and status code(s) can be entered for adding in new records, or enter the information manually.

Entries that are past the building’s limit on days to update (as specified in the “Allow Update on Prior Office Visit” field in the Medical Building Setup page) are display only.

If entering exam records for a group of students is desired, refer to Mass Load Exams section(s) of this document.

To enter a medical exam record in the Daily Log:

1. Select Medical > All > Office and then select the appropriate exam.

   Warning: Any prior Filter used will remain. Do NOT select (Load) for entering individual records until the filter is verified. If you wish to see any existing records for the Test Date, use the next procedure regarding displaying existing records.

2. In the Prompts panel select:
   a. The building for records that will be added.
   b. The test date which defaults to Today’s Date, but may be changed.
   c. If desired, in the Default Location field, enter where the exam was given. The value specified in this field will only default into a new, blank record. It will not update the Location field of any student(s) already listed on the exam page.
   d. If desired, in the Default Status field, enter the status of the exam; for example, P for Pass. The value specified in this field will only default into a new, blank record. It will not update the Status field of any student(s) already listed on the exam page.

3. In the Student Name field, type all or part of the student’s name, then press <Tab>. The matching student OR Student Search window displays students whose name matches. Select the
appropriate student, and then click OK.

For example, if the student’s last name begins with Man and the first name is Robert, type Man, Robert. The Student Search window would list any students whose last name starts with Man and whose first name starts with Robert.

NOTE: If an Exam already exists for the selected student and date, a dialog window will display that ‘An exam already exists for the selected student and date’. The values on the record may be updated and saved, but a new additional record will NOT be added.

4. To view/add additional student exam details, such as notes and referrals, click (Expand) in the left column of the student’s row.

5. Select (Save) to save new entries on the page.

To display a list of students with an existing exam record for a specific test date:

Caution: Care must be taken to NOT re-add the same records on another Test Date. Follow the steps below carefully.

1. Select Medical > All > Office and then select the appropriate exam.
2. In the Prompts > Test Date field using the calendar icon, select the date of the existing records to view.
3. Use a Filter that includes the below example using same date as in the Prompts > Test Date field: (Other items such as, grade or homeroom may be added to the filter.)

<table>
<thead>
<tr>
<th>Area</th>
<th>Field Name</th>
<th>Condition</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hearing</td>
<td>Test Date</td>
<td>=</td>
<td>02/19/2018</td>
</tr>
</tbody>
</table>

4. Select (Load) and the list of student matching the Filter will display. Note that an asterisk (*) next to the student ID indicates that an exam record for this test date has already been saved for the student. In the first row, you can add a student by entering the ID or name. Once any new additional records are complete, then select (Save).

To Delete a medical exam record in the Daily Log:

1. Select Medical > All > Office and then select the appropriate exam.
2. The page defaults for today’s date. Use the above procedures to enter or view existing records.
3. To remove students, click the Delete box on the row for the student(s) to remove, then click (Save) before leaving the page.
Mass Load Exams

On each of the Daily Log exam pages, exam results can be mass added for selected students. For example, general information for vision exams can be mass loaded for a homeroom and then update students as needed.

To Mass Load information in a Daily Log exam page:

1. Select Medical > All > Office and then select the appropriate exam.
2. In the Prompts panel select:
   a. The building for records that will be added.
   b. The test date which defaults to Today’s Date.
   c. If desired, in the Default Location field, enter where the exam was given. The value specified in this field will only default into a new, blank record. It will not update the Location field of any student(s) already listed on the exam page.
   d. If desired, in the Default Status screening field(s), enter the status of the exam; for example, P for Pass. The value specified in this field will only default into a new, blank record. It will not update the Status field of any student(s) already listed on the exam page.
3. In the Filter Panel, enter search criteria to indicate the group of students to be added. The filter will be saved as the default filter for the next time you run the report or option
4. Click (Load) to create the records.
5. The list of records displays. The following items can performed:
   - If students selected by the criteria already had data for the exam date, an asterisk (*) next to the student ID indicates that an exam record for this test date has already been saved for the student, and the specified defaults are not applied because this option does not change existing records.
   - In the first row, you can add a student by entering the ID or name, then press <Tab>. The Student Search window may display students whose name matches. Select the appropriate student, and then click OK.
   - To change information for a specific student, click in the student’s fields and enter data. Records are saved when the focus is moved to a new row.
   - If desired, remove students from the list by clicking the Delete box for the student(s) to remove. The student will be removed when (Save) is selected on the page.
   - To view/add additional student exam details, such as Notes and Referrals, click (Expand).
   - **Reminder for Hearing, Scoliosis and Vision Exams:** If a student fails any portion of the screening a valid state referral and followup MUST be entered.

6. When records on the page are accurate, select (Save).

**Reminders:** There are specific rules in Arkansas for Referral and Follow-ups when pertaining to Vision, Hearing, and Scoliosis. See those areas of the training guide for specifics.

**Note:** If a student fails any portion of the screening a valid state referral and followup MUST be entered.
Hearing Screening Mass Load

On the Daily Log exam page, screening exam results can be entered individually or mass loaded for selected students. For example, general information for hearing exams could be mass loaded for a grade or a homeroom and then update individual students as needed.

This option will add information for a student provided the student does not have existing information for the selected date. If the student does have information entered for the selected date, the Mass Load will not load in new information but the user can update existing data previously saved. Mass Load default values will only default into a new, blank record.

1. Select Medical > All > Office and then select the Hearing exam.
2. In the Prompts panel select:
   a. The building for records that will be added.
   b. The test date which defaults to Today’s Date.
   c. If desired, in the Default Location field, enter where the exam was given. The value specified in this field will only default into a new, blank record. It will not update the Location field of any student(s) already listed on the exam page.
   d. If desired, in the Default Status screening field(s), enter the status of the exam; valid responses are P (Pass) or F (Fail). The value specified in this field will only default into a new, blank record. It will not update the Status field of any student(s) already listed on the exam page.
3. In the Filter Panel, enter search criteria to indicate the group of students to be added. The filter will be saved as the default filter for the next time the option is run.
4. Click 🔄 (Load) to create the records.
5. The list of records displays. The following items can performed:

- If students selected by the criteria already had data for the exam date, an asterisk (*) next to the student ID indicates that an exam record for this test date has already been saved for the student, and the specified defaults are not applied because this option does not change existing records.
- In the first row, you can add a student by entering the ID or name, then press <Tab>. The Student Search window may display students whose name matches. Select the appropriate student, and then click OK.
- To change information for a specific student, click in the student's fields and enter data. Records are saved when the focus is moved to a new row.
- If desired, remove students from the list by clicking the Delete box for the student(s) to remove. The student will be removed when (Save) is selected on the page.
- To view/add additional student exam details, such as Notes and Referral data, click (Expand). \textbf{Reminder for Hearing, Scoliosis and Vision Exams}: If a student fails any portion of the screening a valid state referral and followup MUST be entered. See table below.

6. When records on the page are accurate, select (Save).

\textbf{Note:} To meet Arkansas guidelines if a referral is entered, a follow-up value must be entered. \textbf{Note:} Referral and Follow-up code require a Date entry by the software.

\begin{tabular}{|c|c|c|c|c|c|c|c|}
\hline
\textbf{Valid Referral Codes} & \textbf{Valid Follow-up Codes for Referral of S} & \textbf{Valid Follow-up Codes for Referral U or P} \\
\hline
U – Audiologist & I – In Process & R – Refused Referral \\
P – Family Physician & T – Re-Screened & N – Normal Exam \\
S – School Nurse & X – Left District & J – Treatment \\
& & X – Left District \\
& & I – In Process \\
\hline
\end{tabular}
Scoliosis Screening Mass Load

On the Daily Log exam page, screening exam results can be entered individually or mass loaded for selected students. For example, general information for hearing exams could be mass loaded for a grade or a homeroom and then update individual students as needed.

This option will add information for a student provided the student does not have existing information for the selected date. If the student does have information entered for the selected date, the Mass Load will not add new information but the user can update existing data previously saved. Mass Load default values will only default into a new, blank record.

1. Select Medical > All > Office and then select the Scoliosis exam.

2. In the Prompts panel select:
   a. The building for records that will be added.
   b. The test date which defaults to Today’s Date.
   c. If desired, in the Default Location field, enter where the exam was given. The value specified in this field will only default into a new, blank record. It will not update the Location field of any student(s) already listed on the exam page.
   d. If desired, in the Default Status screening field(s), enter the status of the exam; valid responses are P (Pass) or F (Fail). The value specified in this field will only default into a new, blank record. It will not update the Status field of any student(s) already listed on the exam page.

3. In the Filter Panel, enter search criteria to indicate the group of students to be added. The filter will be saved as the default filter for the next time the option is run.

4. Click (Load) to create the records.
5. The list of records displays. The following items can performed:

- If students selected by the criteria already had data for the exam date, an asterisk (*) next to the student ID indicates that an exam record for this test date has already been saved for the student, and the specified defaults are not applied because this option does not change existing records.

- In the first row, you can add a student by entering the ID or name, then press <Tab>. The Student Search window may display students whose name matches. Select the appropriate student, and then click OK.

- To change information for a specific student, click in the student's fields and enter data. Records are saved when the focus is moved to a new row.

- If desired, remove students from the list by clicking the Delete box for the student(s) to remove. The student will be removed when (Save) is selected on the page.

- To view/add additional student exam details, such as Notes and Referral data, click (Expand). Reminder for Hearing, Scoliosis and Vision Exams: If a student fails any portion of the screening a valid state referral and followup MUST be entered. See table below.

6. When records on the page are accurate, select (Save).

Note: To meet Arkansas guidelines if a referral is entered, a follow-up value must be entered. Note: Referral and Follow-up code require a Date entry by the software.

<table>
<thead>
<tr>
<th>Arkansas State Reporting Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Valid Referral Codes</strong></td>
</tr>
<tr>
<td>O – Orthopedic Physician</td>
</tr>
<tr>
<td>P – Family Physician</td>
</tr>
<tr>
<td>S – School Nurse</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>
Vision Screening Mass Load

On the Daily Log exam page, screening exam results can be entered individually or mass loaded for selected students. For example, general information for hearing exams could be mass loaded for a grade or a homeroom and then update individual students as needed.

This option will add information for a student for the selected date. While not recommended, if the student does have an exam entered for the selected date, the Mass Load could load in an additional exam. See item 2(c) below. Mass Load default values will only default into a new, blank record.

1. Select Medical > All > Office and then select the Vision exam.

2. In the Prompts panel select:
   a. The building for records that will be added.
   b. The test date which defaults to Today's Date.
   c. Do NOT recommend to check Create New Exam Record.
      If this box is checked and the filter criteria selects a student with an exam record for the test date, the student's existing exam record displays with an asterisk and a new row will also display.
   d. The Location field is used to indicate if an Auto Refractor was used in the screening. The value of 'Y' in the Location field will indicate an Auto Refractor was used. Leave the Location field blank/NULL to pull as 'No'. Other values are not valid for SIS. Note: The value specified in this field will only default into a new, blank record. It will not update the Location field of any student(s) already listed on the exam page.
   e. If desired, in the Default Status screening field(s), enter the status of the exam; valid responses are P (Pass) or F (Fail). The value specified in this field will only default into a new, blank record. It will not update the Status field of any student(s) already listed on the exam page.

Note: The Default Status value entered will default into ALL Vision Screening fields with the exception of Right w/Glasses and Left w/Glasses which must be entered individually.

Do NOT check. See 2.c. above.
3. In the Filter Panel, enter search criteria to indicate the group of students to be added. The filter will be saved as the default filter for the next time the option is run.

4. Click ✯ (Load) to create the records.

5. The list of records displays. The following items can be performed:

- If students selected by the criteria already had data for the exam date, an asterisk (*) next to the student ID indicates that an exam record for this test date has already been saved for the student, and the specified defaults are not applied because this option does not change existing records.
- In the first row, you can add a student by entering the ID or name, then press <Tab>. The Student Search window may display students whose name matches. Select the appropriate student, and then click OK.
- To change information for a specific student, click in the student’s fields and enter data. Records are saved when the focus is moved to a new row.
- If desired, remove students from the list by clicking the Delete box for the student(s) to remove. The student will be removed when ✯ (Save) is selected on the page.
- To view/add additional student exam details, such as Notes and Referral data, click ✯ (Expand). **Reminder for Hearing, Scoliosis and Vision Exams**: If a student fails any portion of the screening a valid state referral and followup MUST be entered. See table below.

<table>
<thead>
<tr>
<th>ID</th>
<th>Name</th>
<th>Grade</th>
<th>Location</th>
<th>Time</th>
<th>Right W/O Glasses</th>
<th>Left W/O Glasses</th>
<th>Vision 20</th>
<th>Plus 20</th>
<th>Total 20</th>
<th>LAT MB (Fix)</th>
<th>Vest MB (Fix)</th>
<th>Fusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>17048</td>
<td>Abbott, Emily Jane</td>
<td>06</td>
<td>N</td>
<td>10:28 AM</td>
<td>✯ P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
</tr>
<tr>
<td>16441</td>
<td>Adams, Thomas</td>
<td>06</td>
<td>N</td>
<td>10:28 AM</td>
<td>✯ P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
</tr>
<tr>
<td>16035</td>
<td>Frack, Carol Ann</td>
<td>06</td>
<td>N</td>
<td>10:28 AM</td>
<td>✯ P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
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<tr>
<td>17077</td>
<td>Frack, Charity</td>
<td>06</td>
<td>N</td>
<td>10:28 AM</td>
<td>✯ P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
</tr>
</tbody>
</table>

6. When records on the page are accurate, select ✯ (Save).

**See next page for Arkansas State Reporting Guidelines for Referral/Followup entry.**
**Note:** To meet Arkansas guidelines if a referral is entered, a follow-up value must be entered.
**Note:** Referral and Follow-up code require a Date entry by the software.

<table>
<thead>
<tr>
<th>Arkansas State Reporting Guidelines</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Valid Referral Codes</strong></td>
<td><strong>Valid Follow-up Codes for Referral of S:</strong></td>
</tr>
<tr>
<td>P – Family Physician</td>
<td>I – In Process</td>
</tr>
<tr>
<td>E – Eye Doctor</td>
<td>T – Re-Screened</td>
</tr>
<tr>
<td>S – School Nurse</td>
<td>X – Left District</td>
</tr>
<tr>
<td>G – Guardian can ONLY be used when Colorblind is the only failure</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Immunizations Checklist

Note: Immunization Criteria and Schedules are State Defined, have been pre-loaded by APSCN, and are NOT to be changed at the district level.

The Medical Records System validates student immunizations against required criteria established by the Arkansas Department of Health and the Arkansas Department of Education. This information can then be used to produce letters for students not meeting those requirements.

Immunization Schedules
Determine when vaccines should be given to a student. Schedules are setup only for shots that are part of a series.

Immunization Criteria
Groups the immunization series and schedules together so that all appropriate immunizations for a set of students can be checked at once by the Validate Immunizations program.

Validate Immunizations checks for the following criteria:

<table>
<thead>
<tr>
<th>Criteria 1</th>
<th>Grade KF &amp; 01</th>
<th>DTaP</th>
<th>HepB</th>
<th>IPV/OPV</th>
<th>MMR</th>
<th>Varicella</th>
<th>HepA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Criteria 2</td>
<td>Grade 07</td>
<td>DTaP</td>
<td>HepB</td>
<td>IPV/OPV</td>
<td>MMR</td>
<td>Varicella</td>
<td>TDAP</td>
</tr>
<tr>
<td>Criteria 3</td>
<td>Grade 02-06</td>
<td>DTaP</td>
<td>HepB</td>
<td>IPV/OPV</td>
<td>MMR</td>
<td>Varicella</td>
<td>TDAP</td>
</tr>
<tr>
<td></td>
<td>(11 Yr Old)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Criteria 4</td>
<td>Grade 02-06</td>
<td>DTaP</td>
<td>HepB</td>
<td>IPV/OPV</td>
<td>MMR</td>
<td>Varicella</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(16 Yr Old)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Criteria 5</td>
<td>Grade 08-12</td>
<td>DTaP</td>
<td>HepB</td>
<td>IPV/OPV</td>
<td>MMR</td>
<td>Varicella</td>
<td>TDAP</td>
</tr>
<tr>
<td></td>
<td>(16 Yr Old)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Criteria 6</td>
<td>Grade 08-12</td>
<td>DTaP</td>
<td>HepB</td>
<td>IPV/OPV</td>
<td>MMR</td>
<td>Varicella</td>
<td>TDAP</td>
</tr>
<tr>
<td>Criteria 7</td>
<td>Grade EE</td>
<td>DTaP</td>
<td>HepB</td>
<td>IPV/OPV</td>
<td>MMR</td>
<td>Varicella</td>
<td>TDAP</td>
</tr>
<tr>
<td>Criteria 8</td>
<td>Grade SM/SS</td>
<td>DTaP</td>
<td>HepB</td>
<td>IPV/OPV</td>
<td>MMR</td>
<td>Varicella</td>
<td>TDAP</td>
</tr>
</tbody>
</table>

The above criteria are set up to print a maximum of 99 letters per criteria for each student.
Validating Immunizations and Running Letters

This section details the procedures needed to validate immunizations, and to send letters home to students with immunization deficiencies. For success, it is important to follow the steps given carefully.

Step 1 – Validate Immunizations

Use this page to run the Validate Immunizations process. The system checks the immunizations for a student, based on the immunization criteria and schedules. It determines the status for each immunization, as well as overall status.

1. Select Medical > All > Utilities > Validation Immunizations.
2. Complete prompts for information desired. See below suggestions and field descriptions.

Field Descriptions: (*Asterisk notes a required field)

**Building** - Enter the building code to generate immunization letters. The default building code and description specified in the user's security profile are automatically displayed.

**Calculation Date** - Enter the as-of date to check validations. Select either “Today” or a specific date. Use “Today”, if running at scheduled intervals. The program will check the status of immunizations as of this date; for example, whether a shot is overdue based on the date entered.

**Active Students Only** - Checked if only students who are active in Registration should be checked.

**Series Types** – Select whether all immunization series should be processed or only specified ones. The series list will be further limited to those included in the criteria selected.
- To include all series, select ✶ (asterisk) which will pull all values.
- To include only certain series, choose the values from the drop down.

Criteria List - Select whether all criteria should be processed or only specified ones.
- To include all criteria, select ✶ (asterisk) which will pull all values.
- To include only certain criteria, choose the values from the drop down.

Note: Students are picked up by the first criterion that applies to them.

Margin Of Error - To accept student vaccinations that occurred ahead of schedule, enter the number of days or months to be allowed here. This prompt contains two slots: in the first, enter the number, the second slot, select D (Days) or M (Months). The number default is zero, which means that any vaccinations occurring before the system-calculated due date would be invalid.

For example, if a particular dose should have occurred on or after the student's first birthday, but occurred 4 days before the student's birthday, and 0 is entered at this prompt, this dosage would be considered invalid. If 4 D is entered at this prompt, then the dose would be considered valid.

This prompt is used in conjunction with the Apply Margin of Error to Dose prompt.

Apply Margin Of Error To Doses - The dose number to which the margin of error should be applied.
- To apply the margin to all doses, choose All.
- To apply the margin to selected doses, choose Selected. Then enter the dose numbers in a comma-delimited list.

Status List – Select whether the system should recalculate all statuses or only specified ones.
- To include all statuses, select ✶ (asterisk) which will pull all values.
- To include only certain series, choose the values from the drop down.

Calculate Overall Status On: Indicates whether the students' Overall Status should be calculated based on all series types or on selected series types. Select:
- To calculate the Overall Status based on all series types included in a student's immunization criteria, select ✶ (asterisk) which will pull all values. If selected to calculate immunizations for selected series types, it is possible that not all immunization series records will have been validated for the calculation date.
- To calculate the Overall Status based on selected series types, choose the values from the drop down.

Caution: Using the Selected option may result in a student's Overall Status being set to Meets Requirements based on the immunizations selected when another series that was not included is overdue.

Generate Letters - to create the notification letter merge file. The merge file can then be downloaded to the PC and merged with form letters created in Microsoft® Office Word. This can also be chosen in the Send Communications option after verifying the Validation records.

Generate Notifications - to send immunization notifications electronically via the PLUS 360 Notifications engine to subscribed users configured to receive notifications and optional email notifications.

Generate Grade Period Alerts - Checked if the validation should send immunization email alerts after student grace periods expire. Alerts are sent to:
- An internal user whose email address is specified in the Medical Building Setup. The email lists all students who are not in compliance with the immunization schedule after the grace period has expired.
- Guardians, if the Medical Building Setup's Send Alert Email to Parents box is checked.
This field is enabled if the building is set up to use immunization record alerts in the Medical Building Setup. Otherwise, it is disabled.

3. Set any needed Filter. Normally, this is only to eliminate grade PK students.

<table>
<thead>
<tr>
<th>#</th>
<th>Area</th>
<th>Field Name</th>
<th>Condition</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Demographic</td>
<td>Grade</td>
<td>Is not in</td>
<td>PK - Pre-Kindergarten</td>
</tr>
</tbody>
</table>

4. Select Run in the upper right of the page.

5. After the Validation runs, check the **Immune Validation** log to verify completion. The log may be retrieved by selecting the Tasks/Reports dropdown from the Navigational Bar OR click on the Tasks/Reports bar to open the page.

**Note:** Most of the information on this log is simply informational. Running the Generate Communication List report is best for checking out of compliance records. See next section for instructions on running the Generated Communication List.

**Sample Validate Immunizations Log**
Step 2 – Generate Communication List

Menu Access: Medical > All > Communications > Generate Communication List

Use this report to print information regarding the letters generated by the Validate Immunizations option. The Generated Letters Listing lists for each criteria, the immunization deficiencies found for a student, the student’s ID and name, the calculation date, date printed (if any), the reason for the immunization being listed as deficient, and the number of times the student has been notified. The report is by building and must be repeated if multiple buildings are to be run.

It is recommended this report be checked against the immunizations entered for verification before letters are printed. Using this report, adjust Immunizations with any needed updates. If updates were made, rerun the Validate Immunizations(s) and Generate Communication List. Once this listing contains only students who should receive letters, continue with the next step which is Send Communications.

Field Descriptions: (*Asterisk notes a required field)

Building – Select the building of the students to include in the report. The report displays letters generated for students enrolled in the specified building.

Start Date – Select By Date to use a set date as the start date of the report. Enter the date to begin checking for letter calculations. This refers to the date on which a calculation was run, not the date that resulted in a letter. For example, if the most recent Validate Immunizations(s) was run yesterday, that would be the date entered. Tip: If there were no students that were eligible for a letter in the Immunization Validation run for a date then that Validation date will not be available.

End Date – Select By Date to use a set date as the end date of the report. Enter the last date to check for letter calculations. This refers to the date on which a calculation was run, not the date that resulted in a letter. For example, if the most recent Validate Immunizations was run yesterday, that would be the date entered.
Log Statistics – Checked if the prompts are to be printed as the first page of the report. Otherwise, when running the report, a log page will only be created if an error occurs.

Notifications Listing Procedures

1. Complete prompts for information desired.
2. Select (Run) to process the report.
3. Check the Generated Medical Letter Listing file under the Tasks/Reports area.
   - It is recommended this report be checked against the immunizations entered for verification before letters are printed.
   - Using this report, adjust Immunizations with any needed updates.
   - If updates were made, rerun the Validate Immunizations and Generate Communication List.
   - Once the Generated Medical Letter Listing contains only students who should receive letters, continue with the next step which is Send Communications.

Note: If any errors were encountered during processing, a Generated Medical Letter Listing Errors Error file will exist and should be checked.

Sample Notifications Listing reports

![Sample Notifications Listing report 1](image1)

![Sample Notifications Listing report 2](image2)
**Step 3 - Send Communications**

**Menu Access: Medical > All > Communications > Send Communications**

Use this option to create a data file that can be used to merge with a template letter file(s) to create immunization letters. The information included in the data file depends on the immunization criteria as well as which students have not met their immunization requirements.

**Note:** Before running the Generate Medical Letter Merge File, the Validate Immunizations program must be run to determine which students are not up to date. The Generated Letters Listing is used in verifying records that will receive letters. These are steps 1 and 2 of this document.

**Generate Medical Letter Merge File screen**

![Generate Medical Letter Merge File screen](image)

**Field Descriptions: (*Asterisk notes a required field)**

**Building** - Select the enrollment building of the students for which to generate letters.

**Calc Date** - Select the most recent Validate Immunizations calculation date for which to generate the merge file. A date can only be selected if letters have not been printed for that calculation date.

**Communication Method** - Select whether to generate the merge file to send letters to parents/guardians, send notifications electronically via the PLUS 360 Notifications engine, or both. Select:

- **Generate Letters** - to create the notification letter file. The letter file can then be downloaded to the PC and merged with form letters created in Microsoft® Office Word. This can also be chosen in the Send Notifications option after verifying the Validation records.

- **Generate Notifications** - to send immunization notifications electronically via the PLUS 360 Notifications engine to subscribed users configured to receive notifications and optional email notifications.
Include History – Check if immunization history is to be included for the immunization details included in the letter. If history is not to be included, the merge file includes the immunization, requirement, reason, and notification information for each schedule for which the student has a letter record.

Filter section - Enter search criteria to indicate the group of students to be run.

Sort section – Sorting allows specifying how records should be ordered in a report.

Send Notifications Procedures

1. Complete prompts for information desired.
2. Select any needed filter, such as, grade(s).
3. Select any desired Sort.
4. Select (Run) to process report.
5. Locate the med.txt file under the Tasks/Reports area. Right-click and save the file to the desired location. This file will be used in an Office Word mail merge to create letters. See APSCN Website (www.apscn.org) > SMS > 4.0 Training Documentation > Medical area for help with creating letters using Microsoft Word Letter Merge.
Medical Merge Fields

Medical merge codes are fields from Immunization information and demographic information that may be used to pull in Immunization information to a data file that will later be merged with the letter template created in Word. These files are used to create Immunization letters. Below is a list of the codes that may be pulled into the Immunization letters.

1. building
2. calc_date
3. contact_apartment
4. contact_city
5. contact_complex
6. contact_email
7. contact_email_preference
8. contact_first_name
9. contact_last_name
10. contact_name
11. contact_state
12. contact_street_name
13. contact_street_number
14. contact_street_prefix
15. contact_street_suffix
16. contact_street_type
17. contact_title
18. contact_zip
19. immune_notify
20. respond_to_email
21. student_apartment
22. student_city
23. student_complex
24. student_first_name
25. student_id
26. student_last_name
27. student_name
28. student_state
29. student_street_name
30. student_street_number
31. student_street_prefix
32. student_street_suffix
33. student_street_type
34. student_zip
Utilities

Mass Add Medication Doses

Menu Access: Medical > All > Utilities > Mass Add Medication Doses

Use this page to mass add PRN medications for students. For example, mass add records to indicate that all students can receive Benadryl and Tylenol. Then update individual student records if a student's emergency information indicates that their parents have not given permission for the students to be given the non-prescription medications.

Field Descriptions: (*Asterisk notes a required field)

Building - Enrollment building for which to add medication(s) to students.

Medications - Select the PRN medications to mass add to students. Choose the values from the drop down. Selecting the * (asterisk) will pull all values.

Start Date - Date on which the students may start receiving the medication.

End Date - Last date on which the students may receive the medication.

To Mass Add PRN medications:

1. Select Medical > All > Utilities > Mass Add Medication Doses.
2. On the Prompts panel, enter the PRN medication information to add.
3. On the Filter panel, enter criteria to search for the students to update.
4. Click (Load) to run the search and display students on the Selected Students panel.
5. Review the records carefully.
6. If a student should not be included in the update, select the student's (Delete) checkbox, then click (Delete) on the right side of the Selected Students panel title bar to remove the record.
7. Click (Run).
8. Use the Tasks/Reports options on the Navigation bar to view task status and retrieve reports.
Medical Reports

Menu Access: Medical > All > Reports

Medical Report Options

Medical Center has several reports and they allow users to configure how the report displays information by filtering and sorting information, and setting up whether to run the report on demand or on a specified schedule.

1. Select appropriate Medical Report.
2. Indicate how the report is to be run completing the appropriate sections of the page as shown below.

Filter

Filters allow users to select the records to include in a report or in a process. The system compares the criteria against the corresponding fields in the records being searched and selects only those records containing data that matches. The filter will be saved as the default filter for the next time the report is run.

To filter the records processed:

1. In the criteria lines, define the criteria to select records.

- **Area**: Select the table to search.
- **Field Name**: Select the field to search.
- **Condition**: Select the condition to use for search. The conditions available depend on the selected field's data type.
- **Value**: Enter the value on which to search. If using the *Is In* condition, enter a comma-delimited list of values.

2. If defining more than one line of criteria, select either *And* or *Or* for any additional line in the Filter.
   - **And** - to limit records retrieved to those matching all criteria specified.
   - **Or** - to return records that match the criteria line or the criteria line above it.
Sorting
Sorting allows users to specify how records should be ordered in a report. Enter lines of sort criteria and the system compares the sort criteria against the corresponding fields in the records being searched and prints records in either ascending or descending order based on the sort fields.

To sort the records processed:
1. Select the appropriate sort criteria from the drop-down lists:

   - **Area**: The table to use to sort.
   - **Field Name**: The field to use to sort based on values.
   - **Sort Order**: Defines how to sort values. Users can sort in ascending or descending order.

2. If needed, add another line to the sort. Repeat Step 1 to add a line of criterion.

To Schedule Reports:
Use the *Run* option to schedule when a report should run. Some reports can be scheduled for a single time; others can be run daily, weekly, or monthly.

To schedule a report:
1. Select the appropriate option in the Schedule section of the page.

   - **Now** – Runs the report immediately, rather than scheduling it.
   - **Once** – Sets up the report to run at one specific time and date.  
     **Time**: Enter the time that the report should run. Click a.m. or p.m.  
     **Date**: Enter the date that the report should run.
   - **Daily** – Runs the report either once a day or once every few days.  
     **Time**: Enter the time that the report should run.  
     **Interval**: Enter 1 to run every day. Enter a higher number to run every *nth* day; for example, 2 to run every other day.
   - **Weekly** – Runs the report either once a week or once every few weeks.  
     **Time**: Enter the time that the report should run.  
     **Interval**: Enter 1 to run every week. Enter a higher number to run every *nth* week; for example, 2 to run every other week.  
     **Days of the Week**: Check the day of the week that the report should run on. Users can check multiple days, if desired, for example, Monday and Friday.
   - **Monthly** – Runs the report on a specific day each month.  
     **Time**: Enter the time that the report should run.  
     **Day of the Month**: Enter the day number on which the report should run.

2. After clicking *Run*, retrieve the report from either the Tasks/Reports dropdown in the Navigational Bar or click on the Tasks/Reports bar to open the page.
Daily Log Report

Menu Access: Medical > All > Reports > Daily Log

Use this page to run a report for students who had office visits during the selected time period. The Daily Log Report can contain office visit details, medicines issued, and notes for each student. The report Sort default is by Office Visit Date In, but can be adjusted by user.

Field Descriptions: (*Asterisk notes a required field)

Building* – Select the building of the students to include in the report. The default is the user’s default security building. If the user only has security for this building, this field is display only.

From Date* –
- Select By Date to use a set date as the start date. Enter the first date to check or leave blank to include all information from the beginning of the year.
- Select By Prior Days to run the report for a set number of days. Enter the total number of days to include in the report. Prior days count backward from the end date. This option is useful if scheduling the report to run periodically.

To Date* –
- Today - to use today as the last date to check. This option is useful if scheduling the report to run periodically.
- By Date - to use a set date as the end date of the report. Enter the last date to check, or leave blank to include all information from the start date until the end of the school year.

Include – Select the appropriate information to include on the Daily Log report:
- Office Visit Detail - checked to include information from the Office Visit page.
- Medication Issued - checked to include information from the Medication Log page.
- Notes - checked to include notes entered on the Office Visit page.
Log Statistics – Checked if the prompts are to be printed as the first page of the report. Otherwise, when running the report, a log page will only be created if an error occurs.

Daily Log Sample Report

File name – Daily Log Report

<table>
<thead>
<tr>
<th>Student Id</th>
<th>Name</th>
<th>Date</th>
<th>In Time</th>
<th>Out Time</th>
<th>Room</th>
<th>Pressure</th>
<th>Puls</th>
<th>Temp</th>
<th>Resp</th>
<th>Instr</th>
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</thead>
<tbody>
<tr>
<td>16021</td>
<td>Jones, Sarah</td>
<td>10/22/2015</td>
<td>10/22/2015 8:30:00 AM</td>
<td></td>
<td>-</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>#</th>
<th>Reason</th>
<th>Reason Description</th>
<th>Intervention</th>
<th>Intervention Description</th>
<th>Outcome</th>
<th>Outcome Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>BL</td>
<td>Blister</td>
<td>BA</td>
<td>Bandaid</td>
<td>BTC</td>
<td>Student Sent Back to Cla</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Student Id</th>
<th>Name</th>
<th>Date</th>
<th>In Time</th>
<th>Out Time</th>
<th>Room</th>
<th>Pressure</th>
<th>Puls</th>
<th>Temp</th>
<th>Resp</th>
<th>Instr</th>
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</thead>
<tbody>
<tr>
<td>16033</td>
<td>Banks, Sarah</td>
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<td>10/22/2015 8:40:00 AM</td>
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<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>#</th>
<th>Reason</th>
<th>Reason Description</th>
<th>Intervention</th>
<th>Intervention Description</th>
<th>Outcome</th>
<th>Outcome Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>C</td>
<td>Coughing</td>
<td>L0Z</td>
<td>Lozenge</td>
<td>BTC</td>
<td>Student Sent Back to Cla</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Student Id</th>
<th>Name</th>
<th>Date</th>
<th>In Time</th>
<th>Out Time</th>
<th>Room</th>
<th>Pressure</th>
<th>Puls</th>
<th>Temp</th>
<th>Resp</th>
<th>Instr</th>
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</thead>
<tbody>
<tr>
<td>16023</td>
<td>Johnson, Rudy</td>
<td>10/22/2015</td>
<td>10/22/2015 10:00:00 AM</td>
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<thead>
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<th>#</th>
<th>Reason</th>
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<th>Intervention</th>
<th>Intervention Description</th>
<th>Outcome</th>
<th>Outcome Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>AB</td>
<td>Auration</td>
<td>BA</td>
<td>Bandaid</td>
<td>BTC</td>
<td>Student Sent Back to Cla</td>
</tr>
</tbody>
</table>
Medical Card Report

Menu Access: Medical > All > Reports > Medical Card

Use this page to run a report containing medical information for students. The Medical Card Report contains basic information for each student, such as name and date of birth, as well as selected student medical records.

Medical Card Report Upper section

Field Descriptions: (*Asterisk notes a required field)

Building – Select the building of the students to include in the report. The default is the user’s default security building. If the user only has security for this building, this field is display only.

Start Date –
- **By Date** - to use a set date as the start date. Enter the first date to check.
- **By Prior Days** - to run the report for a set number of days prior to the end date. Enter the total days to include in the report. This option is useful if scheduling the report to run periodically.

End Date –
- **Today** - to use today as the last date to check. This option is useful if scheduling the report to run periodically.
- **By Date** - to use a set date as the end date of the report. Enter the last date to check.

New Page for each student – Check to print a separate page for each student.

Log Statistics – Checked if the prompts are to be printed as the first page of the report. Otherwise, when running the report, a log page will only be created if an error occurs.
Include the following information

When generating the report, data can be selected from student medical records to be included, when available, including general information, referrals, notes, and other details entered for the student.

♦ **Dental** - Check to include data entered on the Dental page, including dental test date, grade, location, and referral information and notes for each date, when available.

♦ **Growth** – Check to include data entered on the Growth page, including general information such as test date, height, weight, and referral information and notes for each date, when available.

♦ **Hearing** – Check to include data entered on the Hearing page, including test date, grade, location, hearing test results, and referral information and notes for each date, when available.

♦ **Physical** – Check to include data entered on the Physical page, including the student's test date, test results for each component of the physical exam, and referral information and notes for each date, when available.

♦ **Scoliosis** - Check to include data entered on the Scoliosis page, including test date, grade, location, and referral information and notes for each date, when available.

♦ **Vision** - Check to include data entered on the Vision page, including test date, grade, location, vision test results, and referral information and notes for each date, when available.

♦ **Medication Issued** - Check to include data entered on the Rx/Tx Log page, including medication(s) given to a student, date, time, dose, comment, and initials of the person administering the medication.

♦ **Office Visit** - Check to include data entered on the Office Visit page, including date, time in/out, blood pressure, pulse, temperature, respiratory rate, the classroom the student was in before coming to the nurse's office, initials of the person making the entry, reason for nurse's office visit, intervention given to the student, the outcome, and any referrals or notes.

♦ **Medical Alert** - Check to include data entered on the Medical Alerts tab of the Emergency page, including the medical alert code, description, and comments.

♦ **Medical Disability** - Check to include data entered on the Disabilities tab of the Emergency page, including the disability code, description, and primary disability information.

♦ **Vaccination** - Check to include data entered on the Immunization page, including vaccination, dose, exemption, override, had disease, disease date, and Immunization dates. the series total, the shots total, dates, series status, and any referrals.

**Note:** If Vaccination is chosen, the report will include all shots the student has received. If series is chosen, it will show how the shot dates were rolled up into series records for validation.

♦ **Codes Legend** - Check to display a legend on the report defining all medical codes. The listing of codes will print at the end of the complete report.
Sample Medical Card

File name – Medical Card Report

Medical Card Report

<table>
<thead>
<tr>
<th>Student Id</th>
<th>Name</th>
<th>Gender</th>
<th>Grade</th>
<th>DOB</th>
<th>Status</th>
<th>Counselor</th>
</tr>
</thead>
<tbody>
<tr>
<td>16014</td>
<td>Harris, Jasmine</td>
<td>F</td>
<td>10</td>
<td>10/20/1997</td>
<td>A</td>
<td>T1677MP</td>
</tr>
</tbody>
</table>

**Hearing Test**

<table>
<thead>
<tr>
<th>Test Date</th>
<th>Grade</th>
<th>Location</th>
<th>Right Ear</th>
<th>Left Ear</th>
</tr>
</thead>
<tbody>
<tr>
<td>3/18/2004</td>
<td>10</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12/30/2005</td>
<td>10</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Scoliosis Exam**

<table>
<thead>
<tr>
<th>Date</th>
<th>Grade</th>
<th>Location</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>12/30/2005</td>
<td>10</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Vision Test**

<table>
<thead>
<tr>
<th>Date</th>
<th>Grade</th>
<th>Location</th>
<th>Right</th>
<th>Left</th>
</tr>
</thead>
<tbody>
<tr>
<td>12/30/2005</td>
<td>10</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Immunization Shots**

<table>
<thead>
<tr>
<th>Shot Code</th>
<th>Dose</th>
<th>Exempt</th>
<th>Override</th>
<th>Had Disease</th>
<th>Disease Date</th>
<th>Immunization Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>DTaP</td>
<td>0</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TDaP</td>
<td>0</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IPV/OPV</td>
<td>0</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Polio</td>
<td>0</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HepB</td>
<td>0</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MMR</td>
<td>0</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varicella</td>
<td>0</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DPT</td>
<td>0</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>EPSDT</td>
<td>0</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Immunization Series**

<table>
<thead>
<tr>
<th>Series Code</th>
<th>Dose</th>
<th>Status</th>
<th>As Of</th>
<th>Overdue</th>
<th>Had Disease</th>
<th>Disease Date</th>
<th>Immunization Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>DTaP</td>
<td>0</td>
<td>OV</td>
<td>10/22/2015</td>
<td>N</td>
<td>N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TDaP</td>
<td>0</td>
<td>OV</td>
<td>10/22/2015</td>
<td>N</td>
<td>N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IPV/OPV</td>
<td>0</td>
<td>OV</td>
<td>10/22/2015</td>
<td>N</td>
<td>N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Polio</td>
<td>0</td>
<td>NA</td>
<td>7/27/2011</td>
<td>N</td>
<td>N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HepB</td>
<td>0</td>
<td>OV</td>
<td>10/22/2015</td>
<td>N</td>
<td>N</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Vision Notice to Parents

The Vision Notice to Parents generates letters to notify the guardian when the student has not passed their most recent vision exam and the reason for failure. The report indicates if the student was screened with glasses. The lower portion of the report is a doctor’s return evaluation. The report prints letters for ALL students with vision failings for the prompted dates whose most recent Followup code is not N, J, L, or A. Criteria must be set to eliminate printing inactive students.

Menu Access: Medical > All > Reports > Vision Notice to Parents

Sample Vision Notice to Parents page

Field Descriptions: (*Asterisk notes a required field)

Building* – Pulls default building of the user or default returns from last session of report use.

Report Date* – This date prints in the upper right of the Notice to Parents Report.

From Date* – The earliest vision test date to be included in the letters.

To Date* – The most recent vision test date to be included in the letters.

Filter Area – Use this option to limit the records when processing the report.

Sort Area - Use this option to specify how the report pages will be sorted. Default is to sort by student name and ID.

Procedures

1. Select Medical Center > Reports > Vision Notice to Parents.
2. Select the building for the report.
3. Select the Report, Start and End Dates.
4. To specify criteria use the Filter area.

Note: The report prints letters for ALL students with vision failings for the prompted dates and criteria must be set to eliminate printing inactive students a letter.
5. Select **Run** to process the report.

6. When the task is complete select **Vision Notice to Parents** from the **Tasks/Reports** page for viewing and printing.

**Sample Vision Notice to Parents Report (Custom)**

**File name – Vision Notice to Parents**

---

**NOTICE TO PARENTS OF NEED FOR AN EYE AND VISION EXAMINATION**

**Date:** 4/5/2018  
**School:** Building 16

**Student:** Banks, Lisa Marie  
**Grade:** 01  
**Teacher:** Mr. Christopher

- **Screened with Glasses:**  
  - YES  
  - NO  

**Reason for Not Passing:**

- **Blurred vision at a distance:**  
  - X  
  - Eye Muscle Problem  
- **Blurred vision at near:**  
  - X  

- **Eye Health:**  
  - X  
  - Plus (+) Lens Test  
- **Other:**  
  - 

**Dear Parent,**

Your child’s performance in school is dependent on his/her ability to see. Eighty percent (80%) of what is learned comes through our eyes. According to Arkansas Code Annotated 6-18-1502, a child who does not pass the eye and vision screening shall be required to have a comprehensive eye and vision examination conducted by an optometrist or ophthalmologist within sixty (60) days of receipt of vision screening report. If you should need assistance in locating an eye doctor, please contact the school nurse. Thank you for your cooperation.

Parent authorization to release medical information (Signature) ____________________________

**School Nurse Signature** ____________________________

---

**REPORT OF DOCTOR'S EVALUATION**

**Visual Acuity**

- **Without Rx**
  - Right: 20/20  
  - Left: 20/20
- **With Rx**
  - Right: 20/20  
  - Left: 20/20

**Eye Muscles**

- **A-Normal**  
- **B-Subnormal**

**Accommodation:**  
**Convergence:**  
**Binocularity:**  
**Eye Movement:**

**Eye/Vision Diagnosis**

- **Right:** Hyperopia  
  - Myopia  
  - Astigmatism  
  - Amblyopia  
  - Muscle Problem  
- **Left:** Hyperopia  
  - Myopia  
  - Astigmatism  
  - Amblyopia  
  - Muscle Problem

**Internal and External Eye Health**

**Glasses Prescribed:** Yes  
**To be worn:** Full Time  
**Distance only:**  
**Reading only:**

**Other problems (comments or instructions)**

**Date of Examination** / /  
**Date of Re-Examination** / /  

**Examiner's Name:** ____________________________  
**Signature:** ____________________________

**Address:** ____________________________  
**Phone:** ____________________________  
**Date:**

Please fax this form to: **School Nurse**  
**Fax Number**

OR Mail this form to: ____________________________
Vision Summary Report

The Vision Screening Summary Report allows the choice of generating either a summary or a detail report. The Detail type report is a listing format. The report will be generated with either screening values from the most recently entered data or if no data exists, a blank line will print under each screening column. The Summary type report is a matrix format. The report shows student totals by grade for different vision screening statuses. Vision exam records in the Summary type report will include those that were administered within the prompted date range.

Menu Access: Medical > All > Reports > Vision Summary

Sample Vision Summary Page

Field Descriptions: (*Asterisk notes a required field)

Building* - Pulls default building of the user or default returns from last session of report use.
From Date* – The earliest vision test date to be included in the report.
To Date* – The most recent vision test date to be included in the report.
Report Type* – Choose between Detail or Summary reports.
Form Completed By – The name to appear on the Summary type report. This field is not applicable for the Detail type report.
Email Address – The email address to appear on the Summary report. This field is not applicable for the Detail type report.
Screener/Title – The name and title of the vision screener(s). Up to 5 screeners and titles may be entered. This field is not applicable for the Detail type report.
Filter Area – Use this option to limit the records when processing the report.

Procedures

1. Select Medical > All > Reports > Vision Summary.
2. Select the building for the report.
3. Select the Start Date and End Date.
4. Select the Report Type of either Detail or Summary.
   Note: The file name will differ depending on the Report Type chosen.
5. Enter the fields of Forms Completed By, Email Address, and Screener/Title, if printing the Summary type report. These fields are not applicable to the Detail type report.
6. To specify criteria use the Filter area.
   Note: Unless criteria is set, all vision exam records that were administered within the prompted date range including inactive students will be included in the Summary type report counts.
7. Click Run to process the Summary Report.
8. When the task is complete select the report from the Task/Reports page for viewing and printing.

Detail Type

The report sorts by grade and homeroom teacher breaking by the homeroom teacher. The listing subtotals Pass/Fail counts by teacher. Failure of color perception test is not reported as vision failure.

Sample Summary Report – Detail type

Report file name – Vision Detail Form
Log file name – Vision Detail Form Log

Below example shows report example when vision data has been entered for students.
Below shows **Detail Type** report example when vision data has not been entered for students. This information can be used for recording screening data.

### Vision Screening

<table>
<thead>
<tr>
<th>Name</th>
<th>External Exam</th>
<th>Vision 20'</th>
<th>+2.00 Test 20'</th>
<th>Lat. MB (Far)</th>
<th>Vert. MB (Far)</th>
<th>Fusion (Far)</th>
<th>Lat. MB (near)</th>
<th>Fusion (near)</th>
<th>Color</th>
<th>Pass/Fail (rescreen)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fujie, Chiharu</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hall, Tyrone, III</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Martinez, Julio</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Velazquez, Carmen David</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Pass:</strong></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total Fail:</strong></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

**Summary Type**

This is a wide report. The report shows student totals by grade for different vision screening statuses. Vision exam records in the Summary type report will include those that were administered within the prompted date range.

Definitions of Summary Report rows:

- **Screened** – Unduplicated count of screenings.
- **Rescreened** – Unduplicated count of records with Follow-up of ‘T’.
- **Referred** – Unduplicated count of records with Referral of ‘P’ or ‘E’.
- **Confirmed Difficulty by Professional** – Follow-up of ‘L’, ‘J’, or ‘A’.
- **Confirmed Normal Eye/Vision by Professional** – Follow-up of ‘N’.

**Summary Report – Summary type**

File name – *Vision Summary Form*
Log file name – *Vision Summary Form Log*
Medical Tables

The following tables were created by APSCN. The Location Table is the ONLY table where additions are allowed. Do NOT edit any medical tables other than Location. If there are suggestions regarding additions to any of the other tables, please e-mail APSCN at adehelpsms@arkansas.gov.

Medical Tables are listed below with the location of the table use within eSchoolPlus. Values are selected from a drop down menu on the applicable pages.

Cognos Medical Table Listings

Medical Table Listings with table values are available in Cognos as shown below:

Location: Medical > General Student Medical
Name: APSCN Medical Table List
Description: The Medical Table List provides the current values of the eSchool tables used in the Medical module. Users can select the desired tables from the prompt on this report. NOTE: With the exception of the Location table, all tables are maintained by the state and should not be adjusted at the district level. The Location table can be maintained at the district level.

Alerts
The Alerts table is used in the eSchoolPlus page of Medical > All > Student > Emergency > on the Alerts panel.

Disability
The Disability table is used in the eSchoolPlus page of Medical > All > Student > Emergency > on the Disability panel.

Exemption
The Exemption table is used in the eSchoolPlus page of Medical > All > Student > Immunizations.

Follow-up
The Followup table is used within several eSchoolPlus Medical locations where a Referral Detail section is available.

Note: There are specific rules in Arkansas for Referral and Follow-ups when pertaining to Vision, Hearing, and Scoliosis. See those areas of the training guide for specifics.

Lens Types
The Lens table is used in the eSchoolPlus Medical Vision Exam areas of Medical > All > Student > Exams > Vision panel and Medical > All > Office > Vision. The Lens values of ‘Y’ or ‘N’ are selected from the drop down menu.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>Student Not Tested with Corrective Lens</td>
</tr>
<tr>
<td>Y</td>
<td>Student Tested with Corrective Lens</td>
</tr>
</tbody>
</table>

Location
The Location medical table is used within several eSchoolPlus Medical areas.

Do NOT remove the ‘Y – Refractor Used’ Location code. This is used in Vision coding for state reporting. See Vision Exam section of this document for use detail.

School districts may add additional information to this table. Contact your system administrator for assistance in adding to this table.
Medicines
The Medicines table is used in the following locations within eSchoolPlus:

- Medical > All > Student > Medication Requirements
- Student > All > Student > Medication Log
- Student > All > Student > Office Visits
- Medical > All > Office > Daily Log

Outcomes
The Outcomes table is used in the following locations within eSchoolPlus:

- Medical > All > Student > Office Visit
- Medical > All > Office > Daily Log.

Referral
The Referral table is used within several eSchoolPlus Medical locations where a Referral Detail section is available.

Note: There are specific rules in Arkansas for Referral and Follow-ups when pertaining to Vision, Hearing, and Scoliosis. See those areas of the training guide for specifics.

Source Document
The Source Document table is used in the eSchoolPlus page of Medical > All > Student > Immunizations.

Screenings (Other)
The Screenings (Other) is used in the following locations within eSchoolPlus:

- Medical > All > Student > Exams > Other Screenings panel
- Medical > All > Office > Other Exams.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Comments</td>
</tr>
<tr>
<td></td>
<td>Converted Comments</td>
</tr>
<tr>
<td>Lice</td>
<td>Head Lice</td>
</tr>
</tbody>
</table>

Interventions
The Interventions table is used in the following locations within eSchoolPlus:

- Medical > All > Student > Office Visits
- Medical > All > Office > Daily Log

Vaccinations
The Vaccinations table is used in the eSchoolPlus page of Medical > All > Student > Immunizations.

Visit Reasons
The Visit Reasons table is used in the following locations within eSchoolPlus:

- Medical > All > Student > Office Visits
- Medical > All > Office > Daily Log

BMI Status
The BMI Status table is used in the eSchoolPlus page of Medical > All > Student > Exams > Growth Panel. The values are calculated upon entry of the Height and Weight of a student.
## Guide Changes for School Year 2019-2020

<table>
<thead>
<tr>
<th>Date</th>
<th>Item</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>8/16/2019</td>
<td>Added information on Auto Refractor in relation to the Location field on Vision screenings.</td>
<td>27,28,55</td>
</tr>
<tr>
<td>8/16/2019</td>
<td>Start Date/End Date – adjusted definitions</td>
<td>72</td>
</tr>
<tr>
<td>8/16/2019</td>
<td>Location Table adjustment</td>
<td>80</td>
</tr>
</tbody>
</table>