

eSchoolPlus+

Medical Training Guide

Version 23



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Arkansas Public School Computer Network



**DIVISION OF ELEMENTARY
& SECONDARY EDUCATION**

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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/BMI (SIS Cycle 7/June)**
- **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 7/June)**

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.

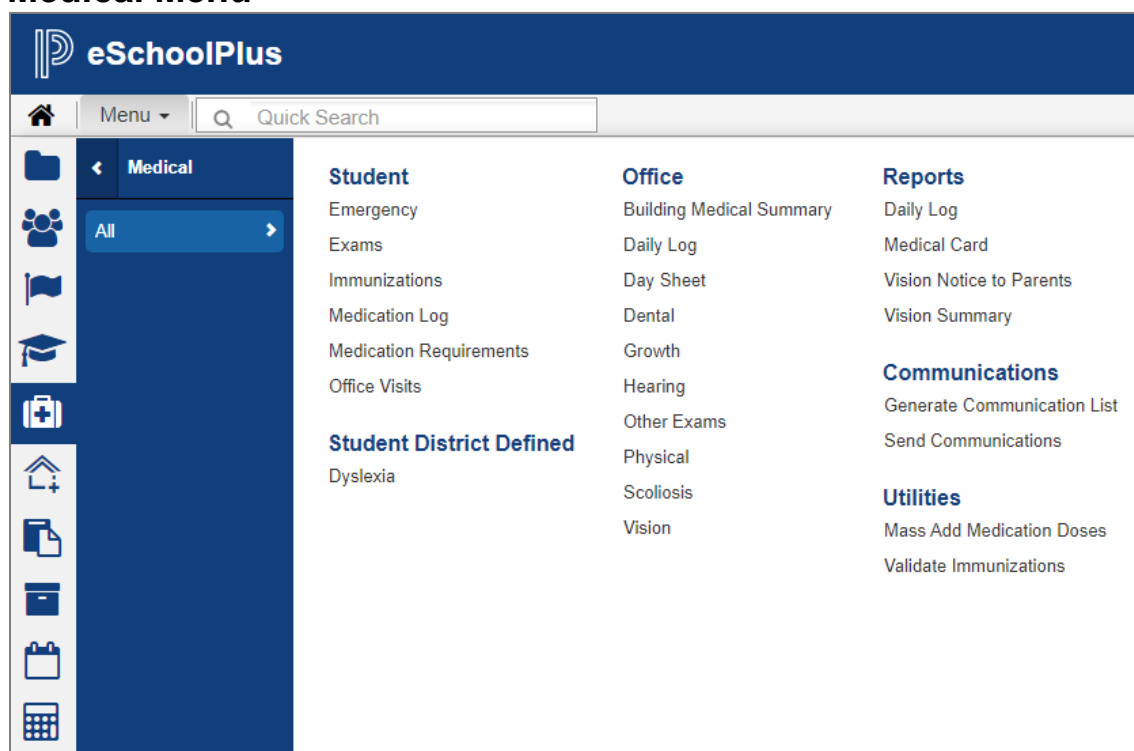
Medical Tables are listed at the back of this document. The Location Table is the only table where additions are allowed. Do NOT edit any medical tables other than Location.

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, Pulse Ox, Temperature, Temperature Method, Respiration, Room, Initials, and Comments for a single student.

Student Search

The Navigational Bar



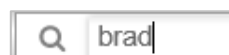
Returns the user to their **Home** page from anywhere in eSchoolPlus.



Click to open the **Menu** listing.



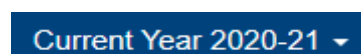
Quick Search is used to enter a search for an active student or a page. The magnifying glass icon is used to open the Student Search.



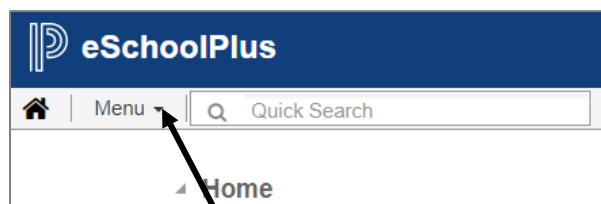
Tasks and Reports are accessible from all pages.



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



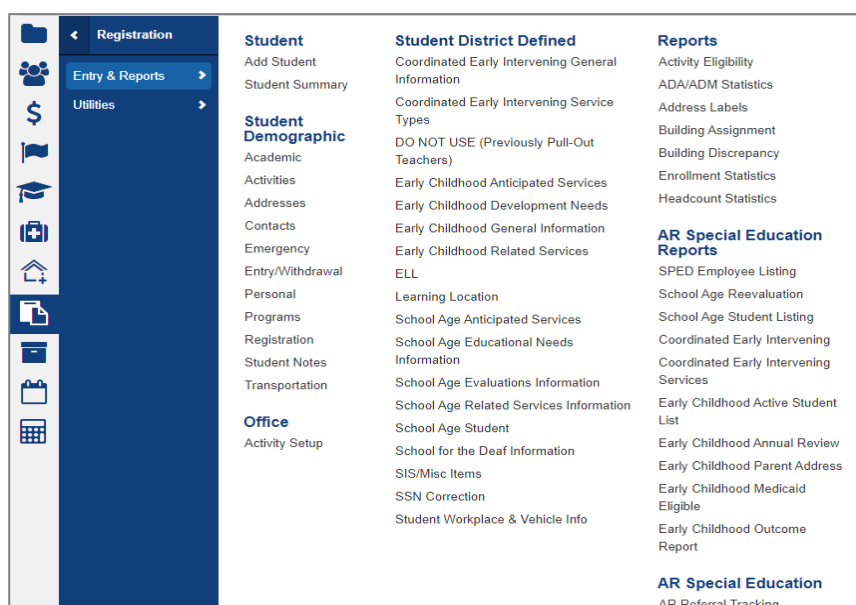
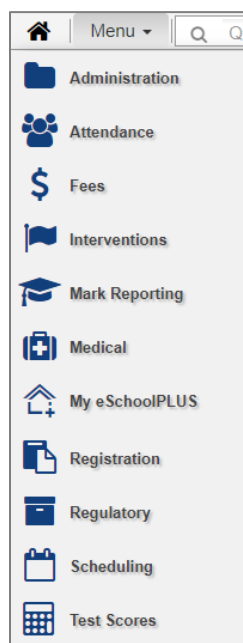
Mega Menu



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* menu items:



Quick Search for Menu Items or Students

Quick Search, located on the toolbar below the system's banner, provides a fast, convenient way to navigate to pages and locate students whose current status is Active with the *exception* of searching by Student ID which will pull students of any status. Because the Quick Search feature is available on all 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 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:

The screenshot shows the eSchoolPLUS interface with the Quick Search field containing 'emer'. The search results are displayed in a dropdown menu. On the left, there is a sidebar with 'Home' and 'Calendar' (Building 1, Monday). The main content area shows a progress bar for 'Day 44' and 'Remaining 192' (18%). The search results are divided into 'Menu Results' and 'Student Results'. Under 'Menu Results', there are three items: 'Emergency', 'Emergency', and 'Emergency Attendance'. Under 'Student Results', there is one item: 'Emerson Burton' with ID '90034'. A red arrow points to the first 'Emergency' menu item, and another red arrow points to the 'Registration > Entry & Reports > Student Demographic' path shown in a tooltip. A text box explains: 'In this example, Emergency displays twice, indicating there are two menu options that share this name. To determine a particular option's menu path, position the cursor on the option.'

Hover over student row to display detail on the student. Or click the student row to open the Student Summary page.

This screenshot shows the same Quick Search interface as the previous one, but with a student detail popup for 'Emerson Burton' (ID 17069). The popup displays a circular profile picture with the initials 'EB' and the following information: Building: Building 16, Grade: 08, Age: 13. The sidebar shows 'Calendar' (Building 16, Thursday). The main content area shows a progress bar for 'Day 87' and 'Remaining 146' (37%).

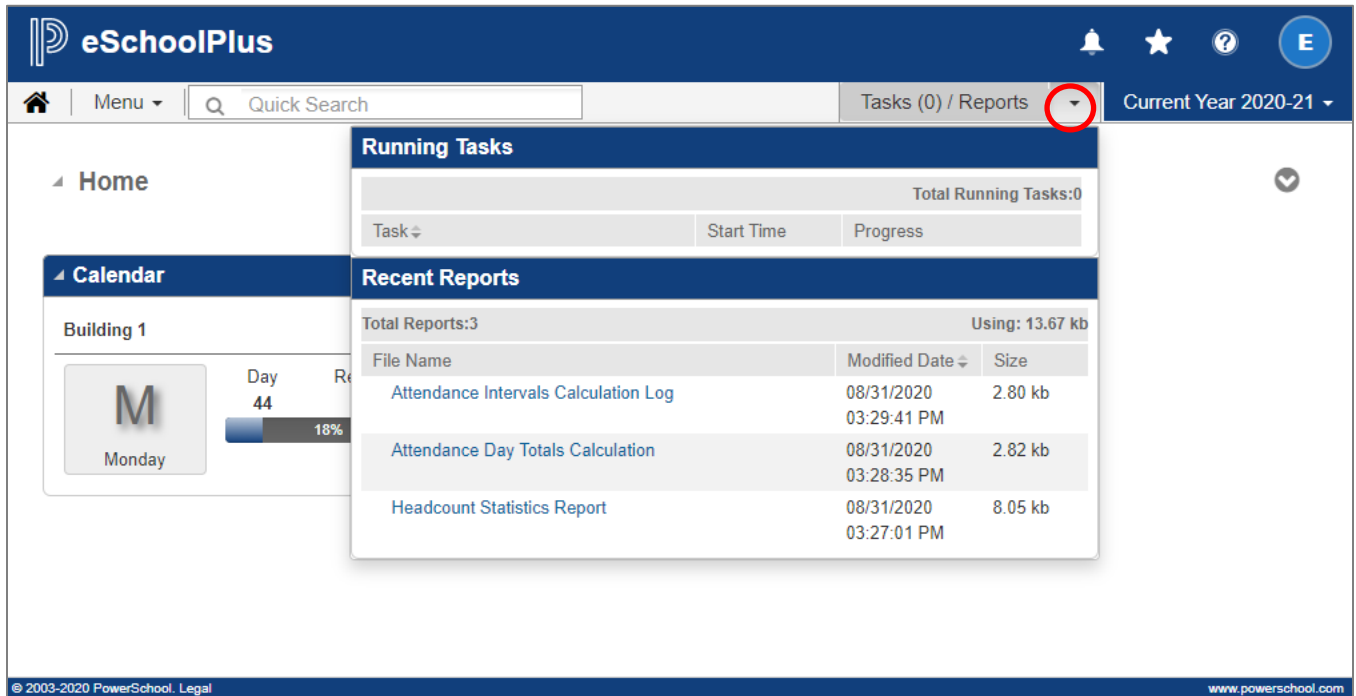
Note: Quick Search searches only for students whose current status is Active. Students with other statuses, including Graduated, Inactive, and Pre-Registered, are filtered out. To find students with other statuses, click on the magnifying glass (Search) in the Quick Search field to display the Student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


Additional information related to search techniques can be found in the section on *Student Searches*.

Tasks and Reports



The screenshot shows the eSchoolPlus interface. At the top, there is a navigation bar with the eSchoolPlus logo, a home icon, a menu dropdown, a quick search bar, and a 'Tasks (0) / Reports' dropdown menu which is circled in red. To the right of the navigation bar are icons for notifications, favorites, help, and a user profile. Below the navigation bar, the main content area is divided into two columns. The left column contains a 'Home' link and a 'Calendar' section for 'Building 1' showing a calendar for Monday, August 44, with a progress bar at 18%. The right column contains a 'Running Tasks' section with 'Total Running Tasks:0' and a 'Recent Reports' section with 'Total Reports:3' and 'Using: 13.67 kb'. The 'Recent Reports' section lists three reports: 'Attendance Intervals Calculation Log' (2.80 kb, 08/31/2020 03:29:41 PM), 'Attendance Day Totals Calculation' (2.82 kb, 08/31/2020 03:28:35 PM), and 'Headcount Statistics Report' (8.05 kb, 08/31/2020 03:27:01 PM).

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 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.

Tasks and Reports

Reports

Total Reports:51 Using: 429.72 kb

File Name	Modified Date	Size	
Recalculate Seats	10/27/2017 12:53:08 PM	7.46 kb	
scheduler error log	10/27/2017 12:52:43 PM	21.00 b	
scheduler report log	10/27/2017 12:52:43 PM	5.27 kb	
scheduler warning log	10/27/2017 12:52:43 PM	53.00 b	
Student Scheduler Error Scan	10/27/2017 12:35:37 PM	8.54 kb	
Student Request Summary	10/27/2017 12:25:45 PM	10.65 kb	
Mass Load Student Requests	10/24/2017 03:35:27 PM	4.11 kb	
Mass Load Student Requests	10/24/2017 03:31:50 PM	4.05 kb	
Mass Load Student Requests	10/24/2017 03:19:39 PM	4.01 kb	
Mass Load Student Requests	10/24/2017 03:15:35 PM	4.11 kb	

Running Tasks

Total Running Tasks:0

Task	Start Time	Progress
------	------------	----------

Scheduled Tasks

Total Scheduled Tasks:1



Task	Run Time	Status	
Headcount Statistics Report	11/06/2017 09:30:00 AM	Waiting	

Page 1 of 6



Page 1 of 1

The Page navigational arrows may be used to move through pages or type in a page number. The number of items to display on the page can be set using the dropdown box.



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 fields - This section displays reports and logs that have been run and the date and time. Reports sort descending by date and time but may be changed by clicking a column header. Each Friday, DIS will run a script to remove reports over 31 days old from users' home directories.





- **Total Reports** - Total number of reports. The number displayed is set in the bottom fields.
- **Using** - Total number of bytes in the reports displayed, expressed in kilobytes (KB), megabytes (MB), or gigabytes (GB).
- **File Name** - Name of the report or log file.
- **Modified Date** - Date and time the report or log was generated.
- **Size** - Size of the file expressed in kilobytes (KB), megabytes (MB), or gigabytes (GB).
-  **(Delete)** - To delete the report or log, select the box, then click  (Delete).

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

- **Total Running Tasks** - Total number of tasks currently being processed.
- **Task** - Name of the calculation or report.
- **Start Time** - Date and time the calculation or report began to run.
- **Progress** - Bar displaying the progress of the task being run, including the percentage, the number of records processed so far, and the total number of records being processed.
-  **(Delete)** - To delete the task, select the box, then click  (Delete) in the upper right of the window.

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 be displayed 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.



- **Total Scheduled Tasks** - Total number of tasks scheduled to run.
- **Task** - File name of the calculation or report.
- **Run Time** - Date and time the calculation or report is scheduled to run.
- **Status** - Status of the task, either Waiting or Disabled. Click the () icon to toggle the status from Waiting to Disabled or the  icon to toggle the status from Disabled to Waiting.
-  **(Delete)** - To delete the task, select the box, then click  (Delete) in the upper right of the window.

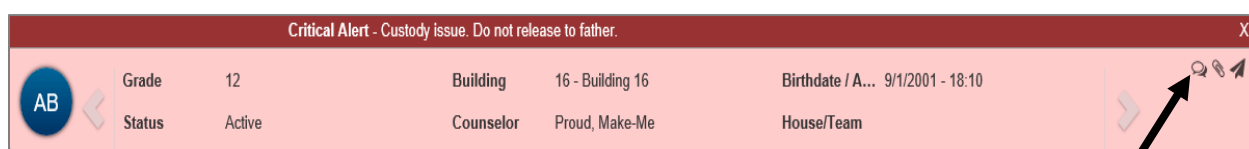
Student Notes



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.

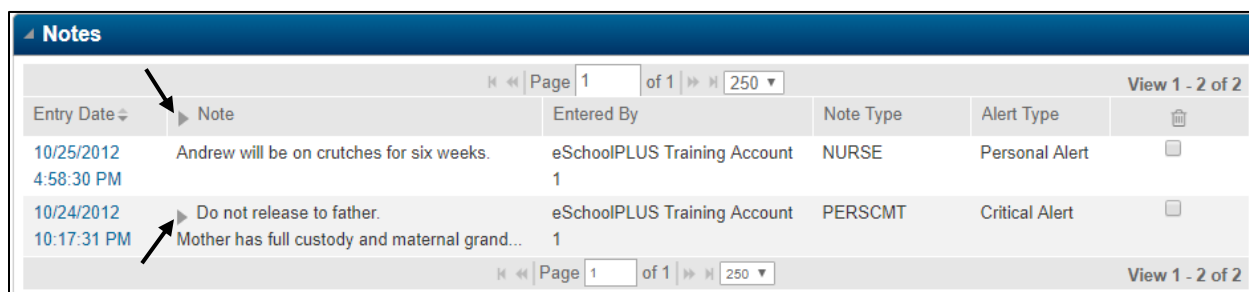




To edit an existing comment, click the  icon. To enter a new Personal or Critical Note for a student, click  View/Edit Notes.

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.



Entry Date	Note	Entered By	Note Type	Alert Type	
10/25/2012 4:58:30 PM	Andrew will be on crutches for six weeks.	eSchoolPLUS Training Account 1	NURSE	Personal Alert	
10/24/2012 10:17:31 PM	Do not release to father. Mother has full custody and maternal grand...	eSchoolPLUS Training Account 1	PERSCMT	Critical Alert	

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 details on setting a note as Critical, Sensitive, or Private.
4. When note information is complete, click the  (Save) icon.

Student Note example:

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 are displayed 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.


Notes					
<div> <div> <div>Page 1</div> <div>of 1</div> <div>250</div> </div> <div>View 1 - 2 of 2</div> </div>					
Entry Date	Note	Entered By	Note Type	Alert Type	
10/25/2012 4:58:30 PM	Andrew will be on crutches for six weeks-	eSchoolPLUS Training Account	NURSE	Personal Alert	

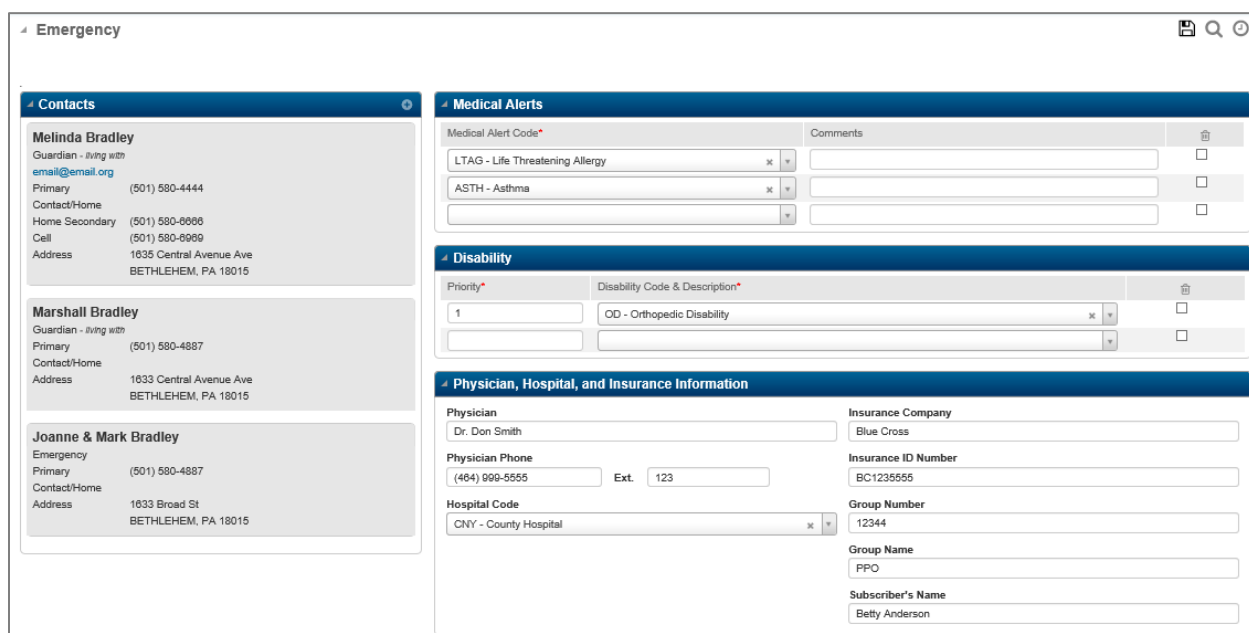
Emergency

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**. Users 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.



Emergency

Contacts

Melinda Bradley
Guardian - living with
email@email.org
Primary (501) 580-4444
Contact/Home
Home Secondary (501) 580-6666
Cell (501) 580-6666
Address 1635 Central Avenue Ave
BETHLEHEM, PA 18015

Marshall Bradley
Guardian - living with
Primary (501) 580-4887
Contact/Home
Address 1633 Central Avenue Ave
BETHLEHEM, PA 18015

Joanne & Mark Bradley
Emergency
Primary (501) 580-4887
Contact/Home
Address 1633 Broad St
BETHLEHEM, PA 18015

Medical Alerts

Medical Alert Code*	Comments	
LTAG - Life Threatening Allergy		<input type="checkbox"/>
ASTH - Asthma		<input type="checkbox"/>

Disability


Priority*	Disability Code & Description*	
1	OD - Orthopedic Disability	<input type="checkbox"/>

Physician, Hospital, and Insurance Information

Physician Dr. Don Smith	Insurance Company Blue Cross
Physician Phone (464) 999-5555 Ext. 123	Insurance ID Number BC1235555
Hospital Code CNY - County Hospital	Group Number 12344
	Group Name PPO
	Subscriber's Name Betty Anderson

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 closes 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 displaying 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.

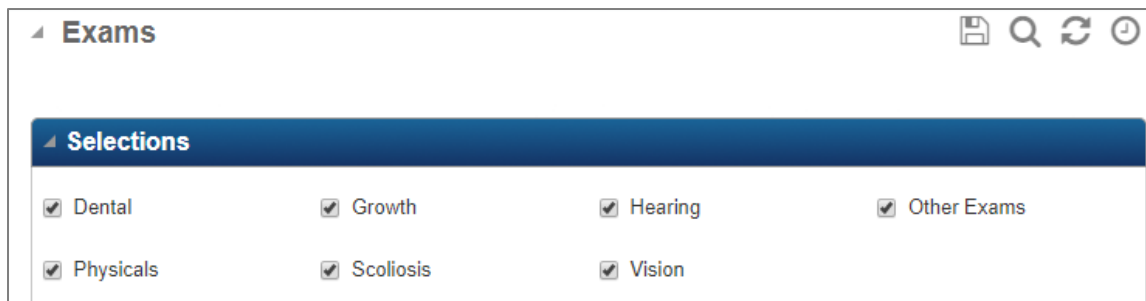
Student Medical Exam Procedures

Viewing 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. All Exams are visible on this page. 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 be held for future accessing of the page.
4. To display an exam's detailed results, click ► (Expand) for the exam.

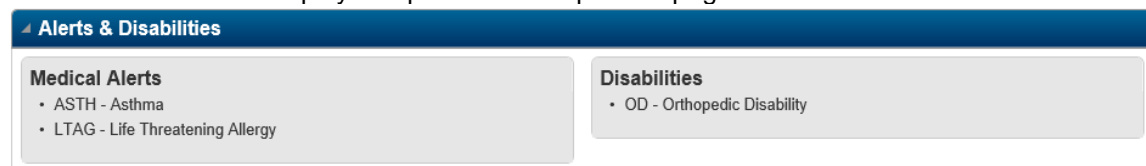
Details Items on Exam Pages

- In the Selections panel, check which Exams to display for the student and click ↻ (Load Records).



The screenshot shows the 'Exams' page interface. At the top, there is a header bar with the title 'Exams' and several icons (save, search, refresh, clock). Below the header is a 'Selections' panel with a blue header. Inside this panel, there are seven checkboxes arranged in two rows: 'Dental', 'Growth', 'Hearing', 'Other Exams' in the first row, and 'Physicals', 'Scoliosis', 'Vision' in the second row. All checkboxes are currently checked.

- Alerts and Disabilities display in a panel at the top of the page.



The screenshot shows the 'Alerts & Disabilities' panel. It has a blue header. Below the header, there are two sections: 'Medical Alerts' and 'Disabilities'. The 'Medical Alerts' section lists 'ASTH - Asthma' and 'LTAG - Life Threatening Allergy'. The 'Disabilities' section lists 'OD - Orthopedic Disability'.

- 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.


Exams

Hearing

GR: 09	Date: 11/08/2017	Right: F	Left: P	Notes: N	Ref: Y
GR: 08	Date: 09/16/2008	Right: P	Left: P	Notes: Y	Ref: N
GR: 06	Date: 09/23/2006	Right: P	Left: P	Notes: N	Ref: N
GR: 06	Date: 09/16/2006	Right: F	Left: P	Notes: N	Ref: Y

Scoliosis

GR: 08	Date: 04/01/2009	Status: Pass	Notes: N	Ref: N
GR: 06	Date: 03/12/2007	Status: Pass	Notes: N	Ref: N

- Click  to add a record to an exam panel. Enter the screening date and test details in the detail panels. Note the Referral Detail is now visible from the screening data page.

Hearing

GR: 09 Date: 11/08/2017 Right: F Left: P Notes: N Ref: N

Grade: 09 - Ninth Grade Right Ear: F - Fail Notes:

Location: Left Ear: P - Pass

Decibel/Frequency Test

Referral Detail

Referral Code*	Referral Date*	Followup Code	Followup Date	Doctor Name	Referral Comments
S - School Nurse	11/08/2017	I - In-Process	11/08/2017		Possible swimmers

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



Grade: 09 - Ninth Grade Right Ear: F - Fail

Location: F - Fail

Decibel/Frequency Test

Referral Detail

Adding 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).

Changing 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 in the time stamp record.

Deleting medical exam results

Note: 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.**

GR	Date	Right	Left	Notes	Ref	Action
GR: 09	Date: 11/08/2017	Right: F	Left: P	Notes: N	Ref: Y	
GR: 08	Date: 09/16/2008	Right: P	Left: P	Notes: Y	Ref: N	

4. Click (Save).

Referral Detail

Example Referrals panel

Referral Detail						
Referral Code*	Referral Date*	Followup Code	Followup Date	Doctor Name	Referral Comments	
S - School Nurse	11/08/2017	I - In-Process	11/08/2017			<input type="checkbox"/>
						<input type="checkbox"/>

General information is displayed 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

The screenshot shows the 'Dental' window with a header bar. Below the header, there is a summary bar for the current record: 'GR: 09 Date: 01/18/2018 Status: Normal Notes: N Ref: N'. The main form area contains several fields: 'Grade' (09 - Ninth Grade), 'Location' (N - Nurse's Office), 'Status' (N - Normal), and a large 'Notes' text area. Below these is a 'Referral Detail' section with a table of referral records. The table has columns for Referral Code*, Referral Date*, Followup Code, Followup Date, Doctor Name, and Referral Comments. There are two rows of data shown, one for GR: 08 and one for GR: 07.

Referral Code*	Referral Date*	Followup Code	Followup Date	Doctor Name	Referral Comments

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/BMI

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

Use this page to add or view growth exam results for a student. The BMI data pulls in state reporting Cycle 7 due in June and should be entered as described. Each new screening requires a line entry with all state required fields.

Growth panel

Growth

GR: 09 Date: 04/01/2020 Notes: N Ref: N

Grade: 09 - Ninth Grade

Location: N - Nurse's Office

Age: 15:03

Height: 64.00 52%

Weight: 120.00 57%

BMI: 20.5957 56% HW - Healthy Weight

AN Reading: N - Negative

Blood Pressure: /

Reason Not Assessed

Referral Detail

Referral Code*	Referral Date*	Followup Code	Followup Date	Doctor Name	Referral Comments

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 growth screening was conducted. (This replaces the previously used Station Form.)

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 decimal format. For example, to indicate 5 feet, 2 1/4 inches tall, the entry would be 62.25.

Height Percentile (%) - The student's height percentile (from 1 to 99) based on the student's age (from ages 24 months to 240 months) and gender.

Weight - The student's weight measured in decimal format. For example, to indicate 95 and 1/2 pounds, the entry would be 95.50.

Weight Percentile (%) - The student's weight percentile (from 1 to 99), based on the student's age (from ages 24 months to 240 months) and gender.

BMI - The body mass index for the student. The formula is weight/height² multiplied by 703 (conversion factor for pounds/inches).

BMI 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.

BMI Status – Indicates the status of the calculated percentile range for the body mass index value indicating where the student's BMI percentile falls for the age and gender.

Code – Description	Min – Max BMI
HW – Healthy Weight	5 - 84
OW – Overweight	85 - 94
OB – Obese	95 - 999
UW – Underweight	0 - 4

AN Reading – Indicates the AN (Acanthosis Nigricans) Reading result. Values are:

N – Negative
P – Positive

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.

Notes - Unlimited free text about the exam.

Reason Not Assessed - Two-letter code to indicate the reason for “Unable to Assess”. Values are:

AB – Absent	PD – Physically Disabled
CR – Child Refused	HT – 2 nd Height Measure not within 1 inch
PR – Parent Refused	WT – Weight Exceeded Scale
PT – Pregnant	OT – Other

Note: The **Reason Not Assessed** column is a required entry if either the Height or Weight column is not filled in. The record cannot be saved without the **Height AND Weight** entry **OR** a **Reason Not Assessed** value.

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 for detail instructions.

For State Reporting Cycle 7 due in June, enter a Referral Code, **G – Guardian**, if the student was referred to the Guardian.

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

Hearing

GR: 09 Date: 11/08/2017 Right: F Left: P Notes: N Ref: Y

Grade: 09 - Ninth Grade Right Ear: F - Fail Left Ear: P - Pass Notes:

Location:

► Decibel/Frequency Test

Referral Detail

Referral Code*	Referral Date*	Followup Code	Followup Date	Doctor Name	Referral Comments	
S - School Nurse	11/08/2017	I - In-Process	11/08/2017		Had swimmer's ear.	<input type="checkbox"/>
S - School Nurse	11/29/2017	T - Re-Screened	11/29/2017			<input type="checkbox"/>
						<input type="checkbox"/>

GR: 08 Date: 09/16/2008 Right: P Left: P Notes: Y Ref: N

GR: 06 Date: 09/23/2006 Right: P Left: P Notes: N Ref: N

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 hearing 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		
<ul style="list-style-type: none"> To meet Arkansas 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. 		
Valid Referral Codes	Valid Follow-up Codes for Referral of S:	Valid Follow-up Codes for Referral U or P:
P – Physician S – School Nurse U – Audiologist	I – In Process T – Re-Screened X – Left District	I – In Process J – Treatment N – Normal Exam R – Refused Referral X – Left District
<p>The following Referral codes are used for students who are NOT screened. When a student is not screened due to one of the below reasons, leave the screening fields blank, select the appropriate Referral code from below with the date. No Follow-up value is required on these codes.</p> <p>PR – Written Parent Refusal UN – Unable to Perform Screening (SPED/Acute Disability) VS – Virtual Student Not Screened</p> <p><i>Note: If the student is not screened for any other reason besides the listed codes, a screening entry should not be added.</i></p>		

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

Adding decibel and frequency ranges for hearing exam results

- After adding and completing fields in the Hearing exam detail fields that display.
- Click ► (Expand) on the Decibel/Frequency Test section.
- 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.
- As needed, change the value for a decibel/range to record the student's status.
- Click 💾 (Save).

Decibel/Frequency Test

Status Codes: F: Fail, N: Normal, P: Pass, W: Watch

Set Default

dB(a)	R	L	R	L	R	L	R	L	R	L	R	L	R	L
-10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
0	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
40	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
50	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
60	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
70	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
80	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
90	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
100	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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 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 viewed 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. This date does not have to be a membership day for the student.

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

Location – Holds a code to identify where the physical 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.

Referral Detail - Expand the Referral Detail panel to access referrals for the student for the exam.

Arkansas State Reporting Guidelines		
<ul style="list-style-type: none"> To meet Arkansas 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. Scoliosis data pulls in State Reporting Cycle 7/June. 		
Valid Referral Codes	Valid Follow-up Codes for Referral of S:	Valid Follow-up Codes for Referral O or P:
O – Orthopedic Physician P – Physician S – School Nurse	I – In Process T – Re-Screened X – Left District	I – In Process J – Treatment N – Normal Exam R – Refused Referral X – Left District
<p>The following Referral codes are used for students who are NOT screened. When a student is not screened due to one of the below reasons, leave the screening fields blank, select the appropriate Referral code from below with the date. No Follow-up value is required on these codes.</p> <p>PR – Written Parent Refusal UN – Unable to Perform Screening (SPED/Acute Disability) VS – Virtual Student Not Screened</p> <p>Note: If the student is not screened for any other reason besides the listed codes, a screening entry should not be added.</p>		

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

The screenshot shows a web-based form titled "Vision". At the top, it displays "GR: 08 Date: 09/16/2008 Notes: N Ref: N". The form is organized into three columns. The first column contains fields for "Grade" (08 - Eighth Grade), "Location" (G - Gym), "External Exam" (P - Pass), "Right W/ Glasses" (Y - Yes), and "Left W/ Glasses" (Y - Yes). The second column contains fields for "Vision 20" (P - Pass), "Plus 20 Test 20'" (P - Pass), "LAT MB (Far)" (P - Pass), "Vert MB (Far)" (P - Pass), and "Fusion (Far)" (P - Pass). The third column contains fields for "LAT MB (Near)" (P - Pass), "Fusion (Near)" (P - Pass), "Color" (P - Pass), and a "Notes" text area. Below these fields is a "Referral Detail" section with a table-like structure for "Referral Code*", "Referral Date*", "Followup Code", "Followup Date", "Doctor Name", and "Referral Comments". At the bottom, it displays "GR: 06 Date: 09/23/2006 Notes: N Ref: N".

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/NULL 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.

Arkansas State Reporting Guidelines		
<ul style="list-style-type: none"> To meet Arkansas 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. Location field is used to indicate if an Auto Refractor was used in the screening. Value = Y Vision data pulls in State Reporting Cycle 7/June. 		
Valid Referral Codes	Valid Follow-up Codes for Referral of S:	Valid Follow-up Codes for Referral P or E:
E – Eye Doctor P – Physician S – School Nurse G – Guardian can ONLY be used when Colorblind is the only failure	I – In Process T – Re-Screened X – Left District	A – Abex No Lens (Abnormal Exam No Lens Prescribed) I – In Process J – Treatment L – Lens Prescribed N – Normal Exam R – Refused Referral X – Left District
<p>The following Referral codes are used for students who are NOT screened. When a student is not screened due to one of the below reasons, leave the screening fields blank, select the appropriate Referral code from below with the date. No Follow-up value is required on these codes.</p> <p>PR – Written Parent Refusal UN – Unable to Perform Screening (SPED/Acute Disability) VS – Virtual Student Not Screened</p> <p>Note: If the student is not screened for any other reason besides the listed codes, a screening entry should not be added.</p>		

Vision Referral example screen:

Referral Detail						
Referral Code*	Referral Date*	Followup Code	Followup Date	Doctor Name	Referral Comments	
S - School Nurse	09/16/2006	I - In-Process	09/16/2006			<input type="checkbox"/>
S - School Nurse	09/23/2006	T - Re-Screened	09/23/2006			<input type="checkbox"/>

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

Student Immunizations Summary Detail

Save Options

Run immunization calculation on save ☐ Generate grace period alert ☐

Overall Immunization Status OV - Overdue

Status

Status Calculated 08/28/2017

Override ☐

Student Status OV - Overdue

Student Exemption

Grace Period

District Entry Date 10/03/2005

Grace Period Alert ☒

Override ☐

Expiration Date 07/31/2016

Comments

Comment

Vaccination Summary

Vaccination	Series Status	Series Total	Shots Total	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Exemption	Referrals
DTaP	CO	5	5	02/14/1996	04/29/1996	08/14/1997	01/14/2000	03/13/2007		0
TDAP	OV	0	0							0
IPV/OPV	OV	4	4	02/14/1996	04/29/1996	08/14/1997	01/14/2000			0
Polio	N/A	N/A	0							0
Hib	N/A	3	3	02/14/1996	04/29/1996	08/14/1997				0

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 details follow.
- ◆ **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. **Note:** APSCN recommends that the Overall Immunization Status NOT BE manually maintained.

To find records where the Override flag is checked, the following search row may be used:

Area	Field Name	Condition	Value
Immunizations	Override	= (equals)	Y

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.

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 the 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 are displayed 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 will 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 vaccination 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

Student Immunizations
Summary
Detail

Save Options

Overall Immunization Status
OV - Overdue

DTAP - Diphtheria-Tetanus-Pertussis
CO - Complete

Doses
Add Referral

Vaccination Date	Source Document	Signed	Warning	Ovr	
02/14/1996		<input checked="" type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
04/29/1996		<input checked="" type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
08/14/1997		<input checked="" type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
01/14/2000		<input checked="" type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
03/13/2007		<input checked="" type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
		<input checked="" type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>

Series

Details

Dates
2/14/1996, 4/29/1996, 8/14/1997, 1/14/2000, 3/13/2007

Exemption

Series Status
CO - Complete

Had Disease
☐
Date

Override
☐

Comments

Alternate Doses

Diph/Tetanus/Accel. Pertussis

Diph/Tetanus/Accel. Pertussis

Diph/Tetanus/Accel. Pertussis

Vaccination Code
Vaccination Dates

Vaccination Code
Vaccination Dates

Vaccination Code
Vaccination Dates

BOOSTER - Tetanus
Booster (DO NOT USE)

DPT - DPT (DO NOT USE)

DT - Pediatric DTP (DO NOT USE)

Diph/Tetanus/Accel. Pertussis

Diph/Tetanus/Accel. Pertussis

Diph/Tetanus/Accel. Pertussis

Vaccination Code
Vaccination Dates

Vaccination Code
Vaccination Dates

Vaccination Code
Vaccination Dates

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 be displayed 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 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

Medication Requirements

Alerts & Disabilities

Medical Alerts

- AB - Allergy-Bee/Wasp
- AS - Asthma

Disabilities

- WC - Wheelchair

Scheduled Medications

Rx/Tx*	Start Date*	End Date*	Add Dose	Time	Comment	Physician
AD - Adderall (Dextroamphetamine & Amphetamine)	08/19/2010	06/06/2018	+	07:45 AM	20 mg daily in the a.m.	Ralph Maxwell
AC - Acetaminophen	08/23/2010	07/01/2012	+			
AL - Albuterol (Proventil, Ventolin)	08/23/2010	07/01/2012	+			
			+			

PRN Medications

Rx/Tx*	Start Date*	End Date*	Comment	Physician
	07/03/2017	07/01/2018		

Scheduled Medications


Scheduled 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.

Add – To add multiple times for giving a medicine on a single date, click , 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  (Expand) icon.

Example PRN Medications Panel

PRN Medications					
Rx/Tx*	Start Date*	End Date*	Comment	Physician	
<input type="text"/>	07/03/2017 	07/01/2018 	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>

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 to 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) to display the records.

Display Medications Issued - Select to display the current period (records that can be edited) or prior records. On this page, the 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.

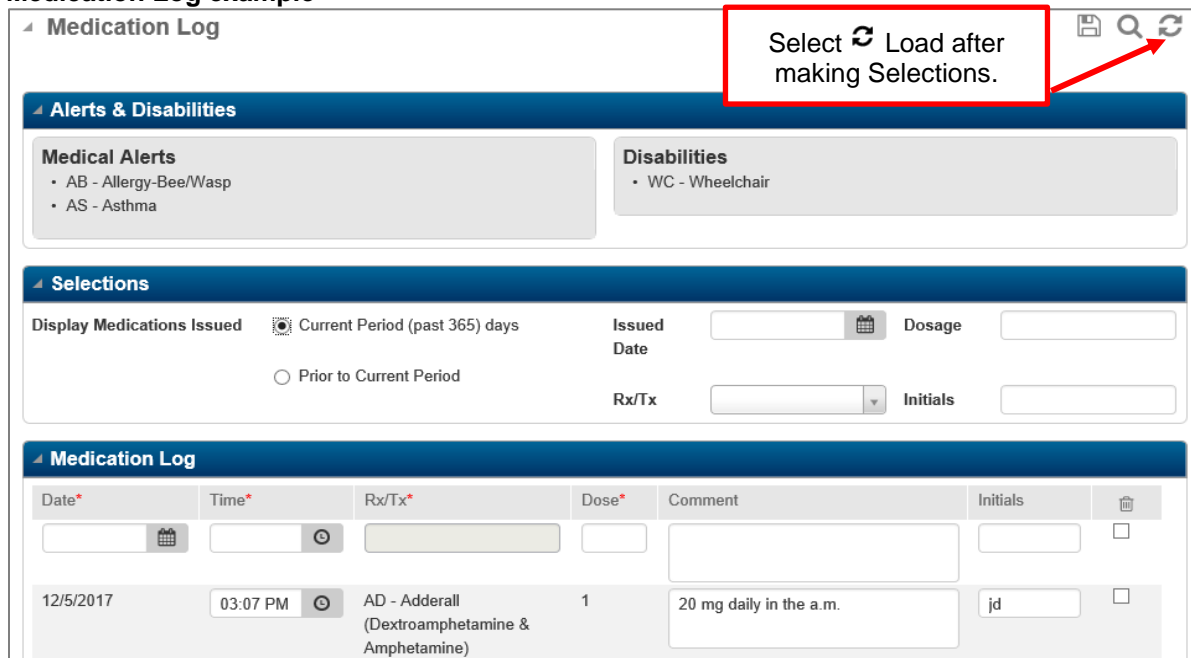
Issued Date - To filter medication records to a specific date, enter the date.

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



Medication Log

Select  Load after making Selections.

Alerts & Disabilities

Medical Alerts

- AB - Allergy-Bee/Wasp
- AS - Asthma

Disabilities

- WC - Wheelchair

Selections

Display Medications Issued ☒ Current Period (past 365) days ☐ Prior to Current Period

Issued Date Dosage

Rx/Tx Initials

Medication Log

Date*	Time*	Rx/Tx*	Dose*	Comment	Initials	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
12/5/2017	03:07 PM	AD - Adderall (Dextroamphetamine & Amphetamine)	1	20 mg daily in the a.m.	jd	<input type="checkbox"/>

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

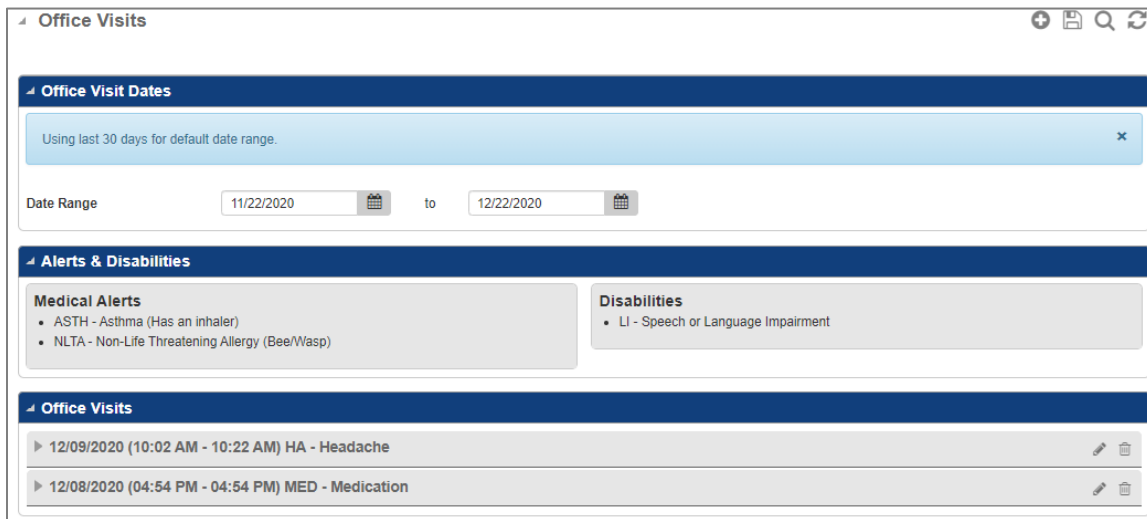
Use this page to add or view office visits for a student. The most current record displays at the top of the page. Entries that are past the building's limit on days to update (as specified in the "Allow Update on Prior Office Visit" field in the Medical Building Setup page) are Display Only.

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).



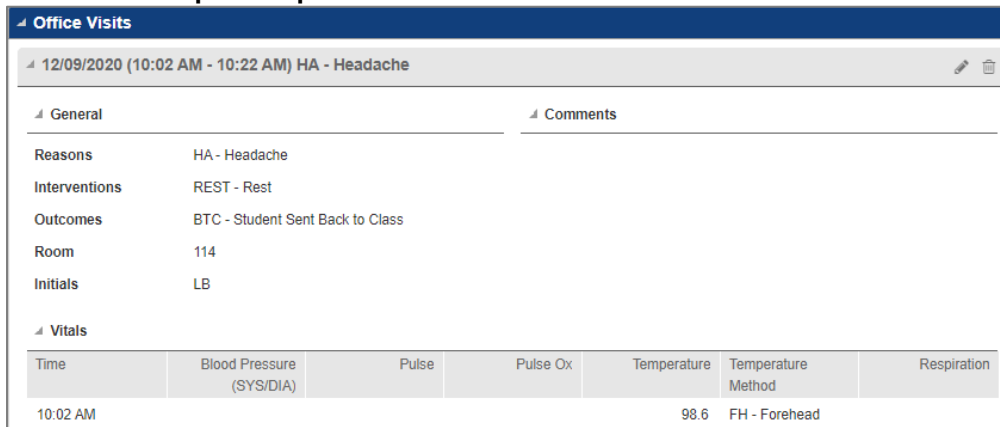
The screenshot shows the 'Office Visits' panel. At the top, there's a header 'Office Visits' with icons for add, print, search, and refresh. Below it is the 'Office Visit Dates' section, which includes a message 'Using last 30 days for default date range.' and a date range selector showing '11/22/2020' to '12/22/2020'. Underneath is the 'Alerts & Disabilities' section, divided into 'Medical Alerts' (listing ASTH - Asthma and NLTA - Non-Life Threatening Allergy) and 'Disabilities' (listing LI - Speech or Language Impairment). At the bottom is a list of office visits, with the most recent one expanded: '12/09/2020 (10:02 AM - 10:22 AM) HA - Headache'.

Office Visits Panel

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

Office Visits expanded panel:




The screenshot shows the expanded 'Office Visits' panel for the visit '12/09/2020 (10:02 AM - 10:22 AM) HA - Headache'. It is divided into two tabs: 'General' and 'Comments'. The 'General' tab is active and shows the following information:




Reasons	HA - Headache
Interventions	REST - Rest
Outcomes	BTC - Student Sent Back to Class
Room	114
Initials	LB

Below this is the 'Vitals' section, which includes a table for vital signs:

Time	Blood Pressure (SYS/DIA)	Pulse	Pulse Ox	Temperature	Temperature Method	Respiration
10:02 AM				98.6	FH - Forehead	



Adding a Student's Office Visit

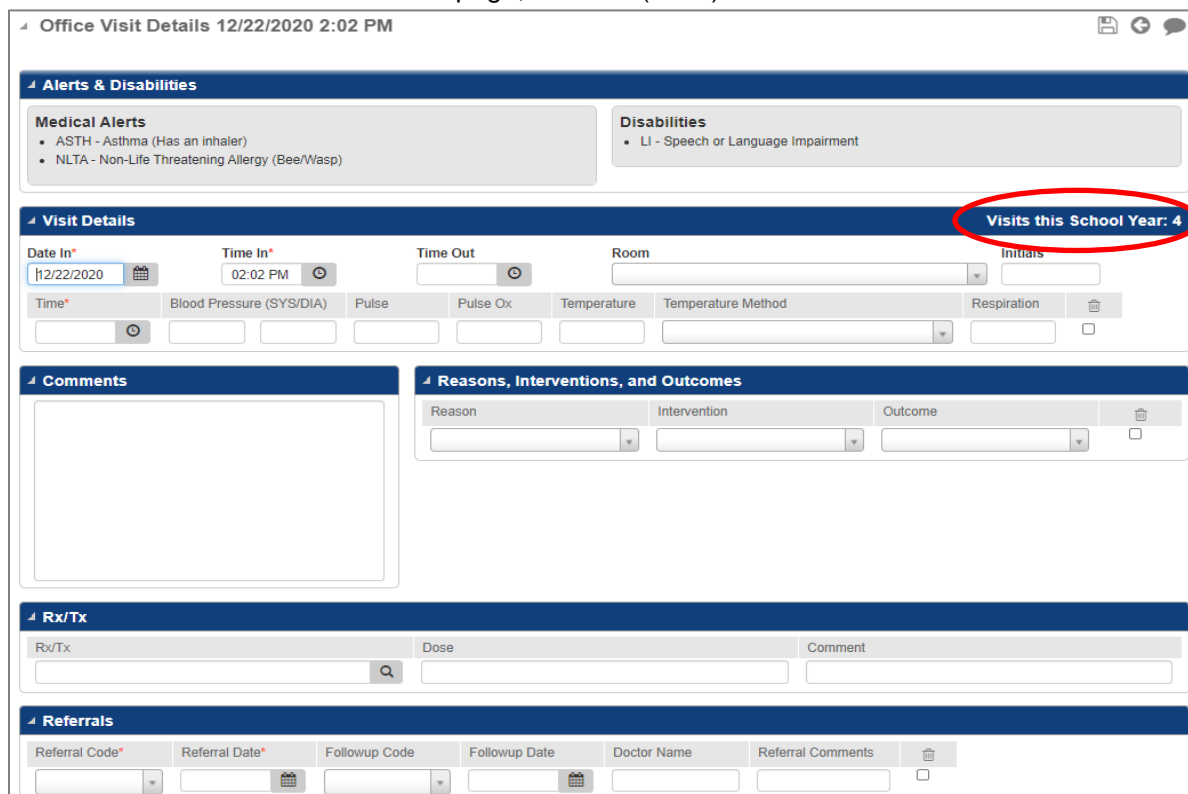
To add a new record, click  (Add) at the top right of the page. After saving a record for the student, referrals or notes can be entered or viewed for the student.

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.
4. Click  (Add). **Note:** The *Visits this School Year* including this visit display.
5. 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).



Office Visit Details 12/22/2020 2:02 PM

Alerts & Disabilities

Medical Alerts

- ASTH - Asthma (Has an inhaler)
- NLTA - Non-Life Threatening Allergy (Bee/Wasp)

Disabilities

- LI - Speech or Language Impairment

Visit Details

Visits this School Year: 4

Date In* 12/22/2020 Time In* 02:02 PM Time Out Room Initials

Time* Blood Pressure (SYS/DIA) Pulse Pulse Ox Temperature Temperature Method Respiration

Comments

Reasons, Interventions, and Outcomes

Reason	Intervention	Outcome

Rx/Tx

Rx/Tx	Dose	Comment

Referrals

Referral Code*	Referral Date*	Followup Code	Followup Date	Doctor Name	Referral Comments

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.

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.

Time* – Time vital statistics taken.

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.


Pulse Ox – The pulse oximeter reading at the time of the office visit.


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


Temperature Method - Indicates how a temperature was measured.

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

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 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

* NURSEVISIT	
THUR. 1/14/2016 8:13 am	 <input type="checkbox"/> Nurse Visit  <p>Ashleigh Bradley was checked in for a Nurse Visit on Jan 14 2016 8:35AM and was released on Jan 14 2016 8:40AM</p>
WED. 1/13/2016 10:13 am	 <input type="checkbox"/> Nurse Visit  <p>Ashleigh Bradley was released from a Nurse Visit on Jan 13 2016 10:45AM</p>
WED. 1/13/2016 10:10 am	 <input type="checkbox"/> Nurse Visit  <p>Ashleigh Bradley was checked in for a Nurse Visit on Jan 13 2016 8:00AM</p>

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.

Dyslexia

New entry: Click the Save icon to create the screen for this student.

Dyslexia Fields

Receives Dyslexia Intervention ☐

Do Not Use (Evaluation Date)

Do Not Use (Exit Date)

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.

Cognos Report, APSCN Dyslexia Evaluation List, under *Team Content > Student Management System > Medical > State Reporting Information* can be used to run a list of students coded with Receives Dyslexia Intervention.

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 to.

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:

Vision Exam Totals										
Grade	Procedure Count	By Location		Unduplicated Student Count	Referral Count	Referral Detail		Followup Count	Followup Detail	
		Type	Count			Type	Count		Type	Count
01	0			0	0			0		
03	0			0	0			0		
04	0			0	0			0		
05	0			0	0			0		
06	8	N (Nurse's Office)	8	4	2	S (School Nurse)	2	2	I (In-Process)	2
07	2	None (Unspecified location)	2	2	0			0		

Summary subpanels:

Medication Summary				
Medication	Description	PR	Cnt	Rx Cnt
AD	Adderall (Dextroamphetamine & Amphetamine)	N	4	1
Total			4	1
Alert Summary				
Code	Description	Student Count		
AB	Allergy-Bee/Wasp	4		
AL	Allergy-Peanut/Treenuts/Nuts	1		
AS	Asthma	4		
ASTH	Asthma	1		
IN	Incontinence	1		
LTAG	Life Threatening Allergy	1		
ST	Stroke	1		
Total				13

Visit Reason Summary		
Visit Reason	Description	Count
AB	Abrasion	3
BS	Insect Sting	1
C	Coughing	1
CL	Chapped Lips	1
HA	Headache	4
MED	Medication	2
PPCT	Paper Cut	2
ST	Sore Throat	1
Total		15
Total number of visits		23
Disability Summary		
Code	Description	Count
AU	Autism	1
CR	Crutches/Cane	2
OD	Orthopedic Disability	1
WC	Wheelchair	1
Total		5

Intervention Summary			
Treatment Code	Description	Count	
BA	Bandaid	4	
BAND	Bandage/Dressing	1	
HOME	Sent Home	1	
MEDS	Medication	2	
REST	Rest	4	
TEMP	Temperature Check	1	
TOPI	Topical Treatment	1	
Total			14
Unduplicated Students			
Office Visits	All Medications	Rx Medications	PRN Medications
9	1	1	0

Tip: If entered in 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

The screenshot shows the 'Daily Log' interface. At the top, there's a 'Selections' panel with filters for 'Building*' (16 - Building 16), 'Date*' (02/19/2018), and 'Initials' (NB). Below this is a section titled 'Daily Log for 02/19/2018' containing a table of office visits.

	Time In*	Time Out	Student Name	Room	Reason	Intervention	Outcome	Rx/Tx	Initials	
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	NB	
●	04:21 PM	04:22	Adams, Thomas	118					NB	
●	03:20 PM	03:36	Jones, Sarah		AB	BA	BTC			






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 a 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's 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 using 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 

Selections

Building: 16 - Building 16
Show Entries Without Times: ☒
Initials: jd

Day Sheet For 02/20/2018

Time	Name	Rx/Tx	Dose	Comment	Issued
07:45 AM	Jones, Sarah	AD - Adderall (Dextroamphetamine & Amphetamine)	1	20 mg daily in the a.m.	 04:03 PM
12:00 PM	Johnson, Rudy	IS - Insulin	1		<div>Issue</div>

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 are also displayed.

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 is displayed 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.

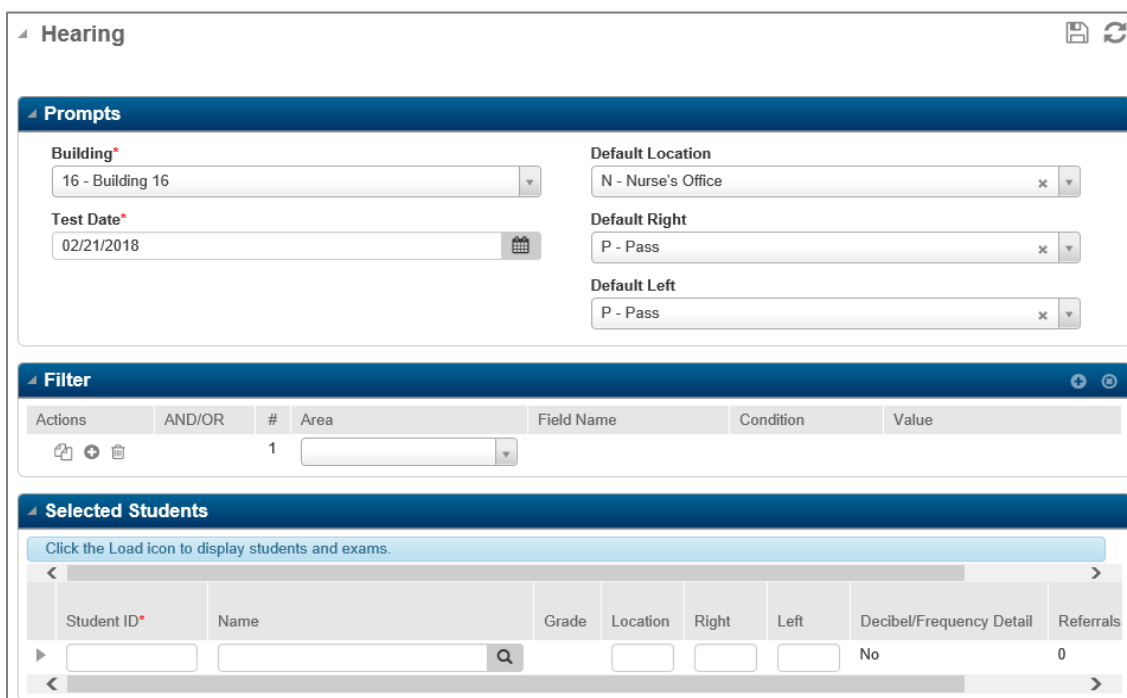
Entries that are past the building's limit on days to update (as specified in the "Allow Update on Prior Office Visit" field in the Medical Building Setup page) are Display Only.

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



Enter a Medical Exam Record(s)

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

Warning: The Filter last used will remain and should always be verified. Do NOT select  (Load) for entering individual records. If you wish to see any existing records for a Test Date, use the next procedure regarding displaying existing records.



The screenshot shows the 'Hearing' exam entry page. It includes a 'Prompts' section with fields for Building (16 - Building 16), Test Date (02/21/2018), Default Location (N - Nurse's Office), Default Right (P - Pass), and Default Left (P - Pass). Below this is a 'Filter' section with a table for filtering records. At the bottom is a 'Selected Students' section with a table for displaying student records.

Actions	AND/OR	#	Area	Field Name	Condition	Value
 		1				


Student ID*	Name	Grade	Location	Right	Left	Decibel/Frequency Detail	Referrals
						No	0

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.


- To view/add additional student exam details, such as notes and referrals, click ► (Expand) in the left column of the student's row.
- Select  (Save) to save new entries on the page.

Display 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.



- Select *Medical > All > Office* and then select the appropriate exam.
- In the Prompts > Test Date field using the calendar icon, select the date of the existing records to view. **Note:** If Vision prompts, Do NOT check Create New Exam Record.
- 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.)

Area	Field Name	Condition	Value
Hearing x ▼	Test Date x ▼	= x ▼	09/12/2022

-  Vision requires TWO date rows to pull up only the correct date's screenings. These dates should be the test date OF the exam and the date after as shown below. **Note:** This requirement is due to Vision having a 'time' along with the date.


Test Date
7/22/2022 2:30:00 PM

AND/OR	#	Area	Field Name	Condition	Value
	1	Vision x ▼	Test Date x ▼	> x ▼	09/12/2022
AND ▼	2	Vision x ▼	Test Date x ▼	< x ▼	09/13/2022

- Select  (Load) and the list of students 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).





Selected Students							
Number of students: 5				* - Exam already exists for student			
Student ID*	Name	Grade	Location	Right	Left	Decibel/Frequency Detail	Referrals
▶ <input type="text"/>	<input type="text"/>					No	0
▶ 17048 *	Abbott, Emily Jane	06	N	P	P	No	0
▶ 16041 *	Adams, Thomas	06	N	P	P	No	0
▶ 17076 *	Burton, Lydia	06	N	P	P	No	0
▶ 16035 *	Frack, Carol Anne	06	N	P	P	No	0
▶ 17077 *	Frack, Charity	06	N	P	P	No	0

Delete 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 far right 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.

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. Create New Exam Record - *Applicable to Vision Exam only*. This field is typically not checked. See *Vision Screening Mass Load* for detail.
 - d. 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.
 - e. 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 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. (See *Vision Screening Mass Load* item 2c. for exception to 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.
 - 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).
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.

Growth/BMI 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 Growth 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. Set to applicable date.
 - c. In the Default Location field, enter where the exam was given. (This replaces the previously used Station Form.) 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. Check the *Show AN Reading* field to display this field in the *Select Students* section for each student row. 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.

Growth

Prompts

Building*
16 - Building 16

Test Date*
04/01/2020

Default Location
N - Nurse's Office

Show AN Reading
☒

Default AN Reading
N - Negative



Filter

Actions	AND/OR	#	Area	Field Name	Condition	Value
		1	Demographic	Current Status	=	Active
	AND	2	Demographic	Grade	is in	09 - Ninth Grade
	AND	3				

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.

Selected Students												
Number of students: 7 * - Exam already exists for student												
Student ID*	Name	Grade	Location	Height	%	Weight	%	BMI	%	BMI Status	Blood Pressure	AN Reading
17032	Brown, Alice	09	N									N
17068 *	Burt, AnnaBelle	09	N	64	52	120	57	20.5957	56	HW - Healthy Weight		N
16006	Fujie, Chiharu	09	N									N
16010	Hall, Tyrone III	09	N									N
16019	Martinez, Julio	09	N									N
16005	McLaughlin, Emily	09	N									N
16015	Velazquez, Carmen David	09	N									N

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 enter BMI data, type in the Height and Weight. **The Reason Not Assessed column is a required entry if either the Height or Weight column is not filled in.** The record cannot be saved without the *Height AND Weight* entry OR a *Reason Not Assessed* value.
- To change information for a specific student, click in the student's fields and enter data.
- 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). For State Reporting Cycle 7 due in June, enter a Referral Code, *G – Guardian*, if the student was referred to the Guardian.

Student ID*	Name	Grade	Location	Height	%	Weight	%	BMI	%	BMI Status	Blood Pressure	AN Reading
17032	Brown, Alice	09	N	64	54	85	2	14.5886	0	UW - Under		

Notes

Referrals

Referral Code*	Referral Date*	Followup Code	Followup Date	Doctor's Name	Referral Comments	
						

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

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. 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.

Hearing [Unsaved Changes]

Prompts

Building*
16 - Building 16

Test Date*
02/21/2018

Default Location
N - Nurse's Office

Default Right
P - Pass




Default Left
P - Pass

Filter

Actions	AND/OR	#	Area	Field Name	Condition	Value
[Copy] [Add] [Delete]		1	Demographic	Current Status	=	Active
[Copy] [Add] [Delete]	AND	2	Demographic	Grade	=	06 - Sixth Grade
[Copy] [Add] [Delete]	AND	3				

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.

Selected Students										
Number of students: 5										
Student ID*	Name	Grade	Location	Right	Left	Decibel/Frequency Detail	Referrals	Notes		
<input type="text"/>	<input type="text"/>					No	0	No		
▶ 17048	Abbott, Emily Jane	06	N	P	P	No	0	No		
▶ 16041	Adams, Thomas	06	N	P	P	No	0	No		
▶ 17076	Burton, Lydia	06	N	P	P	No	0	No		
▶ 16035	Frack, Carol Anne	06	N	P	P	No	0	No		

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.
 - 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 student fails any portion of the screening a valid state referral and follow-up MUST be entered.

Note: Referral and Follow-up code require a Date entry by the software.

Arkansas State Reporting Guidelines		
Valid Referral Codes	Valid Follow-up Codes for Referral of S:	Valid Follow-up Codes for Referral U or P:
P – Physician S – School Nurse U – Audiologist	I – In Process T – Re-Screened X – Left District	I – In Process J – Treatment N – Normal Exam R – Refused Referral X – Left District
<p>The following Referral codes are used for students who are NOT screened. When a student is not screened due to one of the below reasons, leave the screening fields blank, select the appropriate Referral code from below with the date. No Follow-up value is required on these codes.</p> <p>PR – Written Parent Refusal UN – Unable to Perform Screening (SPED/Acute Disability) VS – Virtual Student Not Screened</p> <p>Note: If the student is not screened for any other reason besides the listed codes, a screening entry should not be added.</p>		

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 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 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.

The screenshot shows the 'Scoliosis' mass load interface. At the top, there is a title bar with a left arrow, the word 'Scoliosis', and icons for save and refresh. Below the title bar is a yellow 'Unsaved Changes' button. The main area is divided into two panels: 'Prompts' and 'Filter'.

The 'Prompts' panel contains four fields:




- Building***: A dropdown menu with '16 - Building 16' selected.
- Test Date***: A date field with '02/22/2018' and a calendar icon.
- Default Location**: A dropdown menu with 'N - Nurse's Office' selected.
- Default Status**: A dropdown menu with 'P - Pass' selected.

The 'Filter' panel contains a table with columns: Actions, AND/OR, #, Area, Field Name, Condition, and Value. It lists four filter criteria:

Actions	AND/OR	#	Area	Field Name	Condition	Value
[Icon]		1	Demographic	Current Status	=	Active
[Icon]	AND	2	Demographic	Grade	=	06 - Sixth Grade
[Icon]	AND	3	Demographic	Gender	=	F - Female
[Icon]	AND	4				

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.

Selected Students								
Number of students: 3								
Student ID*	Name	Grade	Location	Status	Referrals	Notes		
<input type="text"/>	<input type="text"/>		<input type="text"/>	<input type="text"/>	0	No	<input type="checkbox"/>	
▶ 17048	Abbott, Emily Jane	06	<input type="text" value="N"/>	<input type="text" value="P"/>	0	No	<input type="checkbox"/>	
▶ 16035	Frack, Carol Anne	06	<input type="text" value="N"/>	<input type="text" value="P"/>	0	No	<input type="checkbox"/>	
▶ 17077	Frack, Charity	06	<input type="text" value="N"/>	<input type="text" value="P"/>	0	No	<input type="checkbox"/>	

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.
 - 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 student fails any portion of the screening a valid state referral and follow-up **MUST** be entered.

Note: Referral and Follow-up code require a Date entry by the software.

Arkansas State Reporting Guidelines		
Valid Referral Codes	Valid Follow-up Codes for Referral of S:	Valid Follow-up Codes for Referral O or P:
O – Orthopedic Physician P – Physician S – School Nurse	I – In Process T – Re-Screened X – Left District	I – In Process J – Treatment N – Normal Exam R – Refused Referral X – Left District
<p>The following Referral codes are used for students who are NOT screened. When a student is not screened due to one of the below reasons, leave the screening fields blank, select the appropriate Referral code from below with the date. No Follow-up value is required on these codes.</p> <p>PR – Written Parent Refusal UN – Unable to Perform Screening (SPED/Acute Disability) VS – Virtual Student Not Screened</p> <p>Note: If the student is not screened for any other reason besides the listed codes, a screening entry should not be added.</p>		

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:

- The building for records that will be added.
- The test date which defaults to Today's Date.
- It is **NOT** recommended 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.

- 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.
- 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 except for Right w/Glasses and Left w/Glasses which must be entered individually.

Vision

Prompts

Building*
16 - Building 16

Test Date*
02/22/2018


Create New Exam Record
☐ **Do NOT check. See 2.c. above.**

Default Location
N - Nurse's Office



Default Status
P - Pass

Filter


Actions	AND/OR	#	Area	Field Name	Condition	Value
		1	Demographic	Current Status	=	Active
	AND	2	Demographic	Grade	=	06 - Sixth Grade
	AND	3				

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.

Selected Students													
Number of students: 4													
Student ID*	Name	Grade	Location	Time	External Exam	Right W/ Glasses	Left W/ Glasses	Vision 20	Plus 20 Test 20'	LAT MB (Far)	Vert MB (Far)	Fusion (
▶ 17048	Abbott, Emily Jane	06	N	10:28 AM	⊙	P			P	P	P	P	P
▶ 16041	Adams, Thomas	06	N	10:28 AM	⊙	P			P	P	P	P	P
▶ 16035	Frack, Carol Anne	06	N	10:28 AM	⊙	P			P	P	P	P	P
▶ 17077	Frack, Charity	06	N	10:28 AM	⊙	P			P	P	P	P	P

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.
 - 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.

Referral Code*	Referral Date*	Followup Code	Followup Date	Doctor's Name	Referral Comments	
▶ 16041	Adams, Thomas	06	N	10:28 AM	⊙	P
▶ 16035	Frack, Carol Anne	06	N	10:28 AM	⊙	P

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 student fails any portion of the screening a valid state referral and follow-up **MUST** be entered.

Note: Referral and Follow-up code require a Date entry by the software.

Arkansas State Reporting Guidelines		
Valid Referral Codes	Valid Follow-up Codes for Referral of S:	Valid Follow-up Codes for Referral P or E:
E – Eye Doctor P – Physician S – School Nurse G – Guardian can ONLY be used when Colorblind is the only failure	I – In Process T – Re-Screened X – Left District	A – Abex No Lens (Abnormal Exam No Lens Prescribed) I – In Process J – Treatment L – Lens Prescribed N – Normal Exam R – Refused Referral X – Left District
<p>The following Referral codes are used for students who are NOT screened. When a student is not screened due to one of the below reasons, leave the screening fields blank, select the appropriate Referral code from below with the date. No Follow-up value is required on these codes.</p> <p>PR – Written Parent Refusal UN – Unable to Perform Screening (SPED/Acute Disability) VS – Virtual Student Not Screened</p> <p>Note: If the student is not screened for any other reason besides the listed codes, a screening entry should not be added.</p>		

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 set up 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:

Criteria 1 Grade KF & 01	DTaP	HepB	IPV/OPV	MMR	Varicella	HepA	
Criteria 2 Grade 07	DTaP	HepB	IPV/OPV	MMR	Varicella	TDAP	MCV4
Criteria 3 Grade 02 -06 (11 Yr Old)	DTaP	HepB	IPV/OPV	MMR	Varicella	TDAP	
Criteria 4 Grade 02 -06	DTaP	HepB	IPV/OPV	MMR	Varicella		
Criteria 5 Grade 08-12 (16 Yr Old)	DTaP	HepB	IPV/OPV	MMR	Varicella	TDAP	MCV4
Criteria 6 Grade 08-12	DTaP	HepB	IPV/OPV	MMR	Varicella	TDAP	
Criteria 7 Grade EE	DTaP	HepB	IPV/OPV	MMR	Varicella	TDAP	
Criteria 8 Grade SM/SS	DTaP	HepB	IPV/OPV	MMR	Varicella	TDAP	MCV4

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.

Validate Immunizations

Prompts

Building* 16 - Building 16

Calculation Date* ☒ Today ☐ By Date

Active Students Only ☒

Series Type(s)*

Criteria List*

Margin Of Error 4 D - Days

Apply Margin of Error to Doses ☒ All ☐ Selected

Status List* ☒ NR - No Record ☒ IP - In Process ☒ OV - Overdue ☒ CO - Completed ☒ MR - Meets Requirements ☒ NA - Not Applicable

Calculate Overall Status On*

Generate Letters ☐

Generate Notifications ☐

Generate Grace Period Alerts ☐

Filter

Actions	AND/OR	#	Area	Field Name	Condition	Value
<input type="button" value="Add"/> <input type="button" value="Delete"/>		1	Demographic	Grade	<>	PK - Pre-Kindergarten
<input type="button" value="Add"/> <input type="button" value="Delete"/>	AND	2				

Run

☒ Now ☐ Once ☐ Daily ☐ Weekly ☐ Monthly

Recommended to "Select All" by clicking the * (asterisk) in each of the fields:

- Series Types
- Criteria List
- Status List
- Calculate Overall Status On

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 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.

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

#	Area	Field Name	Condition	Value
1	Demographic x ▼	Grade x ▼	is not in x ▼	x PK - Pre-Kindergarten

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

10/22/2015

Page 1 of 9

Immunization Validation - Building 16 Log

16 - Building 16

Student ID	Student Name	Date	Description
16041	Adams, Thomas		Series status (for series DTaP - Schedule DTAP) is overdue
16041	Adams, Thomas		Series status (for series HepB - Schedule HEPB) is overdue
16041	Adams, Thomas		Series status (for series IPV/OPV - Schedule IPV/OPV) is overdue
16041	Adams, Thomas		Series status (for series MMR - Schedule MMR) is overdue
16041	Adams, Thomas		Series status (for series VARICELLA - Schedule Var_2_Dose) is overdue
16041	Adams, Thomas		Series status (for series TDAP - Schedule TDAP) is overdue
16039	Albeth, Lucy		Series status (for series DTaP - Schedule DTAP) is overdue
16039	Albeth, Lucy		Series status (for series HepB - Schedule HEPB) is overdue
16039	Albeth, Lucy		Series status (for series IPV/OPV - Schedule IPV/OPV) is overdue
16039	Albeth, Lucy		Series status (for series MMR - Schedule MMR) is overdue
16039	Albeth, Lucy		Series status (for series VARICELLA - Schedule Var_2_Dose) is overdue
16031	Banks, Lisa Marie	10/02/2009	Series date (for series IPV/OPV dose 3 Schedule IPV/OPV) prior to the Not Until Date using the recommended schedule
16031	Banks, Lisa Marie		Series status (for series IPV/OPV - Schedule IPV/OPV) is overdue
16031	Banks, Lisa Marie		Series status (for series VARICELLA - Schedule Var_2_Dose) is overdue
16031	Banks, Lisa Marie		Series status (for series HepA - Schedule HEPA) is

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 will list 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.

Generate Notification Listing Report

Prompts

Building*
16 - Building 16

Start Date*

By Date
08/28/2017

By Prior Days

End Date*

Today

By Date
08/28/2017

Log Statistics
☒

Filter

Actions	AND/OR	#	Area	Field Name	Condition	Value
<div> <div> </div> <div> </div> <div> </div> </div>		1				

Run

Now
Once

Daily
Weekly

Monthly

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

10/22/2015	Generated Medical Letter Listing Building 16								Page 2 of 12
Criteria Number: 2 7TH GRADE									
Schedule	Student ID	Student Name	Calc Date	Date Printed	Reason	Notify	Notification Date	Notified Users	
MCV4_1_ Meningococcal Conjugate Dose	16034	Coakley, Ryan	10/22/2015		Overdue	0		0	
Var_2_Do Varicella se	16034	Coakley, Ryan	10/22/2015		Overdue	0		0	
MCV4_1_ Meningococcal Conjugate Dose	16036	Frack, Charles	10/22/2015		Overdue	0		0	
Var_2_Do Varicella se	16036	Frack, Charles	10/22/2015		Overdue	0		0	

10/22/2015	Generated Medical Letter Listing Building 16								Page 5 of 12
Criteria Number: 5 8TH - 12TH GRADE (16 YR OLD)									
Schedule	Student ID	Student Name	Calc Date	Date Printed	Reason	Notify	Notification Date	Notified Users	
IPV/OPV Polio	16008	Bradley, Andrew	10/22/2015		Overdue	0		0	
MCV4_2_ Meningococcal Conjugate Dose	16008	Bradley, Andrew	10/22/2015		Overdue	0		0	
TDAP Tetanus/Diph/Acell Pertussis	16008	Bradley, Andrew	10/22/2015		Overdue	0		0	
DTAP Diphtheria-Tetanus-Pertussis	16012	Brookheimer, Melody Lee	10/22/2015		Overdue	0		0	
HEPB Hepatitis B	16012	Brookheimer, Melody Lee	10/22/2015		Overdue	1		0	
IPV/OPV Polio	16012	Brookheimer, Melody Lee	10/22/2015		Overdue	0		0	
MCV4_2_ Meningococcal Conjugate Dose	16012	Brookheimer, Melody Lee	10/22/2015		Overdue	0		0	
MMR Measles-Mumps-Rubella	16012	Brookheimer, Melody Lee	10/22/2015		Invalid Dose(s) 10/30/1987, 1/30/1988	1		0	

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 process.

Generate Medical Letter Merge File screen

Send Communications

Prompts

Building*

16 - Building 16

Calc Date

08/28/2017

Communication Method

☒ Generate Letters
☒ Generate Notifications

Include History

☒

Filter

Actions	AND/OR	#	Area	Field Name	Condition	Value
		1				

Sort

Actions	#	Area	Field Name	Sort Order
	1			

Run

☒ Now
 ☐ Once
☐ Daily
 ☐ Weekly
☐ Monthly

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.apskn.org) > SMS > eSchool 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.

Mass Add Medication Doses

Prompts

Building*	<input type="text" value="16 - Building 16"/>
Medications*	<input type="text" value="x ACPRN - Acetaminophen PRN"/> *
Start Date*	<input type="text" value="08/14/2017"/> 📅
End Date*	<input type="text" value="05/31/2018"/> 📅

Filter

Actions	AND/OR	#	Area	Field Name	Condition	Value
		1	<input type="text" value="Demographic"/> x ▼	<input type="text" value="Current Status"/> x ▼	= x ▼	<input type="text" value="Active"/> x ▼
	AND ▼	2	<input type="text" value="Demographic"/> x ▼	<input type="text" value="Grade"/> x ▼	= x ▼	<input type="text" value="06 - Sixth Grade"/> x ▼
	AND ▼	3	<input type="text"/>			

Selected Students

Number of records found: 0

Student ID	Name
------------	------

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

The Medical menu 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.

The screenshot shows a 'Filter' configuration window with a table of criteria lines. The table has columns for Actions, AND/OR, #, Area, Field Name, Condition, and Value.

Actions	AND/OR	#	Area	Field Name	Condition	Value
		1	Demographic	Current Status	=	Active
	AND	2	Demographic	Grade	=	12 - Twelfth Grade
	AND	3				

- **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:

Actions	#	Area	Field Name	Sort Order
	1	Demographic	Grade	Ascending
	2	Demographic	Last Name	Ascending
	3	Demographic	First Name	Ascending
	4			

- **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.

Run

☒ Now
 ☐ Once
☐ Daily
 ☐ Weekly
☐ Monthly

- **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. 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.

Daily Log Report

Prompts

Building* Office Visit Detail ☐

Start Date* ☒ By Date Medication Issued ☐
☐ By Prior Days Notes ☐

End Date* ☐ Today Log Statistics ☐
☒ By Date

Filter

Actions	AND/OR	#	Area	Field Name	Condition	Value
		1	<input type="text"/>			

Sort

Actions	#	Area	Field Name	Sort Order
	1	<input type="text"/>		

Run

☒ Now
 ☐ Once
 ☐ Daily
☐ Weekly
 ☐ Monthly

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*

10/22/2015 Page 1 of 1

Daily Log Report

15-Building 15

Student Id	Name	Date								
16021	Jones, Sarah	10/22/2015								
	<u>In</u>	<u>Out</u>	<u>Room</u>	<u>Pressure</u>	<u>Puls</u>	<u>Temp</u>	<u>Res</u>	<u>Int</u>		
	10/22/2015 8:30:00 AM		-	/						
	<u>Comments</u>									
	<u>#</u>	<u>Reason</u>	<u>Reason Description</u>	<u>Intervention</u>	<u>Intervention Description</u>	<u>Outcome</u>	<u>Outcome Description</u>			
	1	BL	Blister	BA	Bandaid	BTC	Student Sent Back to Cla			
16033	Banks, Sarah	10/22/2015								
	<u>In</u>	<u>Out</u>	<u>Room</u>	<u>Pressure</u>	<u>Puls</u>	<u>Temp</u>	<u>Res</u>	<u>Int</u>		
	10/22/2015 8:40:00 AM		-	/						
	<u>Comments</u>									
	<u>#</u>	<u>Reason</u>	<u>Reason Description</u>	<u>Intervention</u>	<u>Intervention Description</u>	<u>Outcome</u>	<u>Outcome Description</u>			
	1	C	Coughing	LOZ	Lozenge	BTC	Student Sent Back to Cla			
16023	Johnson, Rudy	10/22/2015								
	<u>In</u>	<u>Out</u>	<u>Room</u>	<u>Pressure</u>	<u>Puls</u>	<u>Temp</u>	<u>Res</u>	<u>Int</u>		
	10/22/2015 10:00:00 AM		-	/						
	<u>Comments</u>									
	<u>#</u>	<u>Reason</u>	<u>Reason Description</u>	<u>Intervention</u>	<u>Intervention Description</u>	<u>Outcome</u>	<u>Outcome Description</u>			
	1	AB	Abrasion	BA	Bandaid	BTC	Student Sent Back to Cla			

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

Medical Card Report

Prompts

Building* 16 - Building 16

Start Date* ☒ By Date ☐ By Prior Days

End Date* ☐ Today ☒ By Date

New Page for each student ☐

Log Statistics ☐

Include the following information

Info	Referral	Note	Detail/Others
<input type="checkbox"/> Dental	<input type="checkbox"/> Dental Referral	<input type="checkbox"/> Dental Notes	
<input type="checkbox"/> Growth	<input type="checkbox"/> Growth Referral	<input type="checkbox"/> Growth Notes	
<input type="checkbox"/> Hearing	<input type="checkbox"/> Hearing Referral	<input type="checkbox"/> Hearing Notes	<input type="checkbox"/> Hearing Detail
<input type="checkbox"/> Physical	<input type="checkbox"/> Physical Referral	<input type="checkbox"/> Physical Notes	<input type="checkbox"/> Physical Detail
			<input type="checkbox"/> Normal Exam
			<input type="checkbox"/> Athletic Exam
<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Scoliosis Referral	<input type="checkbox"/> Scoliosis Notes	
<input type="checkbox"/> Vision	<input type="checkbox"/> Vision Referral	<input type="checkbox"/> Vision Notes	
<input type="checkbox"/> Medication Issued			
<input type="checkbox"/> Office Visit		<input type="checkbox"/> Office Visit Notes	<input type="checkbox"/> Office Visit Detail
<input type="checkbox"/> Medical Alert			
<input type="checkbox"/> Medical Disability			
<input type="checkbox"/> Vaccination	<input type="checkbox"/> Vaccination Referral		<input type="checkbox"/> Vaccination Series
<input type="checkbox"/> Codes Legend			

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 be printed at the end of the complete report.

Sample Medical Card

File name –Medical Card Report

10/22/2015		Page 1 of 12	
Medical Card Report			
15-Building 15			
Student Id	Name	Gender	Grade
16014	Harris, Jasmine	F	12
DOB	Status	Counselor	
10/20/1997	A	T1677MP	
Hearing Test			
Date	Grade	Location	Right Ear
3/18/2004	10		
12/30/2005	10		
Scoliosis Exam			
Date	Grade	Location	Status
12/30/2005	10		
Vision Test			
Date	Grade	Location	External Exam
12/30/2005	10		
Immunization Shots			
Overall Status: OV		As Of: 10/22/2015	
		Override: N	
Shot Code	Dose	Exempt	Override
DTaP	0		N
TDAP	0		N
IPV/OPV	0		N
Polio	0		N
HepB	0		N
MMR	0		N
Varicella	0		N
DPT	0		N
EPsDT	0		N
Immunization Series			
Overall Status: OV		As Of: 10/22/2015	
		Override: N	
Series Code	Dose	Status	As Of
DTaP	0	OV	10/22/2015
TDAP	0	OV	10/22/2015
IPV/OPV	0	OV	10/22/2015
Polio	0	NA	7/27/2011
HepB	0	OV	10/22/2015

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

Vision Notice To Parents

Prompts

Building*

16 - Building 16

Report Date*

02/24/2018





Start Date*

07/03/2017





End Date*

02/23/2018

Filter

Actions	AND/OR	#	Area	Field Name	Condition	Value
 		1	Demographic	Current Status	=	Active
 	AND	2				

Sort

Actions	#	Area	Field Name	Sort Order
 	1	Demographic	Last Name	Ascending
 	2			

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. The 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*

<u>NOTICE TO PARENTS OF NEED FOR AN EYE AND VISION EXAMINATION</u>							
Date: 4/6/2018				School: Building 16			
Student: Banks, Lisa Marie				Grade: 01 Teacher: Mr. Christopher			
Your child passed the eye and vision screening:				<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
Screened with Glasses				<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
<u>REASON FOR NOT PASSING</u>							
Blurred vision at a distance	<input checked="" type="checkbox"/>	Eye Muscle Problem	<input type="checkbox"/>	Blurred vision at near	<input checked="" type="checkbox"/>		
Eye Health	<input checked="" type="checkbox"/>	Plus (+) Lens Test	<input checked="" type="checkbox"/>	Other	<input type="text"/>		
Dear Parent,							
<p>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.</p>							
Parent authorization to release medical information (Signature) <input type="text"/>							
School Nurse Signature <input type="text"/>							
<u>REPORT OF DOCTOR'S EVALUATION</u>							
Visual Acuity	@20 feet		@ near		@20 feet		@ near
Without Rx	Right	20/ <input type="text"/>	20/ <input type="text"/>	With Rx	Right	20/ <input type="text"/>	20/ <input type="text"/>
	Left	20/ <input type="text"/>	20/ <input type="text"/>		Left	20/ <input type="text"/>	20/ <input type="text"/>
Eye Muscles	A-Normal		B-Subnormal				
Accommodation:	<input type="text"/>	Convergence:	<input type="text"/>	Binocularity:	<input type="text"/>	Eye Movement:	<input type="text"/>
<u>Eye/Vision Diagnosis</u> <input type="text"/>							
Right	Hyperopia <input type="text"/>	Myopia <input type="text"/>	Astigmatism <input type="text"/>	Amblyopia <input type="text"/>	Muscle Problem <input type="text"/>		
Left	Hyperopia <input type="text"/>	Myopia <input type="text"/>	Astigmatism <input type="text"/>	Amblyopia <input type="text"/>	Muscle Problem <input type="text"/>		
Internal and External Eye Health <input type="text"/>							
Glasses Prescribed:	Yes	No	To be worn:	Full Time	Distance only	Reading only	
Other problems (comments or instructions) <input type="text"/>							
Date of Examination <input type="text"/> / <input type="text"/> / <input type="text"/>				Date of Re-Examination <input type="text"/> / <input type="text"/> / <input type="text"/>			
Examiner's Name: <input type="text"/>				Signature: <input type="text"/>			
Address: <input type="text"/>				Phone: <input type="text"/> Date: <input type="text"/>			
Please fax this form to: School Nurse <input type="text"/>				Fax Number <input type="text"/>			
OR Mail this form to: <input type="text"/>							

Vision Summary Report

The Vision Screening Summary Report allows the choice of generating either a summary or a detailed 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 in 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

Vision Summary Report

Prompts

Building List*

x 16 - Building 16

Screen/Title

Beth Moore

School Nurse

Start Date*

08/15/2016

Ruby Wright

School Nurse

End Date*

02/24/2017

Report Type*

S - Summary

Form Completed By

Mary Alice, RN

Email Address

me@yahoo.com

Filter

Actions	AND/OR	#	Area	Field Name	Condition	Value
		1	<input type="text"/>			

Sort

Actions	#	Area	Field Name	Sort Order
	1	<input type="text"/>		

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 is sorted 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.

10/22/2015

Page 1 of 16

Vision Screening

School: Building 16

Grade: 01

Teacher: Mr. Christopher

Name	External Exam	Vision 20'	+2.00 Test 20'	Lat. MB (Far)	Vert. MB (Far)	Fusion (far)	Lat. MB (near)	Fusion (near)	Color	Pass/Fail (rescreen)
Banks, Lisa Marie										
Banks, Maria	P	P	P	P	P	P	P	P	P	P
Banks, Sarah	P	P	P	P	P	P	P	P	P	P
Total Pass:	2	2	2	2	2	2	2	2	2	2
Total Fail:	0	0	0	0	0	0	0	0	0	0

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

10/22/2015

Page 8 of 16

Vision Screening

School: Building 16

Grade: 09

Teacher: Mr. Herda

Name	External Exam	Vision 20'	+2.00 Test 20'	Lat. MB (Far)	Vert. MB (Far)	Fusion (far)	Lat. MB (near)	Fusion (near)	Color	Pass/Fail (rescreen)
Fujie, Chiharu										
Hall, Tyrone, III										
Martinez, Julio										
Velazquez, Carmen David										
Total Pass:	0	0	0	0	0	0	0	0	0	0
Total Fail:	0	0	0	0	0	0	0	0	0	0

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'.
- Rec'd Examination – Count of Referral of 'P' or 'E' and Follow-up of 'L', 'N', 'J', or 'A'.
- 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*

10/22/2015 4:50:18 PM		Arkansas Department of Education Vision Screening Program 8/17/2015 — 10/22/2015															
Name of District / Private School: Building 16		County:															
Vision Screening Summary Form																	
Number of Students	NG	Prek	K	1st	2nd	3rd	4th	5th	6th	7th	8th	9th	10th	11th	12th	Total	Tran
Screened	0	0	0	0	0	0	0	2	6	0	0	0	0	0	0	8	0
Rescreened	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Referred	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Received Examination	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Confirmed Difficulty by Professional	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Confirmed Normal Eye/Vision by Professional	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Form Completed by: Ruth Nightingale, RN		Name of Screener(s) Beth Moore								Title School Nurse							
Mailing Address: 225 MarketPlace		Ruby Wright								School Nurse							
Little Rock, AR 18018																	
Email Address: rnightengale@schoolmail.org																	

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. Districts may add additional values to the Location table.

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.

Code	Description
N	Student Not Tested with Corrective Lens
Y	Student Tested with Corrective Lens

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 values 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.

Code	Description
Comments	Converted Comments
Lice	Head Lice

Interventions

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

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

Temperature Method

The Temperature Method 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.