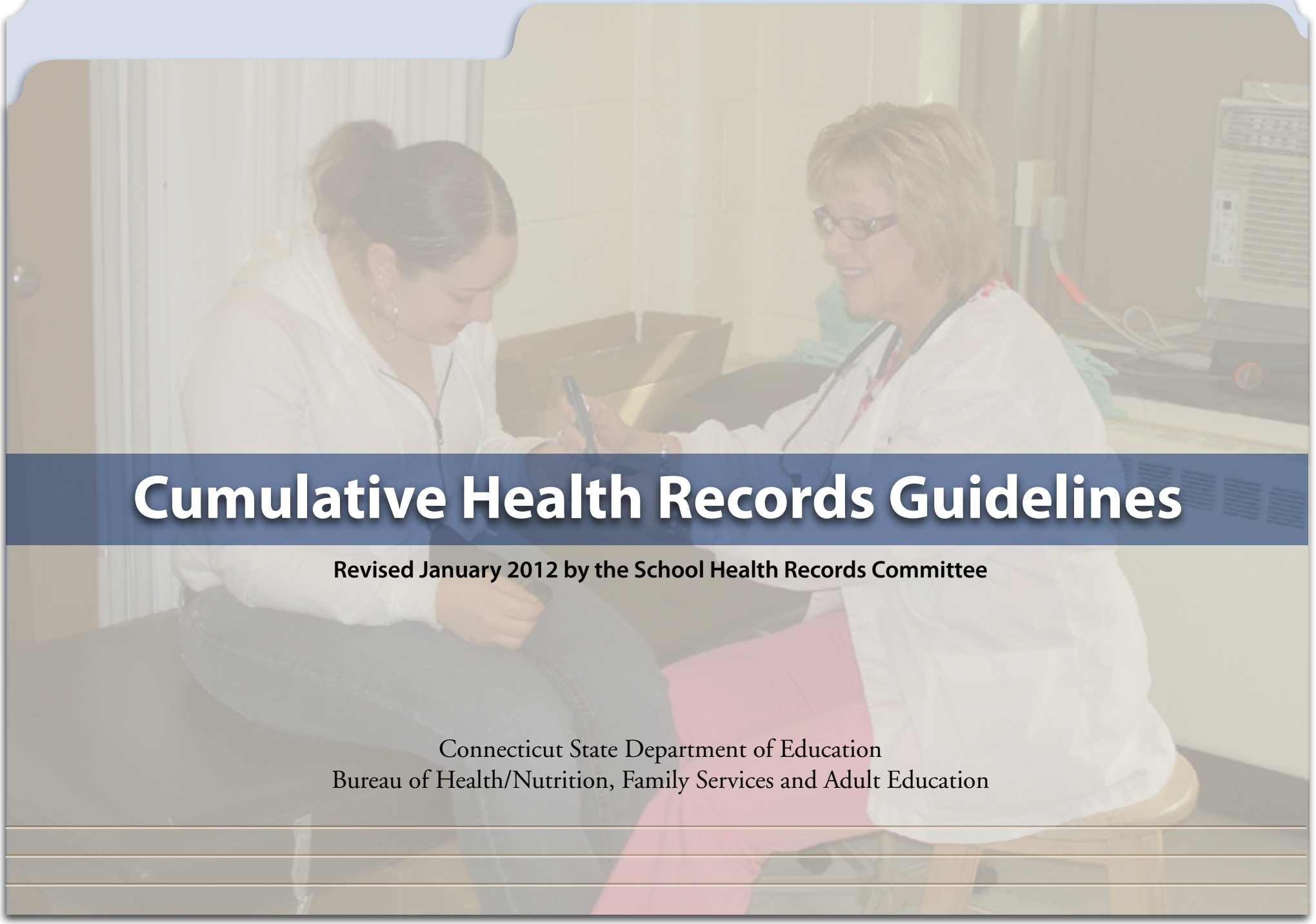

Cumulative Health Records Guidelines

Revised January 2012 by the School Health Records Committee

Connecticut State Department of Education
Bureau of Health/Nutrition, Family Services and Adult Education

CONTENTS

August 1997/Revised October 2002/Revised January 2012

OBJECTIVE

The purpose of these guidelines is to promote consistent written and electronic documentation of student health history as mandated by Connecticut General Statutes Sections 10-206(d) *Health assessment* and 10-204a *Required immunizations*.

CUMULATIVE HEALTH RECORD

The Cumulative Health Record (CHR-1) serves as the official student health record within Connecticut schools. As such, it is recognized as a legal document. It provides a systematic way to organize the collection of health information, and document health services provided to individual students.

For record keeping, written or electronic:

- *black* ink should be used for all documentation;
- life-threatening allergies must be documented on the front of the CHR-1 in *red* ink;
- phone numbers are written in *pencil*; and
- no other notation, no flagging or any other color-coding should be used.

The "student's name" must be printed clearly on each page of the CHR-1.

IDENTIFYING INFORMATION (MUST BE WRITTEN ON THE CHR-1)

Student's Name Print student's legal name clearly (last, first, middle).

Gender Identify by circling M – male or F – female.

Date of Birth Document numerically (mm-dd-yyyy).

Student's Legal Name Change A legal name change must be documented on the CHR-1 and supported by a nursing note that includes the verified date of the name change. A single black line should be drawn through the previous name.

Date Document date of legal name change (mm-dd-yyyy).

Mother/Father/ Guardian's Name Complete full names, including last and first names. If the guardian is named, "guardian" should be circled. Note if the mother/father/guardian is deceased.

Phone Numbers If phone numbers are not available elsewhere (such as emergency forms, computer database) they must be documented on the CHR. All phone numbers are to be written in pencil. Be sure to erase previous or out-of-order phone numbers.

Address Enter current address. If additional space is needed for multiple addresses, check the box marked "See Continuation Sheet" on the last line. Photocopy the front of a blank CHR-1, document the appropriate identifying information and place inside CHR-1.

Entry/Exit Dates Document the dates when a student enters and exits a school (mm-dd-yyyy).

School Name/ Town School name and town must be completed. Update as needed.

NURSE'S NOTES/DOCUMENTATION

Hand-written nurses notes must be maintained in the CHR-1. All original nursing notes must be included in the CHR.

Electronic nurse's notes must be printed and filed in the CHR-1 upon a student's transfer to another school in district or out of district whenever electronic nurses' notes cannot be transferred electronically.

SECTION I — MANDATED HEALTH ASSESSMENTS

In Connecticut, health assessments are required prior to public school entrance, in Grade 6 or 7, and in Grade 9 or 10 (Connecticut General Statutes Section 10-206 *Health Assessments,* http://www.cga.ct.gov/2011/pub/chap169.htm.) The specific grades are determined by the local or regional board of education. Mandated health assessments are also required for students in ungraded classrooms at an age-appropriate time, and for students in approved private special education schools.

All health assessments are to be maintained together, in reverse chronological order, with the most recent Health Assessment Record (HAR-3) placed in the front of the CHR-1.

The following information must be transcribed on to the CHR-1 for all mandated HAR-3:

- school year;
- date of the examination;
- grade; and
- confirmation by initials and date that the mandatory HAR-3 has been:
    1. reviewed by the school nurse;
    2. meets state mandated requirements; and
    3. filed in the CHR-1.

This documentation is required whether or not HAR-3 documentation is recorded electronically.

Note:
Documentation of non-mandated health assessments is not required on the CHR-1.

SECTION II — SPORTS PHYSICALS

This section refers to any sports physicals. The following information may be transcribed on to the CHR-1:

- school year;
- date of the examination; and
- grade.

SECTION III — SIGNIFICANT HEALTH CONDITIONS

This section assists schools in planning a safe and appropriate educational program for the student. Significant health problems may include physical, psychological or social issues, and *functional concerns* that affect students. *Functional concerns* include impairment or limitation of any activity of daily living (such as wheelchair use, severe visual or hearing impairment). Medications or technology used at home may be included in this section. Information listed should be dated and brief.

Important Note:

According to Connecticut General Statutes Section 19a-583, Human immunodeficiency virus (HIV)/Acquired immune deficiency syndrome (AIDS) information cannot be recorded on the CHR-1. Any/all correspondence regarding the HIV/AIDS status of a student without proper consent must be returned to the sender.

SECTION IV — PRESCRIBED MEDICAL INTERVENTIONS IN SCHOOL

This section refers to medications, procedures or treatments administered in school. Medications administered outside school hours may be documented in a nurse's note.

Document the start date, medical interventions, authorizing prescriber, usage summary and end date.

SECTION V — SCREENING RESULTS

This section refers to screenings performed in school or as part of the health assessment (Connecticut General Statutes Section 10-206 *Health Assessments*, http://www.cga.ct.gov/2011/pub/chap169.htm). The grade/school year, dates and results of the screenings must be documented on the CHR-1 or in students' electronic records.

Vision Screening include a numerical value (such as, 20/20). Document glasses/contacts next to the asterisk (*) in current school year.

Auditory record as P – pass or F – fail.

Postural record as P – pass or F – fail.

Other (Specify) refers to other health screenings (such as abnormal tuberculosis [TB] or lead screenings), which should be documented according to local school district procedures.

SECTION VI — REFERRAL INFORMATION

When referring students for screening failure, or for any other health concern, document referral and date. Referrals, outcomes and follow up must be documented in a nursing note and can be indicated in *Section III — Significant Health Conditions.*

SECTION VII — IMMUNIZATION RECORD

Immunization dates must be accurate, clear and documented numerically (mm/dd/yyyy). Record each immunization according to the specific immunization administered. Information on immunization requirements may be accessed at the State Department of Public Health, Connecticut Immunization Program Web site at http://www.ct.gov/dph/site/default.asp.

Electronic record keeping: Indicate if immunization record is documented electronically (check box). A current summary of immunizations must be printed and placed in the CHR-1 when students transfer out of district, withdraw, graduate, exit the school district or per school district protocol.

For *"Other Vaccines,"* complete this section with the name and date of administration of the vaccine (such as Pneumovax mm/dd/yyyy).

The **disease history** line must be used for vaccine preventable diseases including, measles, mumps, rubella, diphtheria, tetanus, polio, hepatitis and chicken pox.

Documentation of disease history or immunity must be confirmed by a blood titer. The name of the provider who has interpreted the blood titer must also be recorded. Record as follows for *"Disease Hx of the above"*:

- *Specify* – identify the disease (such as measles);
- *Date* – place the date of the titer; and
- *Confirmed by* – place the name of the provider who interpreted the titer.

Exception: Chicken pox can be documented here but needs either confirmation by a blood titer or documentation of the disease in writing by a medical doctor, doctor of osteopathic medicine, advanced practice registered nurse or physician assistant.

Exemption: Religious exemption remains in effect until the parent/guardian gives written notice of change. Enter date of written notification on the line next to *"Religious."*

Medical exemption — the underlying issue can be permanent or temporary. **Temporary exemptions must be renewed in writing annually.** Document in a nurse's note if clarification is required.

Immunizations Exemptions Certification Forms are located on the State Department of Public Health Web site at http://www.ct.gov/dph/cwp/view.asp?a=3136&q=388416.

Note: Tuberculin test information should be recorded in *Section V – Screening Results,* not in this section.

TRANSFERRING CUMULATIVE HEALTH RECORDS

Connecticut General Statutes Section 10-206(d), *Health Assessments,* provides guidance for the transfer of students' health records. For students transferring to another school district in Connecticut, the original CHR-1 must be sent to the new school and a true copy retained by the sending school within the local or regional board of education. For a student leaving Connecticut, a copy of the CHR-1 should be sent upon request and the original retained by the local or regional board of education.

The CHR-1 (original or true copy), under this statute, is sent to the chief administrative officer of the school district. For protection of confidential student health information, the chief administrative officer may designate that the information be sent from nursing personnel to nursing personnel.

The Family Education Rights and Privacy Act (FERPA) allows for the transfer of records to the next educational institution without parental consent if the parents have been given reasonable notice either through the annual district notice or prior to forwarding the record and the option to request a copy of the record to be transferred.

CONTENTS OF THE CHR THAT MUST BE TRANSFERRED:

- 504 Accommodation Plans, if housed in the CHR-1.
- Annual Athletic/Sports Physical Exams and Interim Health Histories for sports.
- Controlled Substance Medication Administration Records - original records must be maintained in the school where the controlled medication authorization was received for three years and a copy transferred within the school district and out of the school district. Original records are to be included in the CHR at the end of the school year or summarized on the CHR in the section titled "Medications" or in the student's electronic record at the end of the school year. If the summary is not done, then these sheets must be kept in the CHR for six years after the student leaving the district. **Records for controlled substances must be maintained in a separate file from the CHR, in the school where the order was received and where the controlled medication was administered. This separate file must not be transferred.**
- DCF W-136 form and follow up reports, if housed in the CHR-1 per local school district policy. If the referral involves an assessment from the nurse, a notation of the assessment should be included in the CHR or student's electronic record.

- Developmental/Health Histories.
- Early Childhood Health Assessment Record forms (ED 191).
- Emergency Care Plan (ECP), for the current and prior school years.
- Follow-up Health Care Provider Evaluations.
- HAR-3 forms (Health Assessment Records).
- Health Assessment Data (such as school entry information, mandated health histories, asthma, allergy and diabetes information).
- Health Care Provider Reports.
- Individual noncontrolled Medication Administration Records, unless summarized on the CHR.
- Individualized Health Care Plan (IHCP).
- Mandated Screening Referrals and Follow-up summary.
- Nursing Notes/Documentation (such as progress notes, episodic or daily health room visit documentation, unless summarized on CHR or in the electronic record.)
- Original Medication Authorizations Orders including parental/guardian authorization.
- Prescribed procedure or treatment authorizations must be kept in the CHR for six years after the student leaves the district.
- Prescribed procedure or treatment documentation logs or flow sheets, unless summarized on the CHR or in the electronic record and must be kept in the CHR for six years after the student leaves the district.
- Self-Administration Assessment Forms.
- Special Health Care Procedure Orders, including parental/guardian authorization.
- Summary of Nursing Health Assessments of students for the purpose of IEPs or Section 504 plans (not raw data).

INFORMATION THAT REMAINS FILED IN DISTRICT (NONTRANSFERABLE FORMS):

- Access Sheets.
- Miscellaneous Health Care Provider and Parent Notes.
- Release of information forms.
- Third-party reports (such as medical and psychiatric records).

Important Note:
Any information regarding the HIV/AIDS status of a student cannot be recorded in the CHR. If received without proper consent, information must be returned to the sender according to Connecticut General Statutes Section 19a-583.

INFORMATION NOT TO BE KEPT IN CHR:

- Accident/Incident Reports.
- Controlled Substance Medication Record — **a file (record) separate from the CHR and electronic health record** must be kept with a copy of the individual medication administration sheets for controlled substances and a copy of the medication order for three years. These records must also be stored in the school where the medication was administered. After three years, the file can be destroyed.
- Raw Data from Nursing Assessments.
- Sole Possession Notes.

Destruction of school records
Destruction of any records must be in accordance with the Connecticut Municipality Record Retention Schedule for Education Records (CGS 11-8a) — See *Appendix A — Municipal Records Retention Schedule M8: Education Records (2005)* and for controlled drugs, the Department of Consumer Protection, pursuant to Section 21a-262-3 of the Regulations of the Connecticut State Agencies.

APPENDIX

Municipal Records Retention Schedule M8: Education Records (2005)
http://www.cslib.org/publicrecords/reteducation.pdf

GLOSSARY

Access Sheets. A record indicating the date and the person or agency accessing the student's record as required by the Family Education Rights and Privacy Act.

charter schools. A charter school is a public nonsectarian school organized as a nonprofit corporation and operated independently of a local or regional board of education. Charter schools are authorized by the State Board of Education and are funded by the state. School health records are maintained in the same fashion as any local or regional public school.

Connecticut Early Childhood Health Assessment Record (ED 191). The Health Assessment Record for children in early childhood programs (birth to 5 years old), commonly referred to as the "yellow form."

Cumulative Health Record (CHR-1). The CHR-1 serves as the official student health record in Connecticut schools. As such, it is recognized as a formal part of an educational record and must be maintained as such. It provides a systematic way to organize the collection of student health information.

HAR-3. Health Assessment Record, a form supplied by the Connecticut State Department of Education per Connecticut General Statutes, Section 10-206(d), commonly referred to as the "blue form."

Health Assessment Data. School-generated developmental health histories elicited at school entrance (kindergarten or new entrants) and at the most current grade required by the local school district.

Health Care Provider Evaluations. Any evaluations or reports related to a student's health status or as a result of a health referral made by the school district. This includes all health care provider's evaluations and notes from the current and prior school years.

health care provider notes. Documentation received from health care providers concerning health issues (other than referral follow-up summary reports).

Interdistrict Magnet Schools. A magnet school is a publicly funded school operated by a local or regional school district, by a regional educational service center or by cooperative agreement involving two or more districts. School health records are maintained by the owner of the magnet school.

mandated vision, hearing and scoliosis screening referrals and follow-up summary reports. All mandated screening referral forms including the follow-up summary. This includes all referrals and reports from the current and prior school years.

medication orders. The authorization by an authorized prescriber for the administration of medication to a student during school activities for the current school year. All medication orders for the current and prior school years should be maintained in the CHR-1.

Nursing Notes/Documentation. Documentation on individual student health room visits including assessment data, significant findings, nursing interventions and outcomes.

parent notes. Notes received from parents concerning health issues.

prescribed procedure or treatment authorizations. The authorization by an authorized prescriber for medical procedures (or treatments) for a student and must be kept in the CHR-1 for six years after the student leaves the district.

raw data (including forms). Data collected for completing a health history assessment of a student for an IEP or 504 or other processes.

Regional Educational Service Centers (RESC). A RESC, which provides contracted programs and services to local and regional boards of education, is viewed as an extension of the local school district; therefore, the health record would be returned to the local school district.

release of information. Specific written authorization that the parent/guardian or eligible student has signed granting the school permission to exchange information either verbally or in writing with an outside provider.

Same Health Services. Nurses and others who provide same health services to nonpublic and nonprofit schools pursuant to Connecticut General Statutes Section 10-217a, must maintain records in the same fashion as the local or regional public school district.

Section 504 Accommodation Plan. Accommodation plan developed by the district, pursuant to Section 504 of the Rehabilitation Act of 1973, to meet the student's needs. A copy of the 504 plan related to a student's health care needs should be filed in the CHR-1. Originals are filed in the student's academic record.

Sole Possession Notes. Records that are kept in the sole possession of the school nurse, are used only as a personal memory aid, and are not accessible and discussed with any other person.

specific health information questionnaires, (such as for, asthma, allergy, diabetes and seizures). Questionnaire forms that are updated by parents to provide the school nurse with medical or other information specific to a student's health issue.

summary of nursing health assessment for an IEP, 504 or other processes. The summary of the most recent collection and analysis of a student's health needs or data relevant to their educational progress. These summaries are used to plan interventions and accommodations in collaboration with the school team to promote student's health and learning.

Third-Party Reports. Reports sent to an educational institution upon request of the school from an outside provider or source (such as hospitals, clinics, and private providers). These records may be, but are not limited to, medical records and evaluations, psychological evaluations and reports. These third-party records shall not be transferred to the new district without written parental permission. A notation should be made on the CHR-1 stating that third party information was received, including the date of the report and the provider name. Medical records or evaluations completed by the medical advisor or psychiatrist employed by the district or as the result of an evaluation at the expense of the school are not considered third-party reports.

usage summary. A summary of the indication for medication administration.

yearly sports physical exams and interim health histories for sports. Yearly physical assessments required by the Connecticut Association of Schools, Connecticut Interscholastic Athletic Conference or local district in order for students to participate in sports.

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