



Synergy[™]

Student Information System

Synergy SIS[©]

Health User Guide



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This edition applies to Synergy SIS™ Student Information System software and all subsequent releases and modifications until indicated with new editions or revisions.

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ABOUT THIS MANUAL

Edupoint Educational Systems develops software with multiple release dates for the software and related documentation. The documentation is being released in multiple volumes to meet this commitment.

The table below lists the release date, software version, documentation volume number, and the content included in each volume of documentation to date.

Software and Document History

Date	Volume	Edition	Revision	Content
August 2009	1	1	1	Initial release of this document
March 2010	1	1	2	Updated to include changes from the November 2009 release and the February and March 2010 patches
June 2011	1	1	3	Updated to include changes from the June 2011 release
February 2013	1	1	4	Updated to include changes from the February 2013 release

CONVENTIONS USED IN THIS MANUAL

Bold Text

Bold Text - Indicates a button or menu or other text on the screen to click, or text to type.



Tip – Suggests advanced techniques or alternative ways of approaching the subject.



Note – Provides additional information or expands on the topic at hand.



Reference – Refers to another source of information, such as another manual or website



Caution – Warns of potential problems. Take special care when reading these sections.

BEFORE YOU BEGIN

Before installing any of the Edupoint family of software products, please be sure to rescreen the system requirements and make sure the district's computer hardware and software meet the minimum requirements. If there are any questions about the system requirements, please contact an Edupoint representative at (877) 899-9111.



Caution: The Edupoint family of software does not support the use of pop-up blockers or third-party toolbars in the browser used to access Synergy SIS. Please disable any pop-up blockers (also known as pop-up ad blockers) and extra toolbars in the browser before logging into any Edupoint product.

At any point, if there are any technical difficulties, please contact the Edupoint technical support team at support@edupoint.com or by phone at 1-877-899-9111 option 1.

Chapter One: HEALTH

In this chapter, the following topics are covered:

- ▶ Screening health records
- ▶ Adding & editing health records
- ▶ Working with the Medication & Service Monitor

This user guide covers the **Health** folder, where student immunizations records are entered and student health screening results are recorded. Screens in the Health folder can also record any health-related incidents and track student medications that need to be administered by school personnel. Alerts can be configured to warn staff in any screen in Synergy SIS when the student has a medical condition such as a food-related allergy.

The setup and configuration of the screens in this user guide, as well as the security for each screen, is explained in the companion guide to this manual. The companion guide is titled the *Synergy SIS – Health Administrator Guide*.

VIEWING HEALTH RECORDS

The **Health** screen searches by student for health conditions and medications required. It includes immunizations and a health history for each student. To access the **Health** screen:

1. Open the **Synergy SIS Navigation Tree** by clicking on the Tree button.

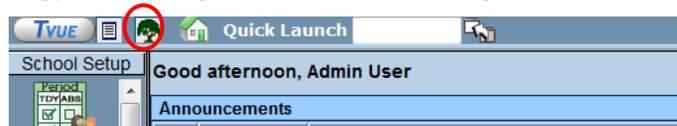


Figure 1.1 – Synergy SIS Navigation Tree

2. Expand the **Synergy SIS** folder by clicking on the blue triangle pointing right, next to the word Synergy SIS. Once clicked, the triangle will turn green and point downward.

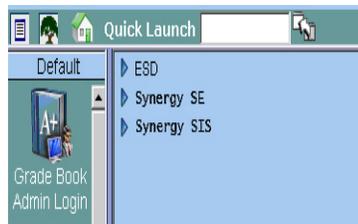


Figure 1.2 – Synergy SIS Folder



Figure 1.3 – Synergy SIS Folder Expanded

3. Under the Synergy SIS folder, open the **Health** folder by clicking on the blue triangle pointing right, next to the words Health. Once clicked, the triangle will turn green and point downward.



Figure 1.4 – Health Folder



Figure 1.5 – Health Folder Expanded

4. Click on the **Health** icon. The health screen will appear in the content pane on the right side of the screen.



Figure 1.6 – Health Screen Icon

To find a **Health** record, there are two methods: **Scroll or Find mode**. To scroll through the student records to find the student:

1. Click on the **right Scroll button** to advance to the first health record. Records are sorted alphabetically by student last name.

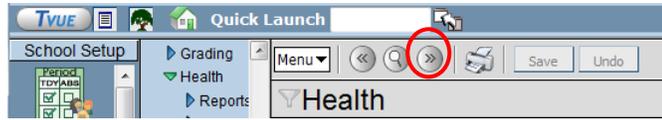


Figure 1.7 – Right Scroll Button

2. To scroll in reverse descending order, click the **left Scroll button**.



Figure 1.8 – Left Scroll Button

3. Continue clicking on the scroll button until the desired health record appears.

To switch to the Find mode to look for a **Health** record:

1. Click on the **Find Mode** button.



Figure 1.9 – Find Mode Button

2. Enter either the entire last name or the first part of the last name of the student in the **Last Name** box.

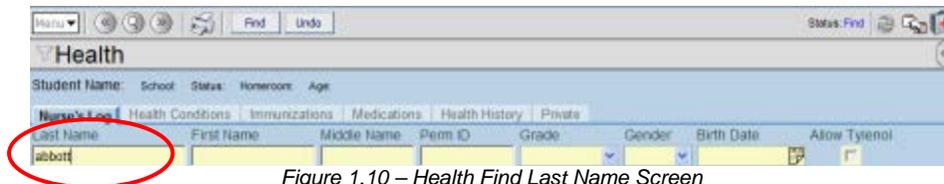


Figure 1.10 – Health Find Last Name Screen

3. Click the **Find** button or press the **Enter** key. The first student with the last name entered into the Find screen will appear. Then use the scroll buttons to find the exact student.



Note: In the Find Mode, students can also be found by searching by any of the yellow fields on the screen. For example, a first name may be entered in addition to the last name. This will bring up a pop-up screen with a list of students matching the criteria entered when the Find button is clicked. To select a student, click on their name and the student record selected will appear in the Health screen. For more about finding students in any screen, please refer to the *Synergy SIS – Student Information User Guide*.

Once the desired record has been located, the information in the Health screen is:
 On the **Nurse's Log tab**, a record of all visits to the nurse's office as well as any accidents or other health-related incidents is detailed. In the list of records, the date of the visit as well

as the time the student entered and left is recorded. It also shows who referred the student to the nurse, the staff member who treated the student, and the clinical code for the student's issue.

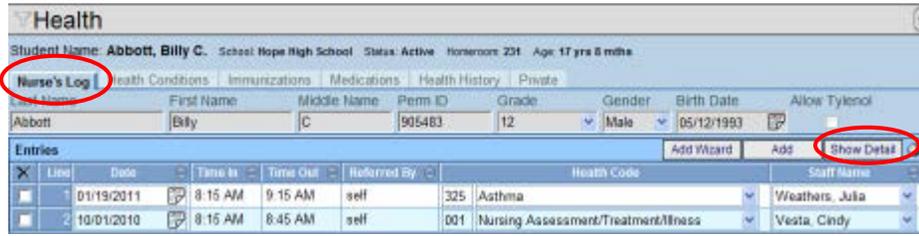


Figure 1.11 – Health Screen, Nurse's Log Tab

For a detailed screen of each visit, click the **Show Detail** button. Select the record to view by clicking on the Date of the record on the left side of the screen. The selected record is highlighted in green.

In the detailed screen of each record, the **Log tab** shows all of the information displayed on the main screen, as well as the date set for follow-up, when parent contact was attempted and made, a subjective description of the student's condition, and the assessment of the student's condition and treatment plan. Additional clinical codes may also be listed.

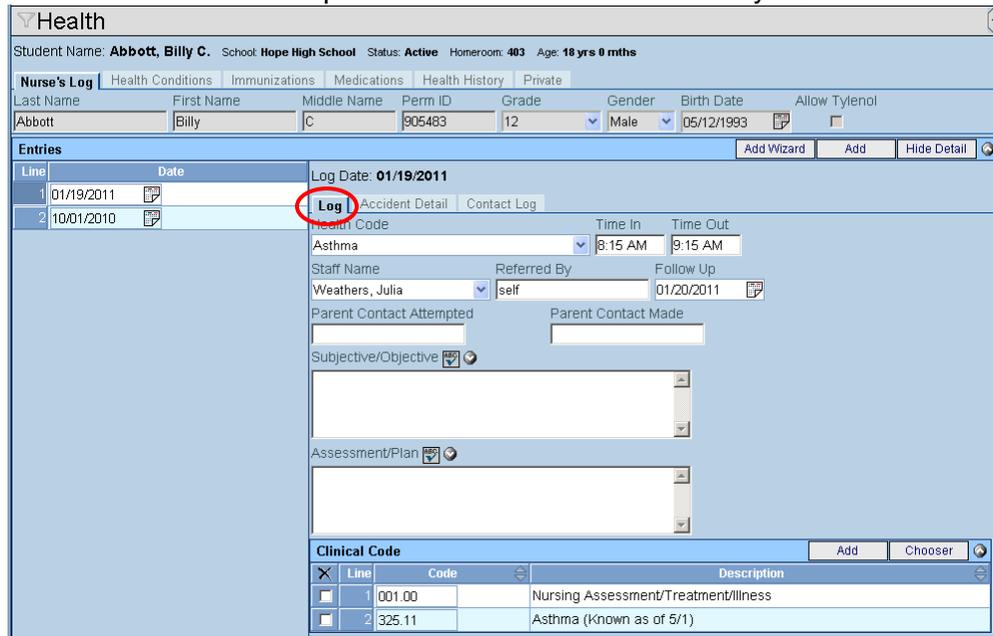


Figure 1.12 – Health Screen, Nurse's Log Tab, Detailed Screen, Log Tab

On the **Accident Detail tab** of the detailed screen, it records the date, time, and location of the accident and, if appropriate, an end date. It also shows who initially assisted the student and the staff member who supervised the medical treatment. Additional details that may be recorded include the status of the student's accident insurance, if additional medical care was recommended and if so, where the student was taken and who picked up the student and when. It records why the student was at the location, any witnesses to the incident, the follow-up care needed by the student, any preventative measures taken to prevent future incidents, and other people notified as well.

The screenshot displays the 'Health' application interface. At the top, it shows the student's name 'Abbott, Billy C.', school 'Hope High School', status 'Active', homeroom, and age '10 yrs 6 mths'. Below this is a navigation bar with tabs: 'Nurse's Log', 'Health Conditions', 'Immunizations', 'Medications', 'Health History', and 'Private'. The 'Nurse's Log' tab is active, showing a table of entries. The first entry is highlighted, showing a date of '02/12/2013'. To the right of the table is a detailed form for the accident, including fields for 'Log Date', 'Accident Date', 'Accident Time', 'Initial Care Given/By Whom', 'Accident Location', 'End Date', 'Supervising Staff Member', 'Medical Care Recommended', 'Student covered by School Accident Insurance', 'Taken Where After Accident', 'Picked Up By', 'Time Taken', 'Reason Injured Person was on the Premises', 'Witnesses', 'Follow Up', 'Preventative Measures Taken', and 'Other Persons Notified'.

Figure 1.13 – Health Screen, Nurse's Log Tab, Detailed Screen, Accident Detail Log

A letter and form detailing the accident can also be printed to be sent home to the student's parents.



Note: A Mail Merge may need to be created if one is not been provided by the district.

To print the accident form:

1. Leave the **Merge Document** and **Merge Language** fields blank

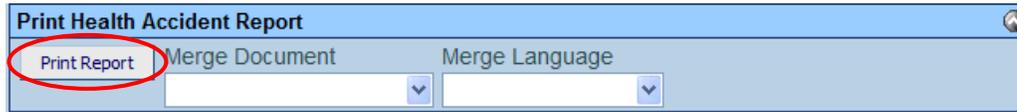


Figure 1.14 – Health Screen, Nurse’s Log Tab, Detailed Screen, Printing the Accident Report Form

2. Click the **Print Report** button. The Student Accident/Incident Report form pops-up in a separate PDF window. This report can also be generated from the Reports folder using report HLT203.

Hope High School						Year: 2008-2009
Student Accident/Incident Report						Report: HLT203
Student information						
Student Name: Abbott, Billy	Perm ID: 905483	Gender: M	Grade: 12	Phone: 480-555-1214	Homeroom: 231	
Address: 1955 S Val Vista Dr		City: Mesa	State: AZ	Zip Code: 85234		
Accident information						
Accident Location: Gym			Accident Date: 03/20/2009	Time Accident Occured: 9:07 AM		
Reported by: McGrew, Tom	Date Reported: 01/14/2010	Parent Contact Attempted At: 9:08 AM	Parent Contacted At: 9:08 AM			
Describe Accident, Give Specific Location and Condition of Premises: Billy fell down in gym class and fractured his ankle.						
Medical information						
Detailed Injury Description: His mother picked him up and took him to the hospital.						
Care Given/By Whom: Joe Coach				Medical Care Recommended: Yes		
Reason Injured Person was on the Premise(s) (lunch, P.E., etc.): Gym class						
Persons Familiar with Circumstances(Name & Title): Joe Coach, Suzie Student						
Staff Member Responsible for Student Supervision at Time of Incident:			Student Covered by School Accident Insurance: No			
Where Taken After Incident(Specify home, hospital, etc.): Hospital			By Whom: Mother	Time Taken: 10:15 AM		
Follow-Up:						
Preventative Measure Taken:						
Signatures						
Principal Signature: _____			Date Signed: _____			
Nurse Signature: _____			Date Signed: _____			
Printed by Admin User at 01/14/2010 8:39 AM Edupoint School District Page 1 of 1						

Figure 1.15 – Student Accident/Incident Report

To print a cover letter to accompany the form:

1. Select the mail merge document from the **Merge Document** drop-down list.

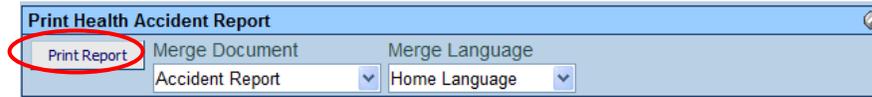


Figure 1.16 – Health Screen, Nurse’s Log Tab, Detailed Screen, Printing the Accident Report Letter

2. Select which language to use for the letter from the **Merge Language** drop-down list.
3. Click the **Print Report** button. The **Student Accident/Incident Letter** pops-up in a separate PDF window.



Figure 1.17 – Student Accident/Incident Letter

On the **Contact Log** tab of the detailed screen of the Nurse's Log tab, it records all contact with the parent and/or student regarding the health incident. For each contact, it can show how the contact was made, who made the contact, the date and time of contact, the type of outcome of the contact, and any notes regarding the contact.



Figure 1.18 – Contact Log Tab, Detailed Screen, Nurse's Log

On the **Health Conditions** tab, a list of any ongoing health conditions the student has can be recorded, such as asthma or diabetes. For each condition, it can show a start and end date as well as the date, the condition was recorded in the system. The Health Conditions column shows the type of condition such as a medical alert or allergy. Details of the condition can be recorded in the Comment column.

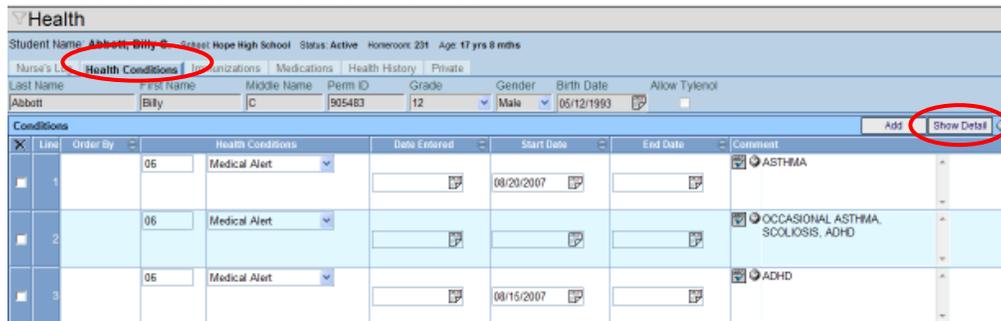


Figure 1.19 – Health Screen, Health Conditions Tab

To see the details of the condition:

1. Click the **Show Detail** button.
2. Select the record to view by clicking on the Order By number of the record on the left side of the screen. The selected record is highlighted in green. The detailed screen of the record shows the same information available through the main screen.
3. To return to the main screen, click the **Hide Detail** button.

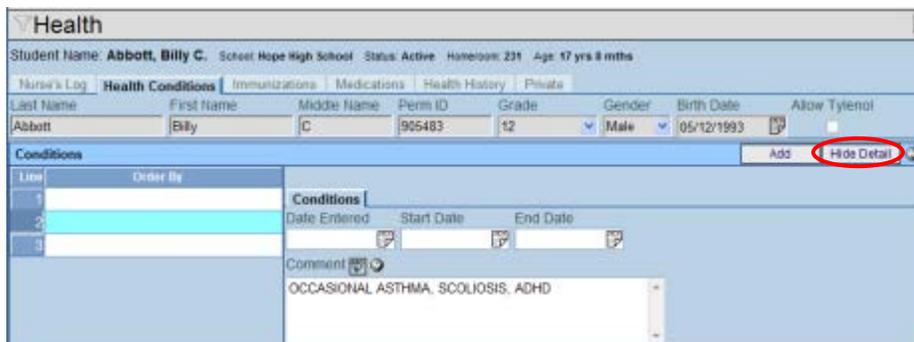


Figure 1.20 – Health Screen, Health Conditions Tab, Detailed Screen

On the **Immunizations** tab, a list of the required immunizations is shown with the status of the student's compliance with the requirement. Below the summary, the dates of each vaccination dose are listed.

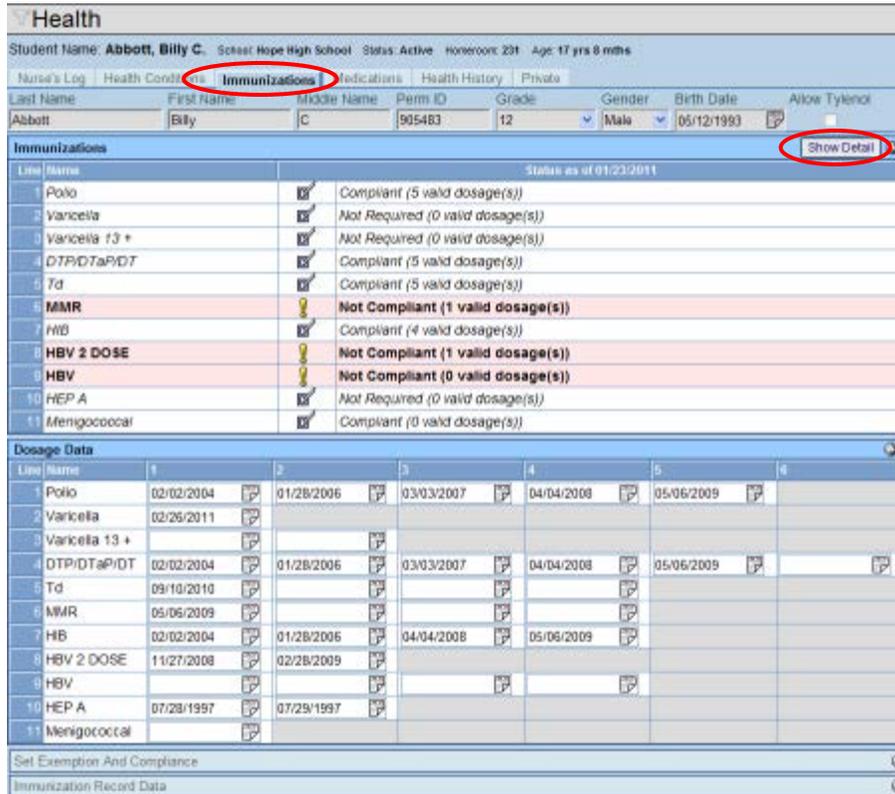


Figure 1.21 – Health Screen, Immunizations Tab

- To see the details of an immunization requirement, click the **Show Detail** button. Select the record to view by clicking on the name of the immunization on the left side of the screen. The selected record is highlighted in green.

On the detailed screen of each immunization, the **Date** column shows the date of the student's doses and the **Due By** column shows the date by when the student should have received the dose. For each required dosage, the student can be registered as compliant by checking the **Override Compliance** box and any comments regarding the override can be recorded in the **Comment** column.

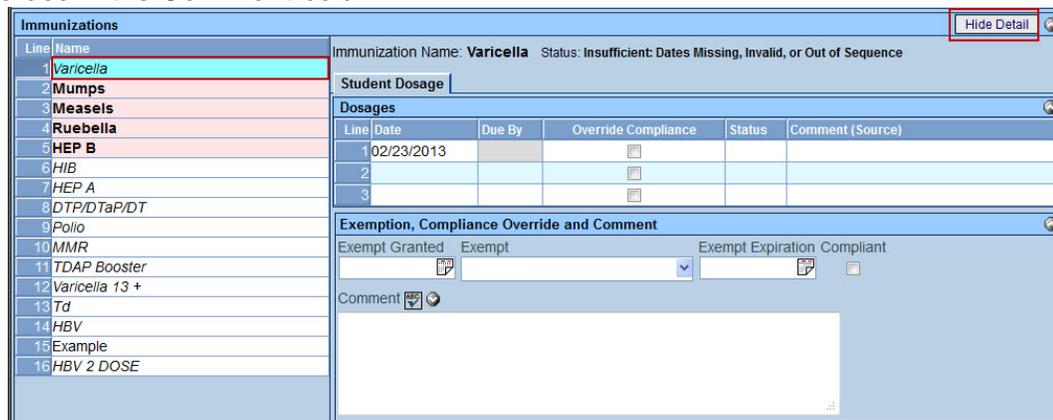


Figure 1.22 – Health Screen, Immunizations Tab

The exemption or override compliance for the entire requirement is recorded in the **Exemption, Compliance Override, and Comment** section.

1. To return to the main Immunization screen, click the Hide Detail button.
2. To view the overall Exemption and Compliance for the student, expand the **Set Exemption and Compliance** section by clicking the **Maximize**  button at the right-hand side of the section. This section shows any exemptions or compliance override for all immunization requirements. Click the **Minimize**  button to hide this section again.

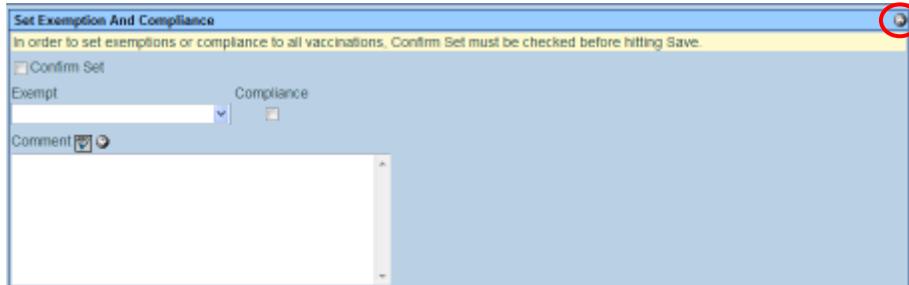


Figure 1.23 – Health Screen, Immunizations Tab, Exemption and Compliance

- To view additional immunization information (used for California’s and Arizona’s Immunization Records), expand the **Immunization Record Data** section by clicking the **Maximize** button at the right-hand side of the section. This section shows staff and immunization status information and can be displayed in the Arizona and California state immunization records. Click the **Minimize** button to hide this section again.

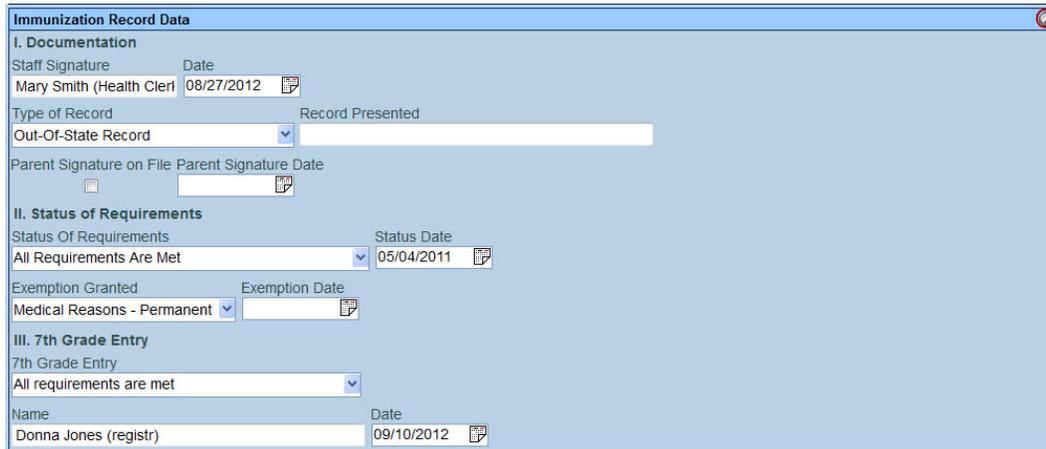


Figure 1.24 – Health Screen, Immunizations Tab, Immunization Record Data

On the **Medications tab**, a list of any current medications and/or current procedures that are administered by school staff is displayed. For each medication administered to a student, it shows the name of the medication and the remaining units in stock, the date the medication started being given to the student and the date it will be stopped. It also shows the time and number of units that should be given to the student, the quantity that makes up one unit and the days on which the medication is given.

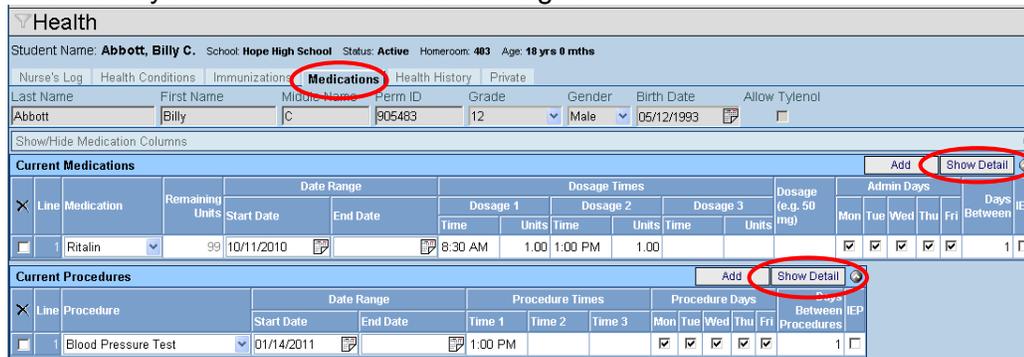


Figure 1.25 – Health Screen, Medications Tab

For each procedure, it shows the type of procedure such as a blood sugar test, the times and days the procedure is needed, and the date the procedure started and ended. For both procedures and medications, if there is an IEP for the student it can be indicated.

- To hide the **Admin Days** columns for the medications to reduce the width of the screen, expand the **Show/Hide Medication Columns** section by clicking the **Maximize** button at the right-hand side of the section. Check the **Admin Days** box and then click the **Refresh Grid** button. Click the **Minimize** button to hide this section again.

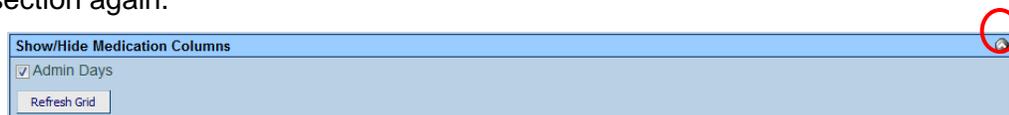


Figure 1.26 – Show/Hide Medication Columns

- When the Admin Days are hidden, the **Medications tab** appears as shown below.

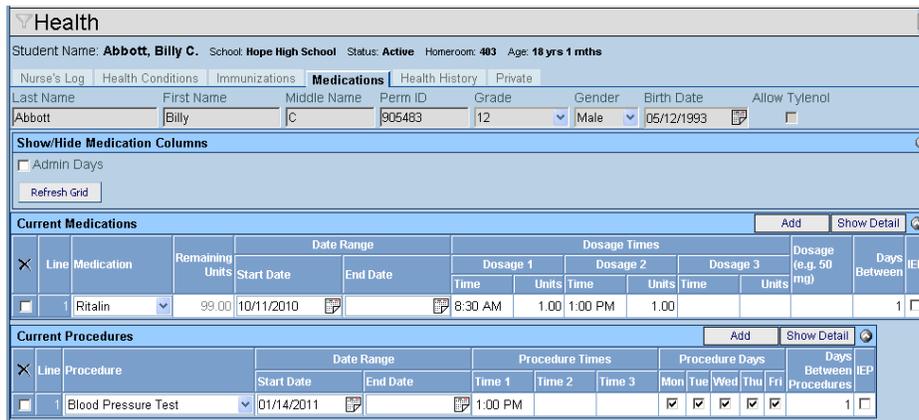


Figure 1.27 – Health Screen, Medications Tab, Admin Days Hidden

- For a detailed screen of each medication, click the **Show Detail** button in the Current Medication section. Select the record to view by clicking on the Medication name on the left side of the screen. The selected record is highlighted in green.

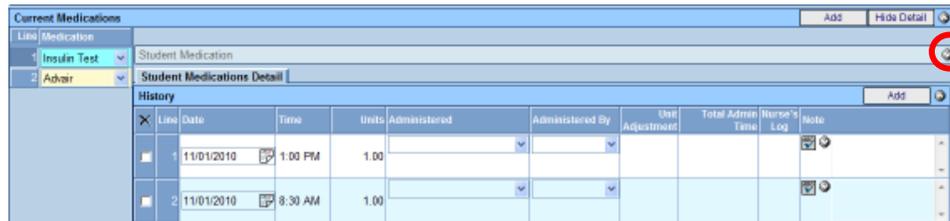


Figure 1.28 – Current Medications Detail

For each medication, it shows each date and time the medication was administered, and/or each time additional dosages of the medication were added to storage. It also records who administered the medication or who received the additional medication and any notes.

- To see the details of the medication, click on the **Maximize button** of the Student Medication section.
- Additional details that can be entered here are the **Medication Type**, the **Route of Admin**, the **Refill Threshold**, the **School Provided** checkbox to indicate the school provides the medication, the **Prescribing Physician**, a **Note**, **Side Effects**, **Administer In**, and **Student Health Conditions Related to this Medication**. To return to the main screen, click the **Hide Detail** button.

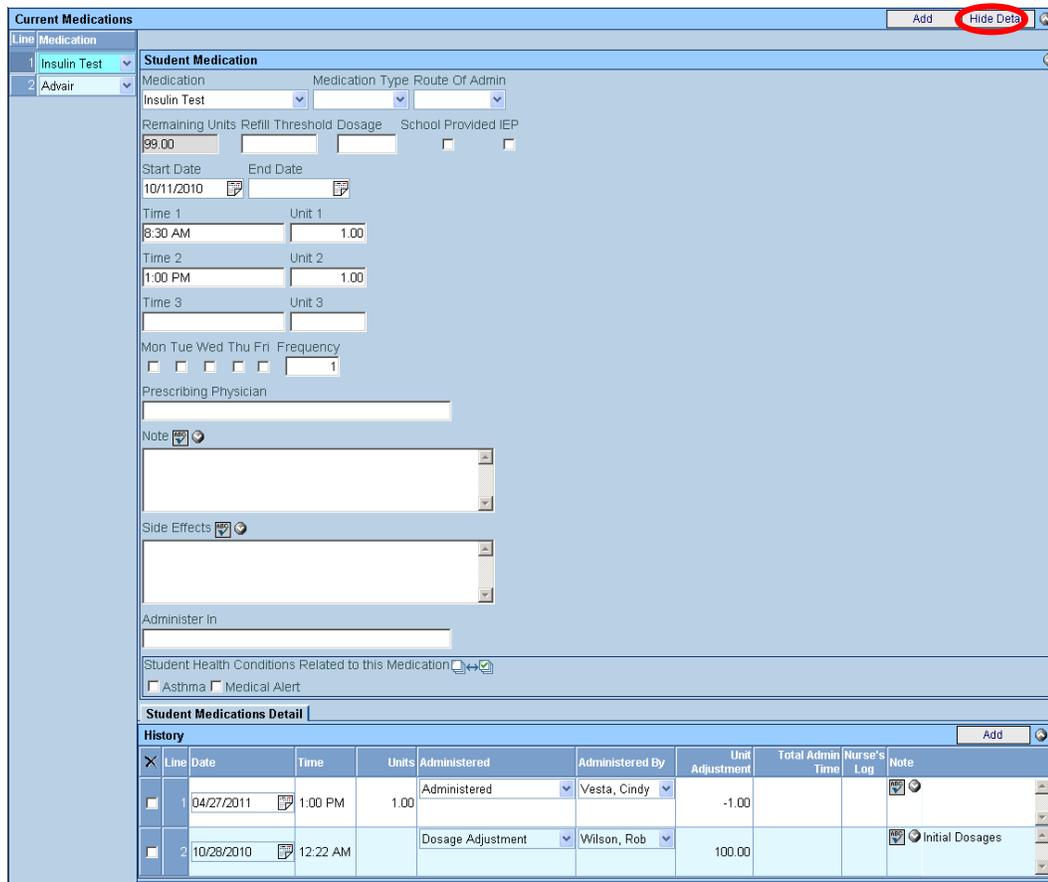


Figure 1.29 – Medications Tab, Detailed Screen, Student Medication Detail

- For a detailed screen of each procedure, click the **Show Detail** button in the Current Procedures section. Select the record to view by clicking on the name of the Procedure on the left side of the screen. The selected record is highlighted in green.



Figure 1.30 – Current Procedures Detail

For each procedure, it shows each date and time the procedure was administered, who administered it, the time it took, and any notes.

- To see the details of the procedure itself, click on the **Maximize** button in the Student Medication Procedure section. A **Location** and a **Note** can be seen here.

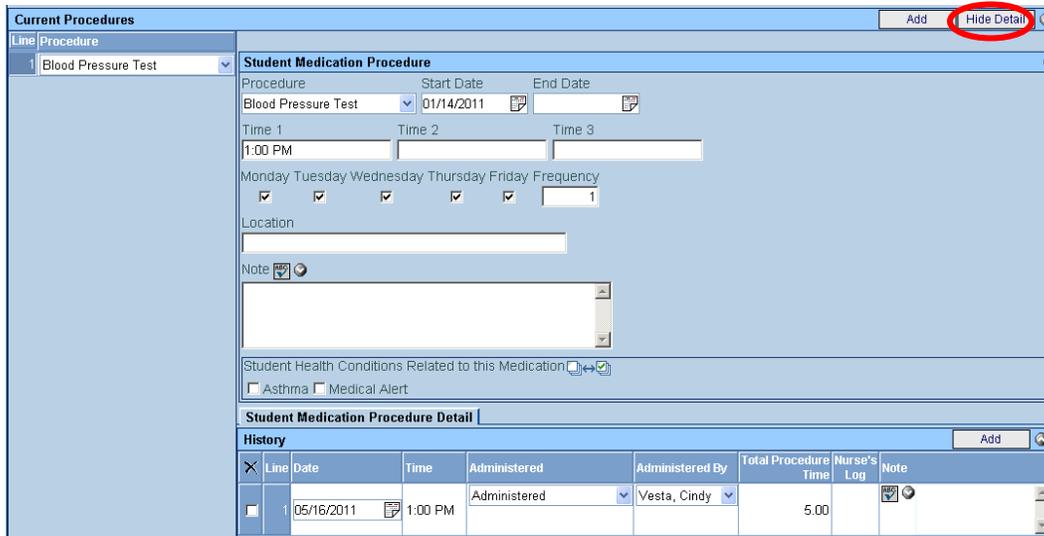


Figure 1.31 – Student Medication Procedure Detail

- To return to the main screen, click the **Hide Detail** button.

The **Health History** tab lists a record of all incidents in which the student was involved for both the current school year and any other schools and years. The Nurse’s Log tab only lists incidents for the school and year in focus. It also lists any medications and procedures that are no longer actively administered and have an end date. The information displayed for each incident, medication and procedure is the same as on the Nurse’s Log tab and Medications tab.

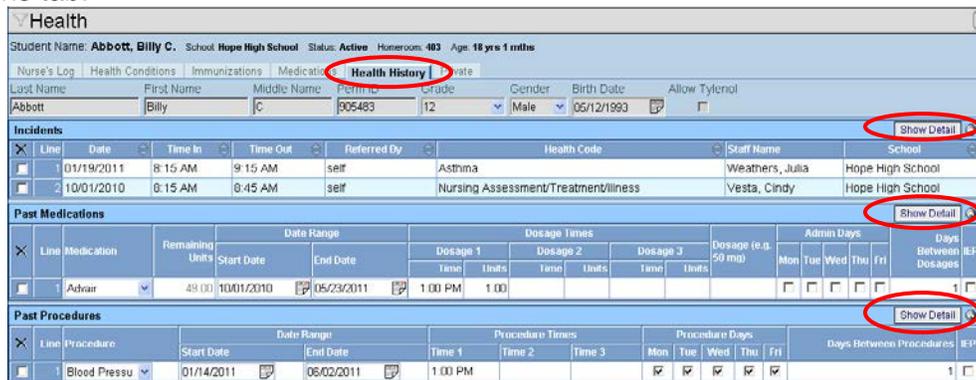


Figure 1.32 – Health Screen, Health History Tab

- For a detailed screen of each incident, click the **Show Detail** button in the Incidents section. Select the record to view by clicking on the Date of the record on the left side of the screen. The selected record is highlighted in green. The details displayed are the same details available through the Nurse’s Log tab.

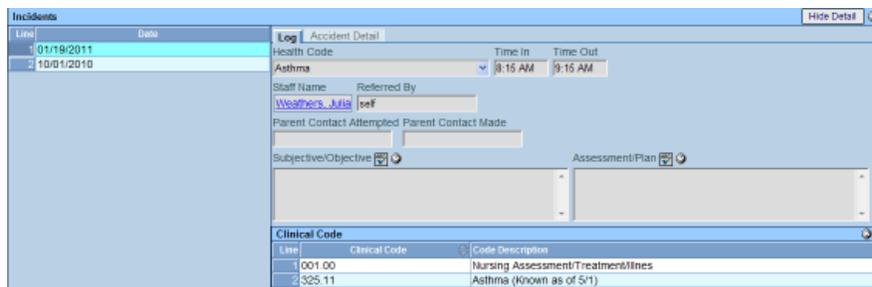


Figure 1.33 – Health History Tab, Incidents Detail

- To see details of an accident, click on the **Accident Detail** tab. These are also the same details available on the **Nurse's Log** tab. To return to the main screen of the record, click the **Hide Detail** button.

The screenshot shows the 'Incidents' application window. On the left, a table lists incidents with columns for 'Line', 'Date', and 'Location'. The second row, dated 10/01/2010, is highlighted in green. The main area displays the 'Accident Detail' form, which includes fields for 'Accident Case', 'Accident Time', 'Initial Care Given/By Whom', 'Accident Location', 'End Date', 'Staff Name', 'Medical Care Recommended', 'Ins Coverage', 'Taken Where After Accident (Specify Home, Hospital, etc.)', 'Picked Up By', 'Time Taken', 'Reason Injured Person was on the Premises (lunch, P.E., etc.)', 'Witnesses', 'Follow Up', and 'Preventative Measures Taken'. A 'Hide Detail' button is located in the top right corner of the window.

Figure 1.34 – Health History Tab, Incidents Detail, Accident Detail Tab

- For a detailed screen of each medication, click the **Show Detail** button in the Past Medication section. Select the record to view by clicking on the Medication name on the left side of the screen. The selected record is highlighted in green.

The screenshot shows the 'Past Medications' application window. On the left, a table lists medications with columns for 'Line' and 'Medication'. The first row, 'Advair', is highlighted in green. The main area displays the 'Student Medications Detail' form, which includes a 'History' table. A 'Show Detail' button is circled in red in the top right corner. The 'History' table has columns for 'Line', 'Date', 'Time', 'Units', 'Administered', 'Administered By', 'Unit Adjustment', 'Total Admin Time', 'Nurse's Log', and 'Note'. A single record is shown in the history table.

Line	Date	Time	Units	Administered	Administered By	Unit Adjustment	Total Admin Time	Nurse's Log	Note
1	03/14/2011	1:00 PM	1.00	Administered	Weathers, Ju	-1.00			

Figure 1.35 – Health History Tab, Past Medications Detail

- To see the details of the medication, click on the **Maximize** button of the Student Medication section. The details of both sections are the same as on the Medications tab. To return to the main screen, click the **Hide Detail** button.

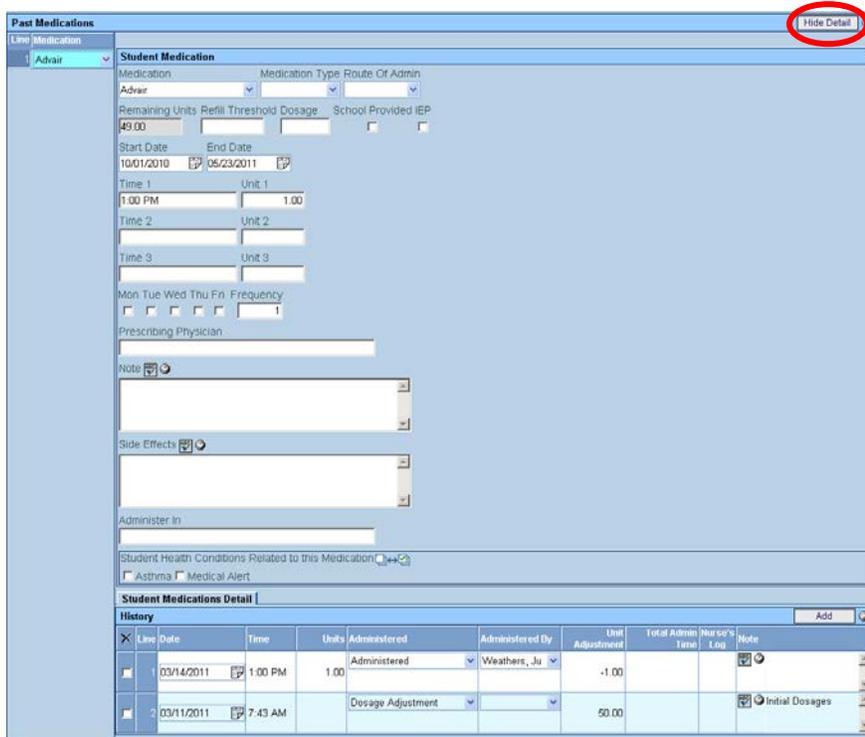


Figure 1.36 – Health History Tab, Past Medications, Student Medication Detail

- For a detailed screen of each procedure, click the **Show Detail** button in the Past Procedures section. Select the record to view by clicking on the name of the Procedure on the left side of the screen. The selected record is highlighted in green.



Figure 1.37 – Health History Tab, Past Procedures Detail

- For each procedure, it shows each date and time the procedure was administered, who administered it, the time it took, and any notes. To see the details of the procedure itself, click on the **Maximize** button in the Student Medication Procedure section.
- A **Location** and a **Note** can be seen here. To return to the main screen, click the **Hide Detail** button.

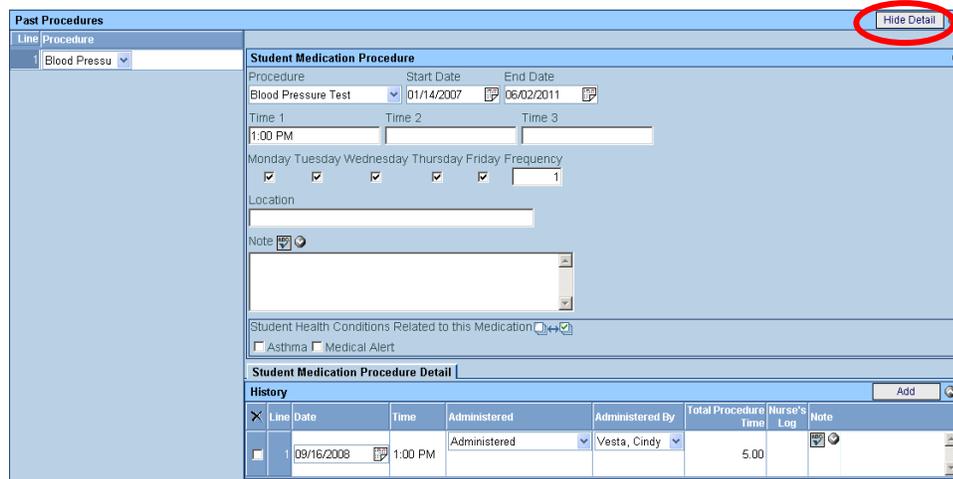


Figure 1.38 – Health History Tab, Past Procedures, Procedure Detail

On the **Private** tab, staff may make comments regarding the student's health that are not displayed in the ParentVUE and StudentVUE software. Each comment is shown with the date and staff name of who entered the comment.

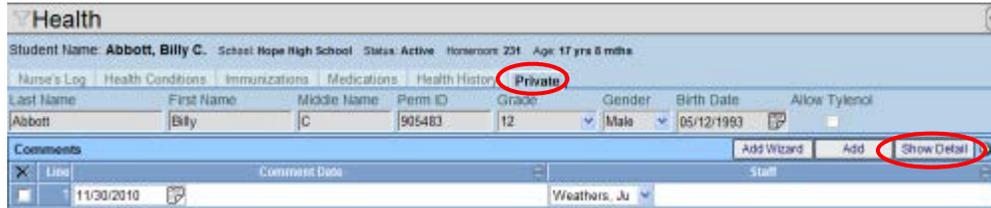


Figure 1.39 – Health Screen, Private Tab

1. For a detailed screen of each comment, click the **Show Detail** button. Select the record to view by clicking on the Date of the record on the left side of the screen. The selected record is highlighted in green.

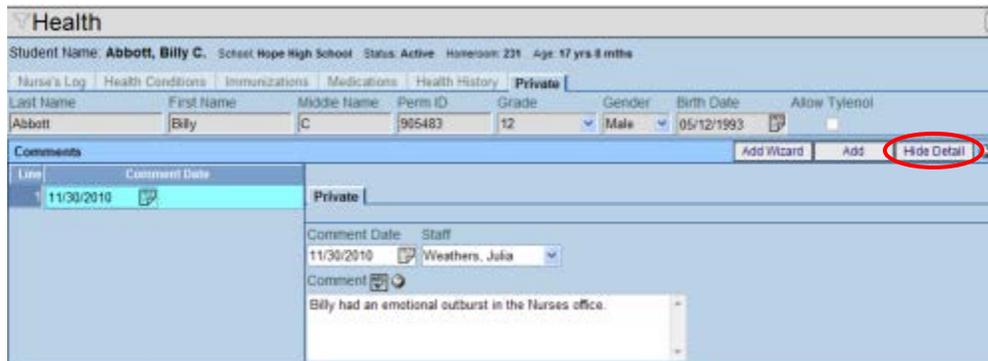


Figure 1.40 – Health Screen, Private Tab, Detailed Screen

2. The comment is displayed on the right side of the screen. To return to the main screen, click the **Hide Detail** button.

ADDING & EDITING HEALTH RECORDS

When editing the information about a student, **each tab must be edited separately and all changes saved before switching to a new tab.** To edit the health data for a student:

1. Check to make sure the current **focus** is set to a school and not the district. The focus is indicated in the top right-hand corner of the screen.



Figure 1.41 – Checking Current Focus

2. Change to Update mode by clicking the **Edit** button at the top of the screen. If the button is not available, Update mode is already turned on.



Figure 1.42 – Edit Button

Nurse's Log Tab

To add and edit the records on the Nurse's Log tab:

1. Click on the **Nurse's Log** tab, where a record of all visits to the nurse's office as well as any accidents or other health-related incidents is detailed. To edit the records, click on the data to modify and change the information as desired. Boxes with a gray background cannot be changed.

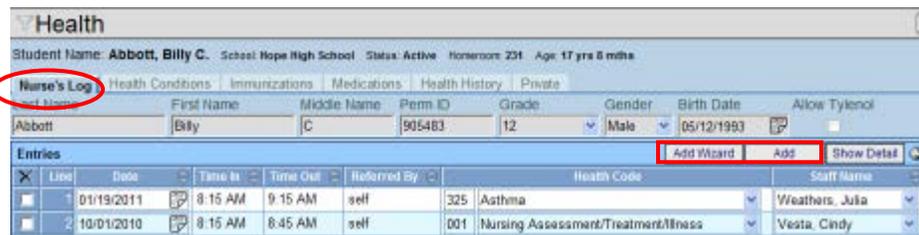


Figure 1.43 – Health Screen, Nurse's Log Tab

2. The **Date** must be entered in MM/DD/YY format or they can be selected by clicking on the Calendar  button. The **Health Code** can be selected either by clicking on the drop-down arrow, or by entering the numeric code.
3. To add a record, click on either the **Add Wizard** button or the **Add** button. The Add button just adds an additional record on the main screen and additional details must then be added by clicking the Show Detail button. The Add Wizard button allows both the information on the main screen and the detailed screen to be recorded.
4. To add a record using the Add Wizard button, click the **Add Wizard** button.

- The Health Incident Detail Add screen pops-up in a separate window. Mandatory fields are highlighted in green. Enter the date of the incident in the **Date** field. The date must be entered in MM/DD/YY format or they can be selected by clicking on the Calendar  button.

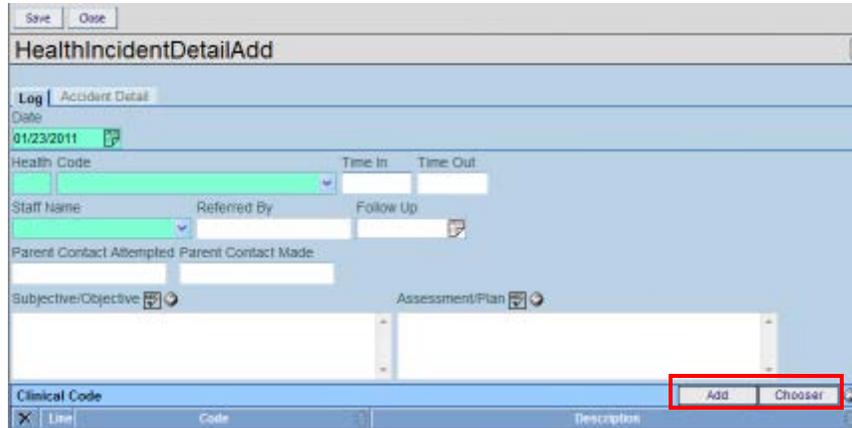


Figure 1.44 – Health Incident Detail Add Screen, Log Tab

- The **Health Code** can be selected either by clicking on the drop-down arrow, or by entering the numeric code.
- Enter the **Time In**, **Time Out**, **Staff Name**, **Referred By**, **Follow-up**, **Parent Contact Attempted**, and **Parent Contact Made**.
- The **Subjective/Objective** description of the incident and the **Assessment/Plan** can be checked for spelling by clicking the **Spellcheck**  button.
- To add an individual **Clinical Code**, click the **Add** button. To select more than one code, click the **Chooser** button.
- If the **Add button** is used, a new row is added for the clinical code. Enter the number of the code in the **Code** column. When a correct code is entered, the description is automatically filled in. To remove a code, check the box in the **X** column.

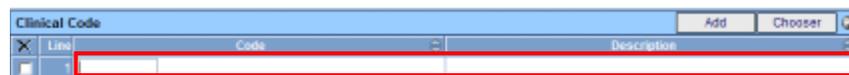
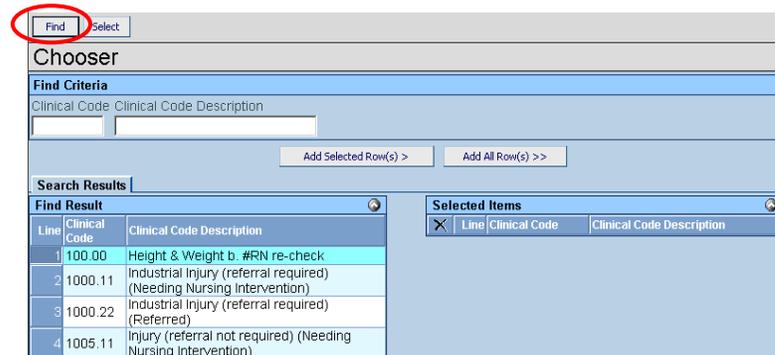


Figure 1.45 – Clinical Code, Add Button

- If the **Chooser** button is used, the Chooser screen pops-up in a separate window. Enter all or part of the Code and/or Description and click the **Find** button.



Line	Clinical Code	Clinical Code Description
1	100.00	Height & Weight b. #RN re-check
2	1000.11	Industrial Injury (referral required) (Needing Nursing Intervention)
3	1000.22	Industrial Injury (referral required) (Referred)
4	1005.11	Injury (referral not required) (Needing Nursing Intervention)

Figure 1.46 – Chooser Screen

- The clinical codes matching the criteria entered are displayed in the Find Result grid. Click on a code to select it, and then click the **Add Selected Row(s)>** button. To add multiple codes at a time, hold the CTRL button down while clicking on multiple codes to select them. To add all the codes matching the criteria, click the **Add All Row(s) >** button.

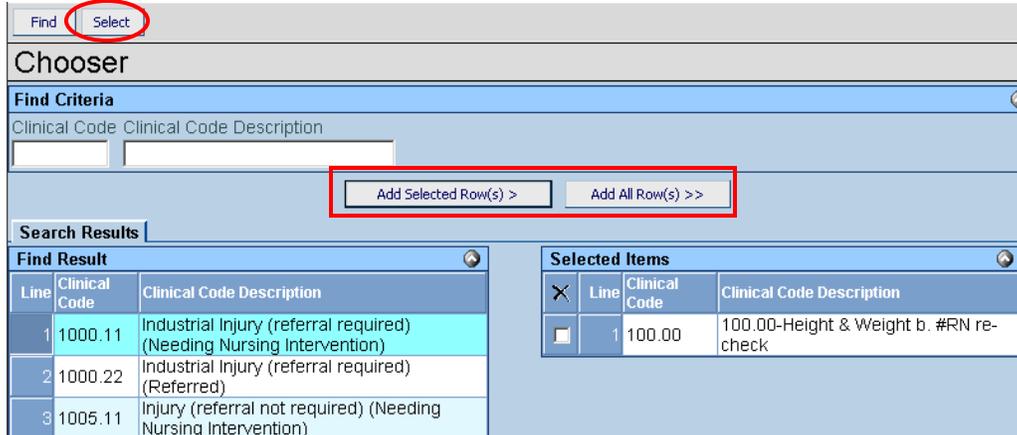


Figure 1.47 – Chooser Screen, Selecting

- The codes are moved to the Selected Items grid. To remove a code from the Selected Items grid, click the box in the X column. When all the codes needed are in the Selected Items grid, click the **Select** button to add them to the Clinical Codes grid.

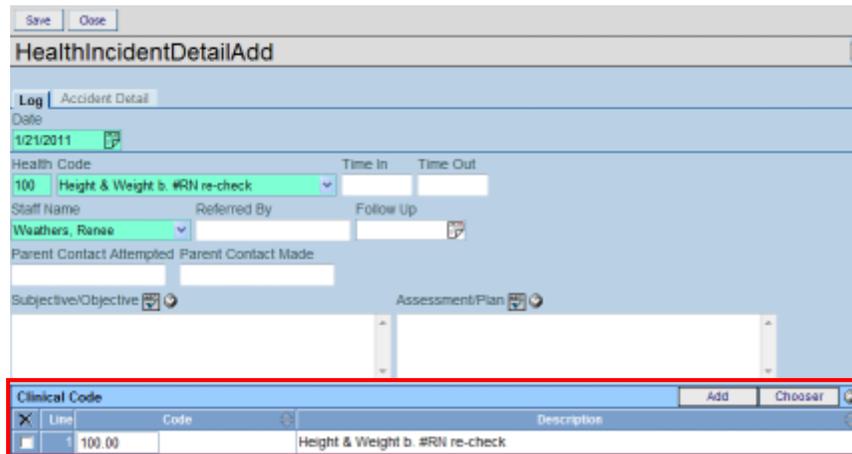


Figure 1.48 - Adding a Clinical Code

- If the health incident is an accident, click on the **Accident Detail** tab to record additional information.

Figure 1.49 – Health Incident Detail Add Screen, Accident Detail Tab

- The dates on this tab must be entered in MM/DD/YY format or they can be selected by clicking on the Calendar button on each field. To check the text entered for spelling, click the Spellcheck button on each field.
- To add a Supervising Staff Member, click the gray arrow. The Find Staff screen pops-up. Enter all or part of the **Last Name**, **First Name**, and/or **Middle Name** of the staff and click the **Find** button.

Line	Last Name	First Name	Middle Name
1	McBride	Drew	

Figure 1.50 – Find Staff Screen

- The staff matching the criteria entered is listed in the Search Results grid. Click on the **staff name** and it is then highlighted in green. Click the **Select** button at the top of the screen to enter the staff name in the group.

Line	Last Name	First Name	Middle Name
1	McBride	Drew	
2	McGrew	Tom	
3	Media Center		Media Center

Figure 1.51 – Find Staff Screen, Search Results

- The staff member's name is entered in the Supervising Staff Member box.

19. When all the information has been added for the incident, click the **Save** button at the top of the screen to save the record.
20. To edit or add details for each visit, click the **Show Detail** button.



Figure 1.52 – Health Screen, Nurse's Log Tab

21. Select the record to view by clicking on the **Date** of the record on the left side of the screen. The selected record is highlighted in green.

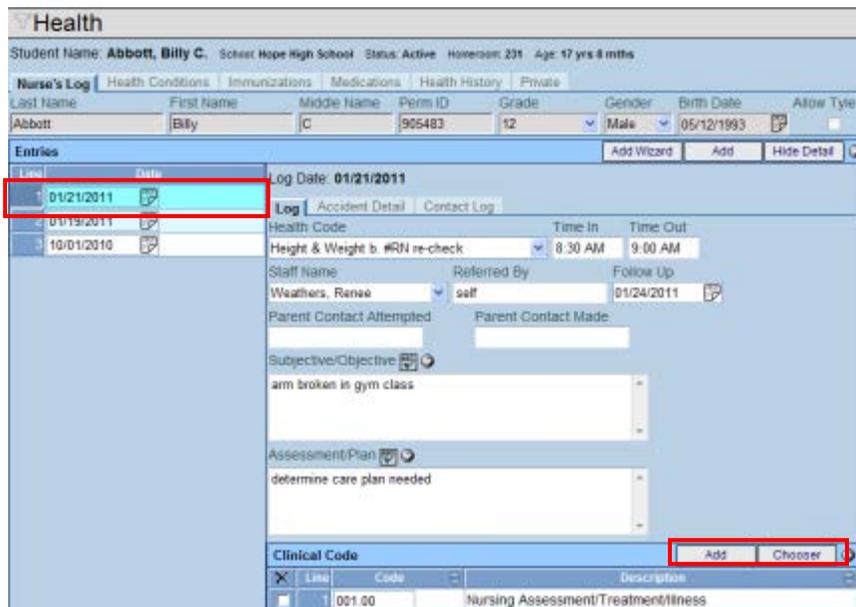


Figure 1.53 – Health Screen, Nurse's Log Tab, Detailed Screen, Log Tab

In the detailed screen of each record, the **Log tab** shows all of the information displayed on the main screen, as well as the date set for follow-up, when parent contact was attempted and made, a subjective description of the student's condition, and the assessment of the student's condition and treatment plan. The **Subjective/Objective** description of the incident and the **Assessment/Plan** can be checked for spelling by clicking the **Spellcheck** button.

22. To add an individual **Clinical Code**, click the **Add** button. To select more than one code, click the **Chooser** button.
23. If the **Add button** is used, a new row is added for the clinical code. Enter the number of the code in the **Code** column. When a correct code is entered, the description is automatically filled in. To remove a code, check the box in the **X** column.

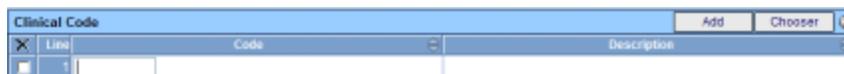


Figure 1.54 – Clinical Code, Add Button

24. If the **Chooser** button is used, the Chooser screen pops-up in a separate window. Enter all or part of the Code and/or Description and click the **Find** button.

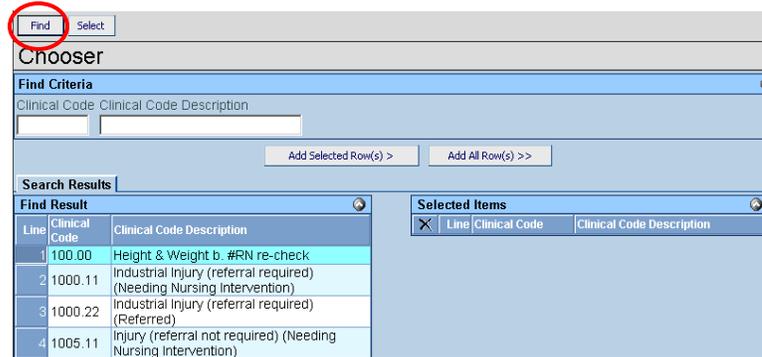


Figure 1.55 – Chooser Screen

25. The clinical codes matching the criteria entered are displayed in the Find Result grid. Click on a code to select it, and then click the **Add Selected Row(s)>** button. To add multiple codes at a time, hold the CTRL button down while clicking on multiple codes to select them. To add all the codes matching the criteria, click the **Add All Row(s) >** button.

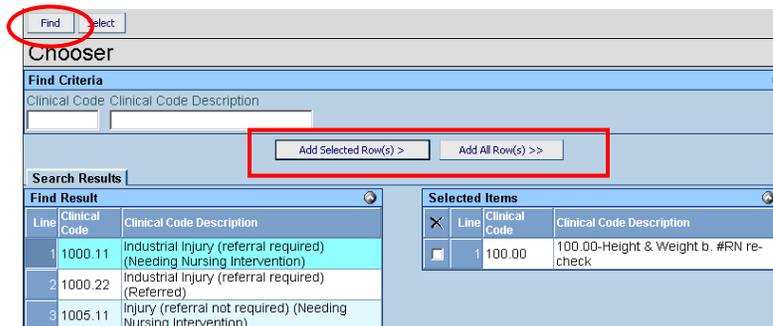


Figure 1.56 – Chooser Screen, Selecting

26. The codes are moved to the Selected Items grid. To remove a code from the Selected Items grid, click the box in the **X** column. When all the codes needed are in the Selected Items grid, click the **Select** button to add them to the grid.

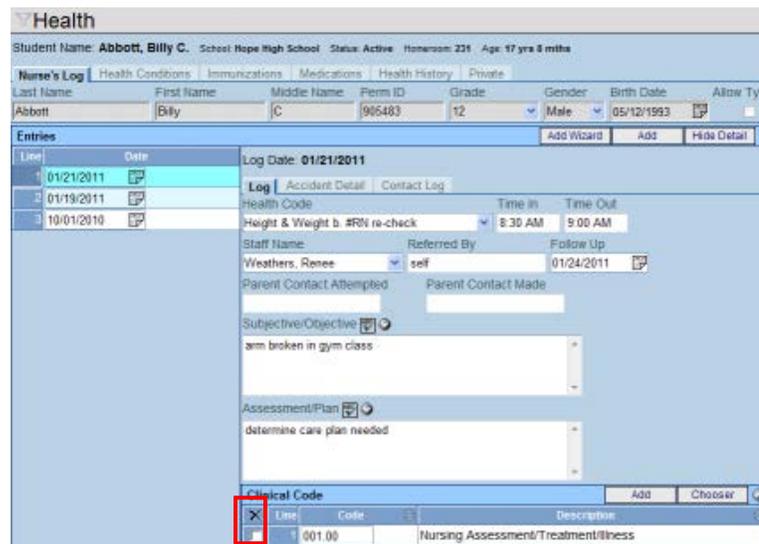


Figure 1.57 – Health Screen, Nurse's Log Tab, Detailed Screen, Log Tab

On the **Accident Detail tab** of the detailed screen, it records the date, time, and location of the accident and, if appropriate, an end date. It also shows who initially assisted the student and the staff member who supervised the medical treatment. Additional details that may be recorded include the status of the student's accident insurance, if additional medical care was recommended and if so, where the student was taken and who picked up the student and when. It records why the student was at the location, any witnesses to the incident, the follow-up care needed by the student, and any preventative measures taken to prevent future incidents as well.

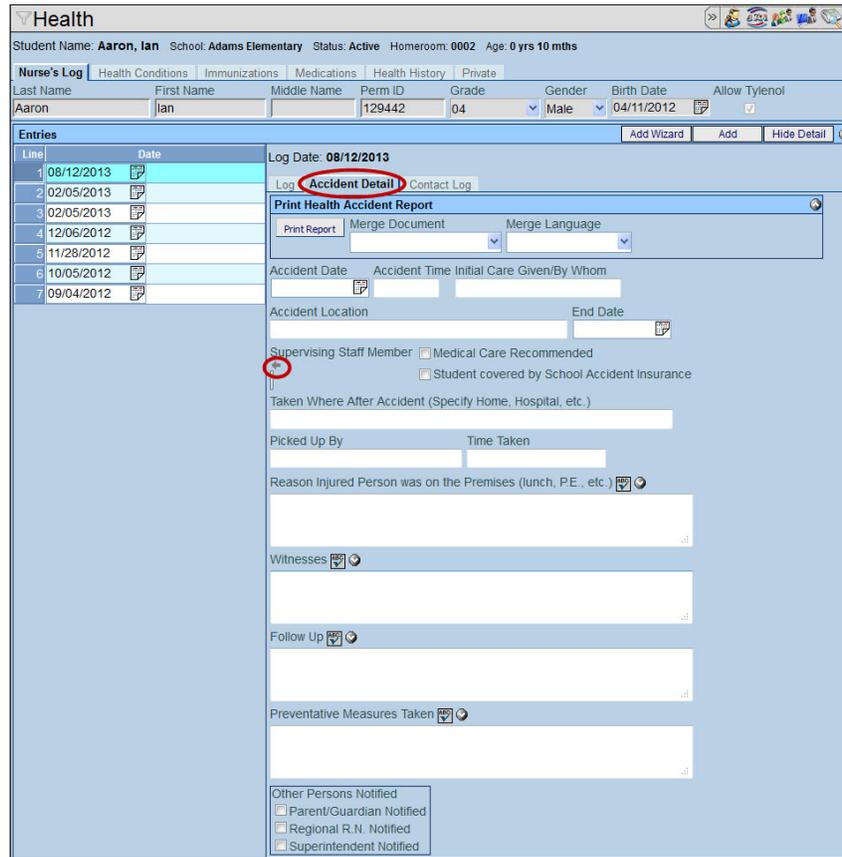


Figure 1.58 – Health Screen, Nurse’s Log Tab, Detailed Screen, Accident Detail Log

27. The dates on this tab must be entered in MM/DD/YY format or they can be selected by clicking on the Calendar  button on each field. To check the text entered for spelling, click the Spellcheck  button on each field.
28. To add a Supervising Staff Member, click the gray arrow. The Find Staff screen pops-up. Enter all or part of the **Last Name**, **First Name**, and/or **Middle Name** of the staff and click the **Find** button.



Figure 1.59 – Find Staff Screen

29. The staff matching the criteria entered is listed in the Search Results grid. Click on the **staff name** and it is then highlighted in green. Click the **Select** button at the top of the screen to enter the staff name in the group.

The screenshot shows a software interface for finding staff. At the top, there are buttons for 'Find', 'Close', 'Select', and 'Clear Selection'. Below these is a search bar containing 'Find: Staff'. Underneath is a 'Find Criteria' section with three input fields: 'Last Name' (containing 'm'), 'First Name', and 'Middle Name'. Below that is a 'Search Results' section with a table of results.

Line	Last Name	First Name	Middle Name
1	McBride	Russ	
2	McGrew	Tom	
3	Media Center	Media Center	

Figure 1.60 – Find Staff Screen, Search Results

30. The staff member's name is entered in the Supervising Staff Member box.
31. A letter and form detailing the accident can also be printed to be sent home to the student's parents. To print the form, leave the **Merge Document** and **Merge Language** fields blank and click the **Print Report** button.

The screenshot shows a window titled 'Print Health Accident Report'. It contains three main elements: a 'Print Report' button (circled in red), a 'Merge Document' dropdown menu, and a 'Merge Language' dropdown menu. Both dropdown menus are currently blank.

Figure 1.61 – Health Screen, Nurse's Log Tab, Detailed Screen, Printing the Accident Report Form

32. The **Student Accident/Incident Report** form pops-up in a separate PDF window. This report can also be generated from the Reports folder using report HLT203.

Hope High School Student Accident/Incident Report						Year: 2008-2009 Report: HL1203
Student Information						
Student Name Abbott, Billy		Parm ID 905483	Gender M	Grade 12	Phone 480-555-1214	Homeroom 231
Address 1953 S Val Vista Dr			City Mesa	State AZ	Zip Code 85234	
Accident Information						
Accident Location: Gym				Accident Date: 03/20/2009	Time Accident Occured: 9:07 AM	
Reported by: McGrew, Tom		Date Reported: 01/14/2010	Parent Contact Attempted At: 9:08 AM	Parent Contacted At: 9:08 AM		
Describe Accident, Give Specific Location and Condition of Premises: Billy fell down in gym class and fractured his ankle.						
Medical Information						
Detailed Injury Description: His mother picked him up and took him to the hospital.						
Care Given/By Whom: Joe Coach				Medical Care Recommended: Yes		
Reason Injured Person was on the Premises(lunch, P.E., etc.): Gym class						
Persons Familiar with Circumstances(Name & Title): Joe Coach, Susie Student						
Staff Member Responsible for Student Supervision at Time of Incident:				Student Covered by School Accident Insurance: No		
Where Taken After Incident(Specify home, hospital, etc.): Hospital				By Whom: Mother	Time Taken: 10:15 AM	
Follow-Up:						
Preventative Measure Taken:						
Signatures						
Principal Signature: _____				Date Signed: _____		
Nurse Signature: _____				Date Signed: _____		
Printed by Admin User at 01/14/2010 8:39 AM Edupoint School District Page 1 of 1						

Figure 1.62 – Student Accident/Incident Report

33. To print a cover letter to accompany the form, select Accident Report from the **Merge Document** drop-down list and select which language to use for the letter from the **Merge Language** drop-down list. Then click the **Print Report** button.



Figure 1.63 – Health Screen, Nurse’s Log Tab, Detailed Screen, Printing the Accident Report Letter

34. The **Student Accident/Incident Letter** pops-up in a separate PDF window.



Figure 1.64 – Student Accident/Incident Letter

35. To record any contact made with the student or parent regarding the incident, click on the **Contact Log tab** of the detailed screen.



Figure 1.65 – Contact Log Tab, Detailed Screen, Nurse’s Log

36. To add a new contact, click the **Add** button in the Contact Log grid.

37. A new blank line is then added to the grid. Enter the **Date** of contact by typing the date in MM/DD/YY format or it can be selected by clicking on the Calendar  button.

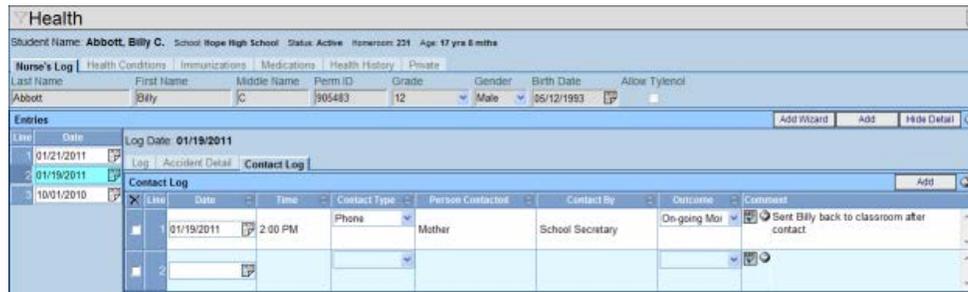


Figure 1.66 – Adding a Record of Contact

38. Enter the **Time** in HH:MM AM/PM format, and select how contact was made from the **Contact Type** drop-down list. Enter the name of the person who made contact in the **Contact By** column.
39. Select the type of **Outcome** from the drop-down list, and enter any notes or comments in the **Comment** column. The Comment can be checked for spelling by clicking the Spellcheck  button.
40. Click the **Save** button at the top of the screen to save any changes to the detail. To return to the main screen, click the **Hide Detail** button.
41. To delete an incident record, check the box in the **X** column and click the **Save** button at the top of the screen.

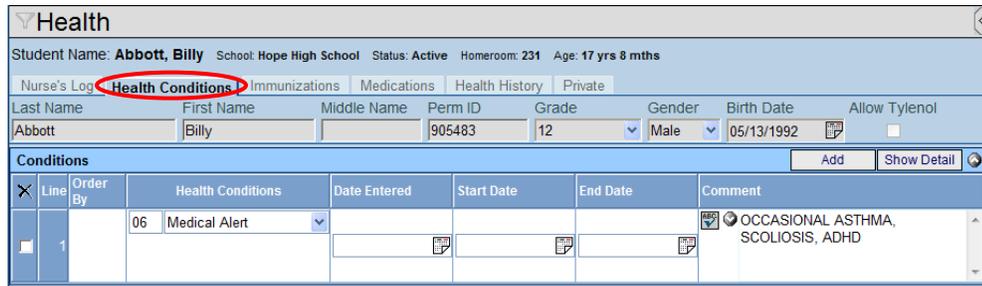


Figure 1.67 – Deleting Incidents

Health Conditions Tab

On the **Health Conditions** tab, a list of any ongoing health conditions the student has can be recorded, such as asthma or diabetes. To add or edit a health condition:

1. To edit a condition, click in the boxes and edit the data shown in each row. Dates must be entered in MM/DD/YY format or they can be selected by clicking on the Calendar  button. The Comment can be checked for spelling by clicking the **Spellcheck**  button.



Health

Student Name: **Abbott, Billy** School: Hope High School Status: Active Homeroom: 231 Age: 17 yrs 8 mths

Nurse's Log **Health Conditions** Immunizations Medications Health History Private

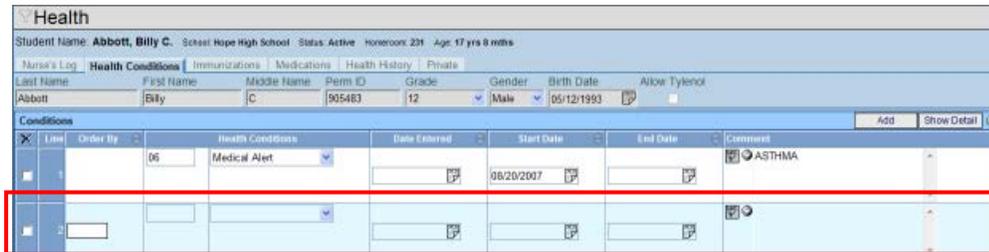
Last Name: Abbott First Name: Billy Middle Name: Perm ID: 905483 Grade: 12 Gender: Male Birth Date: 05/13/1992 Allow Tylenol:

Line	Order By	Health Conditions	Date Entered	Start Date	End Date	Comment
1	06	Medical Alert				OCCASIONAL ASTHMA, SCOLIOSIS, ADHD

Add Show Detail

Figure 1.68 – Health Screen, Health Conditions Tab

2. To add a condition, click the **Add** button in the Conditions section. A new blank line is added to the Conditions grid.



Health

Student Name: **Abbott, Billy C.** School: Hope High School Status: Active Homeroom: 231 Age: 17 yrs 8 mths

Nurse's Log **Health Conditions** Immunizations Medications Health History Private

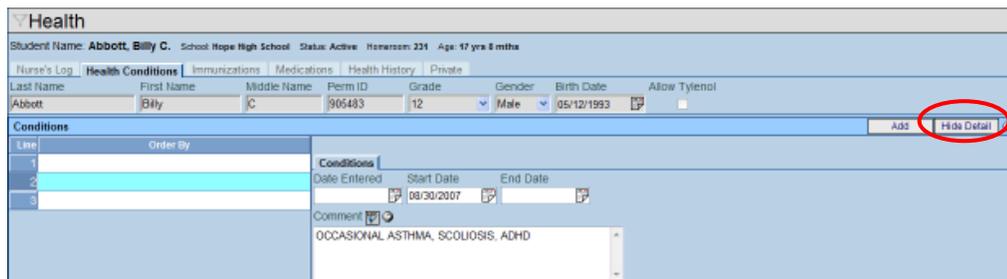
Last Name: Abbott First Name: Billy Middle Name: C Perm ID: 905483 Grade: 12 Gender: Male Birth Date: 05/12/1993 Allow Tylenol:

Line	Order By	Health Conditions	Date Entered	Start Date	End Date	Comment
1	05	Medical Alert		08/20/2007		ASTHMA
2						

Add Show Detail

Figure 1.69 – Adding a Health Condition

3. Enter the details of the condition, and then click the **Save** button at the top of the screen.
4. To add or edit the details of the condition, click the **Show Detail** button. Select the record to view by clicking on the Order By number of the record on the left side of the screen. The selected record is highlighted in green.
5. The detailed screen of the record shows the same information available through the main screen. To return to the main screen, click the **Hide Detail** button.



Health

Student Name: **Abbott, Billy C.** School: Hope High School Status: Active Homeroom: 231 Age: 17 yrs 8 mths

Nurse's Log **Health Conditions** Immunizations Medications Health History Private

Last Name: Abbott First Name: Billy Middle Name: C Perm ID: 905483 Grade: 12 Gender: Male Birth Date: 05/12/1993 Allow Tylenol:

Line	Order By	Health Conditions	Date Entered	Start Date	End Date	Comment
1	05	Medical Alert		08/20/2007		ASTHMA
2						

Add Hide Detail

Conditions

Date Entered: Start Date: End Date:

Comment: OCCASIONAL ASTHMA, SCOLIOSIS, ADHD

Figure 1.70 – Health Screen, Health Conditions Tab, Detailed Screen

6. To delete a condition, check the box in the **X** column and click the **Save** button at the top of the screen.

Immunizations Tab

On the **Immunizations tab**, a list of the required immunizations is shown with the status of the student's compliance with the requirement. Below the summary, the dates of each vaccination dose are listed. To add or edit a student's immunizations records:

1. Click in the boxes in the **Dosage Data** grid and enter or change the dates on when the student received a dosage of each vaccine. Dates must be entered in MM/DD/YY format or they can be selected by clicking on the Calendar  button.

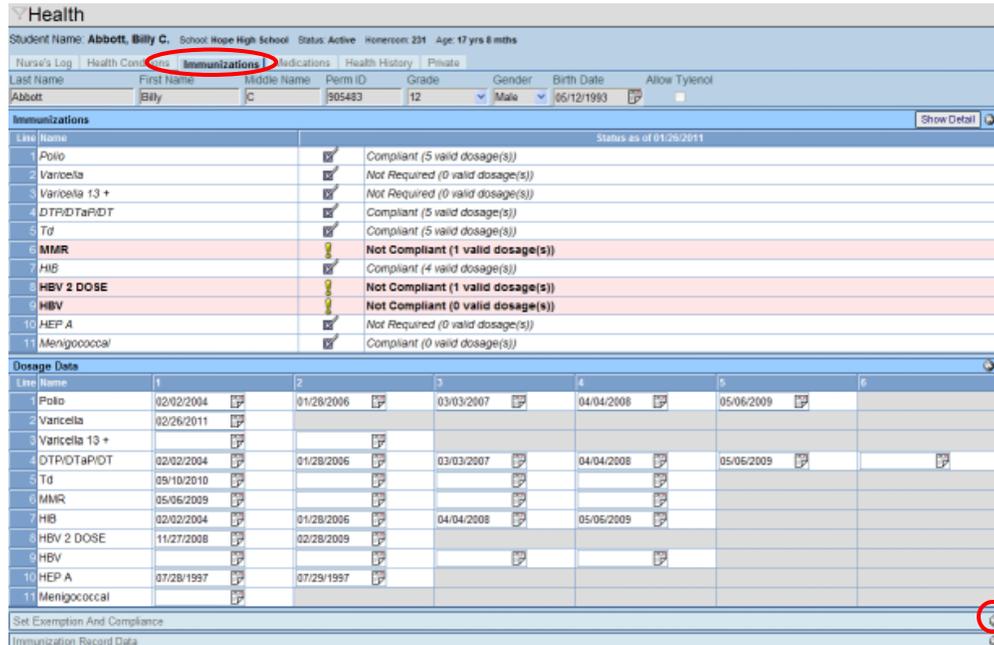


Figure 1.71 – Health Screen, Immunizations Tabs

2. Click the **Save** button at the top of the screen to save the changes to the records.
3. To record an overall exemption for the student, expand the **Set Exemption and Compliance** section by clicking the **Maximize**  button at the right side.

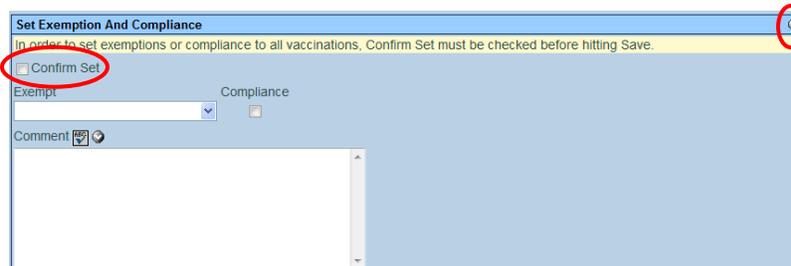


Figure 1.72 – Health Screen, Immunizations Tab, Exemption and Compliance

4. Select the reason for the exemption from the Exempt drop-down list, and check the **Compliance** box to set the student in compliance with all immunization requirements. Be sure to check the **Confirm Set** box. Comments can be checked for spelling by clicking the **Spellcheck**  button.
5. Click the **Save** button at the top of the screen to save the changes. Click the **Minimize**  button to hide this section again.

- To record an exception or waiver for an individual vaccination, click the **Show Detail** button in the Immunizations section.

The screenshot shows the 'Health' screen for a student named Billy C. Abbott. The 'Immunizations' tab is active, displaying a table of immunization records. The 'Show Detail' button is circled in red.

Line	Name	Compliance	Status
1	Polio	Compliant (5 valid dosage(s))	
2	Varicella	Not Required (0 valid dosage(s))	
3	Varicella 13 +	Not Required (0 valid dosage(s))	
4	DTP/dTaP/dT	Compliant (5 valid dosage(s))	
5	Td	Compliant (5 valid dosage(s))	
6	MMR	Not Compliant (1 valid dosage(s))	
7	HIB	Compliant (4 valid dosage(s))	
8	HBV 2 DOSE	Not Compliant (1 valid dosage(s))	
9	HBV	Not Compliant (0 valid dosage(s))	
10	HEP A	Not Required (0 valid dosage(s))	
11	Meningococcal	Compliant (0 valid dosage(s))	

Figure 1.73 – Health Screen, Immunizations Tab, Show Detail

- Select the record to view by clicking on the name of the immunization on the left side of the screen.

The screenshot shows the detailed view for the 'Varicella' immunization. The 'Immunization Name' is 'Varicella' and the status is 'Insufficient: Dates Missing, Invalid, or Out of Sequence'. The 'Student Dosage' table shows three doses with dates, due by dates, and compliance checkboxes. The 'Exemption, Compliance Override and Comment' section includes fields for 'Exempt Granted', 'Exempt', 'Exempt Expiration', and 'Compliant', along with a 'Comment' field.

Line	Date	Due By	Override Compliance	Status	Comment (Source)
1	02/23/2013		<input type="checkbox"/>		
2			<input type="checkbox"/>		
3			<input type="checkbox"/>		

Figure 1.74 – Health Screen, Immunizations Tab

- On the detailed screen of each immunization, the **Date** column shows the date of the student's doses and the **Due By** column shows the date by when the student should have received the dose. For each required dosage, the student can be registered as compliant by checking the **Override Compliance** box and any comments regarding the override can be recorded in the **Comment** column.
- The exemption or override compliance for the entire requirement is recorded in the Exemption, Compliance Override, and Comment section. Enter the date the exemption was granted in the **Exempt Granted** date field. Select the reason for the exemption from the **Exempt** drop-down list, and enter the date for the **Exempt Expiration** if needed in MM/DD/YY format. Check the **Compliant** box to make the entire requirement compliant, and record a **Comment** as necessary. The comments can be checked for spelling by clicking the Spellcheck button.
- Click the **Save** button at the top of the screen to save the changes. To return to the main Immunization screen, click the **Hide Detail** button.

- To edit additional immunization information used for the California Immunization Record, expand the **Immunization Record Data** section by clicking the **Maximize** button at the right-hand side of the section.

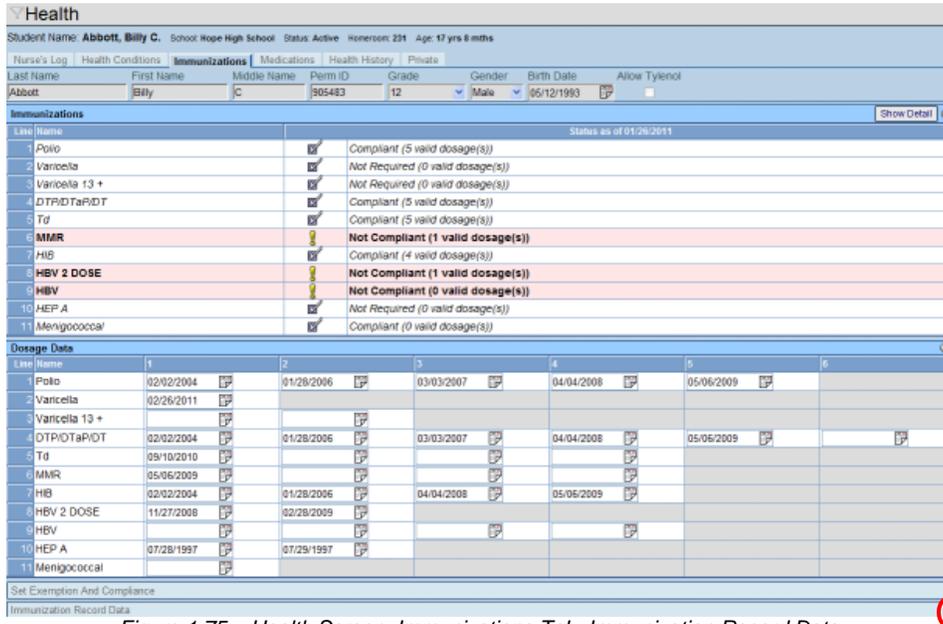


Figure 1.75 – Health Screen, Immunizations Tab, Immunization Record Data

- This section shows staff and immunization status information that is displayed on the California Immunization Record. Enter the data as required. Dates must be entered in MM/DD/YY format or they can be selected by clicking on the Calendar button.

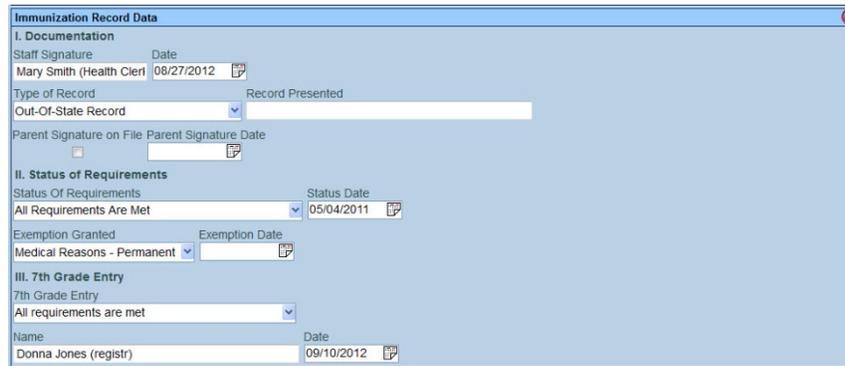


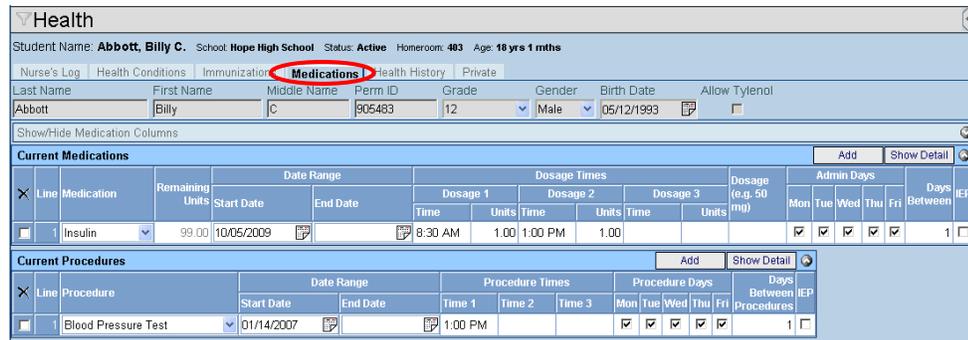
Figure 1.76 – Health Screen, Immunizations Tab, Immunization Record Data

- Click the **Save** button at the top of the screen to save the changes. Click the **Minimize** button to hide this section again.

Medications Tab

On the **Medications tab**, a list of any current medications and/or current procedures that are administered by school staff is displayed. To add or edit a medication or procedure:

- To edit a medication or procedure, click in the boxes and edit the data shown in each row. Dates must be entered in MM/DD/YY format or they can be selected by clicking on the Calendar  button. The Remaining Units value is calculated automatically.



Health

Student Name: **Abbott, Billy C.** School: **Hope High School** Status: **Active** Homeroom: **403** Age: **18 yrs 1 mths**

Nurse's Log | Health Conditions | Immunization | **Medications** | Health History | Private

Last Name: **Abbott** First Name: **Billy** Middle Name: **C** Perm ID: **905483** Grade: **12** Gender: **Male** Birth Date: **05/12/1993** Allow Tylenol:

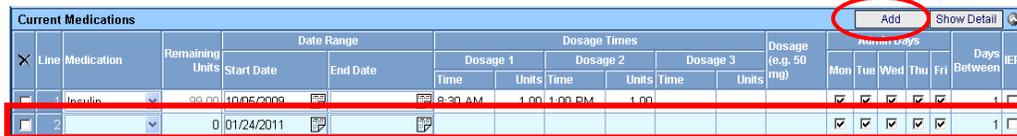
Show/Hide Medication Columns

X	Line	Medication	Remaining Units	Date Range		Dosage Times						Dosage (e.g. 50 mg)	Admin Days					Days Between	IEP		
				Start Date	End Date	Dosage 1		Dosage 2		Dosage 3			Mon	Tue	Wed	Thu	Fri				
<input type="checkbox"/>	1	Insulin	99.00	10/05/2009		8:30 AM	1.00	1:00 PM	1.00											1	<input type="checkbox"/>

X	Line	Procedure	Date Range		Procedure Times			Procedure Days					Days Between	IEP		
			Start Date	End Date	Time 1	Time 2	Time 3	Mon	Tue	Wed	Thu	Fri				
<input type="checkbox"/>	1	Blood Pressure Test	01/14/2007		1:00 PM										1	<input type="checkbox"/>

Figure 1.77 – Health Screen, Medications Tab

- Click the **Save** button at the top of the screen to save any changes.
- To add a medication, click on the **Add** button in the Current Medications section. A new blank line is added to the Current Medications section.



X	Line	Medication	Remaining Units	Date Range		Dosage Times						Dosage (e.g. 50 mg)	Admin Days					Days Between	IEP		
				Start Date	End Date	Dosage 1		Dosage 2		Dosage 3			Mon	Tue	Wed	Thu	Fri				
<input type="checkbox"/>	1	Insulin	99.00	10/05/2009		8:30 AM	1.00	1:00 PM	1.00											1	<input type="checkbox"/>
<input type="checkbox"/>	2		0	01/24/2011																1	<input type="checkbox"/>

Figure 1.78 – Adding a Medication

- Select the type of **Medication**, and then enter the number of units added to stock initially in the **Remaining Units** column.
- Enter the **Start Date** for the first date the medication must be given, and enter an **End Date** if known for the last date the medication should be given. The dates must be entered in MM/DD/YY format or they can be selected by clicking on the Calendar  button.
- Enter the **Time** of day and number of **Units** that must administered each day. Up to three dosages of the medication can be given each day.
- Enter the measurement of the medication that equals one unit in the **Dosage** column.
- Check the boxes in the **Admin Days** columns for the days on which the medication is to be given. If not given every day, also enter the **Days Between** dosages.
- If the student has an IEP, check the **IEP** box.
- Click the **Save** button at the top of the screen to save the changes.
- To delete a medication, check the box in the **X** column, and then click the **Save** button at the top of the screen.

- To record when each dose of a medication is administered or to add more medication to stock, click the **Show Detail** button in the Current Medication section.

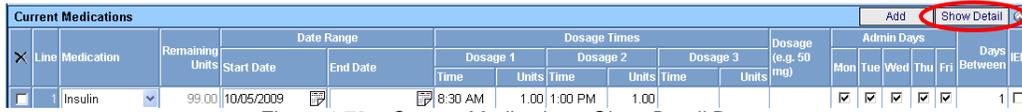


Figure 1.79 – Current Medications, Show Detail Button

- The detailed records appear on the right side of the screen. Select the record to edit by clicking on the Medication name on the left side.



Figure 1.80 – Current Medications Detail

- To record when the medication was administered to the student, click the **Add** button in the History section and a new blank line is added to the section.

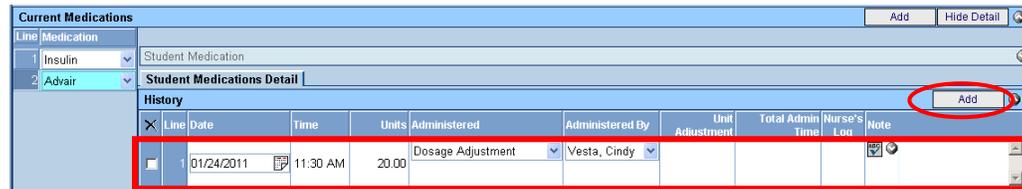


Figure 1.81 – Current Medications Detail, Adding a Record

- Enter the **Date** and **Time** the medication was given to the student, and the number of **Units**.
- From the **Administered** drop-down list, select **Administered**. If the student was absent or did not show up at their scheduled time, select **Absent** or **No Show**. If Absent or No Show, be sure to enter 0 as the number of units. The **Unit Adjustment** is automatically calculated.
- Select the staff who administered the medication from the **Administered By** drop-down list, and enter the time it took in the **Total Admin Time**. The **Nurse's Log** column is not used at this time. Additional comments can be added in the **Note** column, and these comments can be checked for spelling by clicking the Spellcheck button.
- To record when additional medication is added to stock, click the **Add** button in the History section and a new blank line is added to the section.
- Enter the number of **Units** added to stock, and select **Dosage Adjustment** from the **Administered** column. Also, select the **Date** the dosages were added, and enter the number of units in the **Unit Adjustment** column. The rest of the columns can be entered as needed.
- To remove a history record, check the box in the **X** column.
- Click the **Save** button at the top of the screen to save the changes.

22. To edit or add additional details click on the **Maximize button** of the Student Medication section.

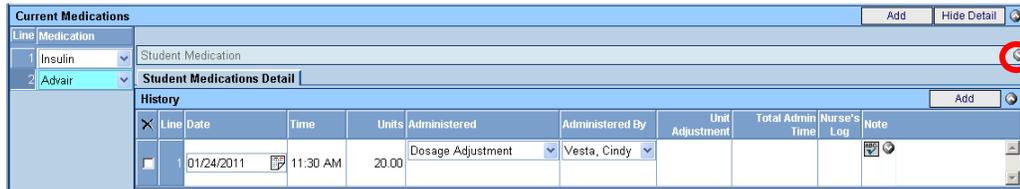


Figure 1.82 – Current Medications, Detailed Screen

23. Additional details that can be entered here are the **Medication Type**, the **Route of Admin**, the **Refill Threshold**, the **School Provided** checkbox to indicate the school provides the medication, the **Prescribing Physician**, a **Note**, **Side Effects**, **Administer In**, and **Student Health Conditions Related to this Medication**. To return to the main screen, click the **Hide Detail** button.

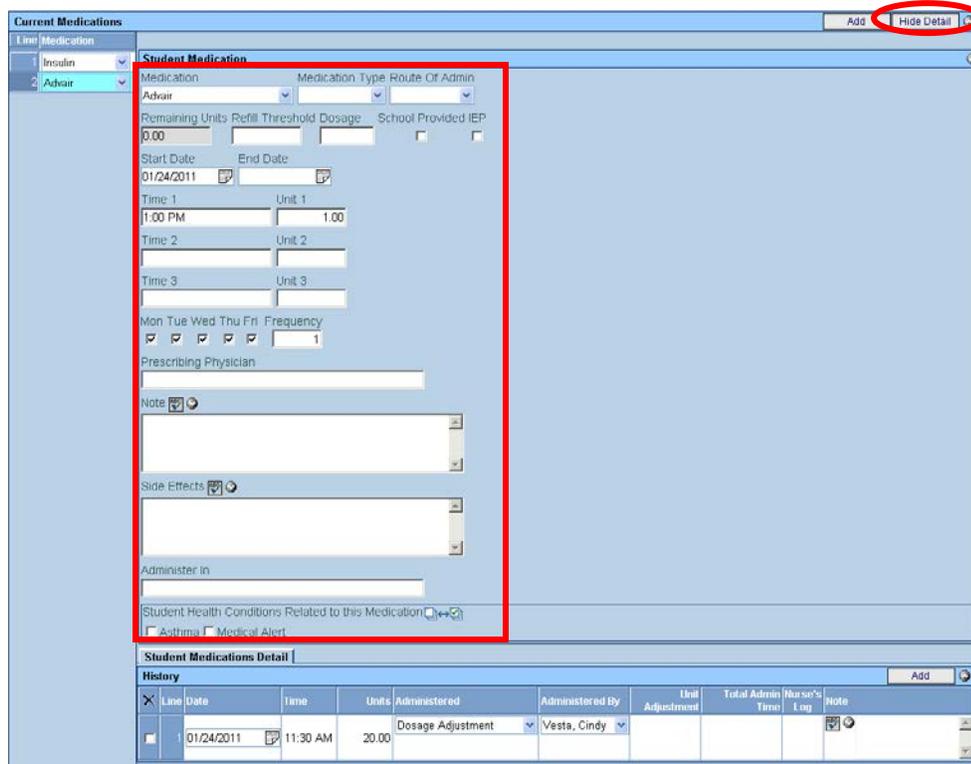


Figure 1.83 – Adding Additional Details to a Medication

24. Click the **Save** button at the top of the screen to save the changes.

- To add a procedure, click on the **Add** button in the Current Procedures section. A new blank line is added to the Current Procedures section.

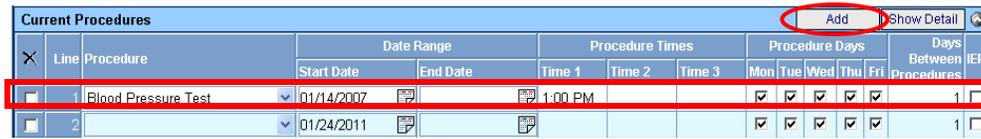


Figure 1.84 – Current Procedures, Adding

- Select the type of **Procedure**, and then enter the **Start Date** for the first date the procedure must be completed, and enter an **End Date** if known for the last date the procedure should be completed. The dates must be entered in MM/DD/YY format or they can be selected by clicking on the Calendar button.
- Enter the **Time** of day the procedure should be completed each day. Each procedure can be given up to three times each day.
- Check the boxes in the **Admin Days** columns for the days on which the procedure is to be given. If not given every day, also enter the **Days Between** procedures.
- If the student has an IEP, check the **IEP** box.
- Click the **Save** button at the top of the screen to save the changes.
- To delete a procedure, check the box in the **X** column, and then click the **Save** button at the top of the screen.
- To record when a procedure was administered, click the **Show Detail** button in the Current Procedures section.



Figure 1.85 – Current Procedures, Show Detail Button

- The detailed records appear on the right side of the screen. Select the record to view by clicking on the name of the Procedure on the left side of the screen. The selected record is highlighted in green.



Figure 1.86 – Current Procedures Detail

- Click the **Add** button in the History section and a new blank line is added to the section.

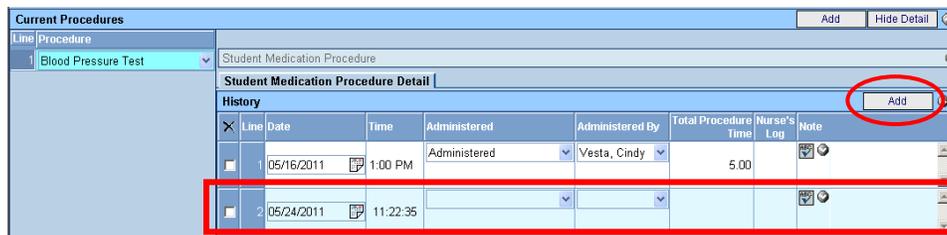


Figure 1.87 – Current Procedures Detail, Adding a Record

35. Enter the **Date** and **Time** the procedure was given to the student.
36. From the **Administered** drop-down list, select **Administered**. If the student was absent or did not show up at their scheduled time, select **Absent** or **No Show**.
37. Select the staff who administered the procedure from the **Administered By** drop-down list, and enter the time it took in the **Total Procedure Time**. The **Nurse's Log** column is not used at this time. Additional comments can be added in the **Note** column, and these comments can be checked for spelling by clicking the Spellcheck  button.
38. To remove a history record, check the box in the **X** column.
39. Click the **Save** button at the top of the screen to save the changes.
40. To edit the details of the procedure itself, click on the **Maximize** button in the Student Medication Procedure section.



Figure 1.88 – Current Procedures Detail

41. A **Location** and a **Note** can be modified here, as well as the information from the main screen. Click the **Save** button at the top of the screen to save the changes

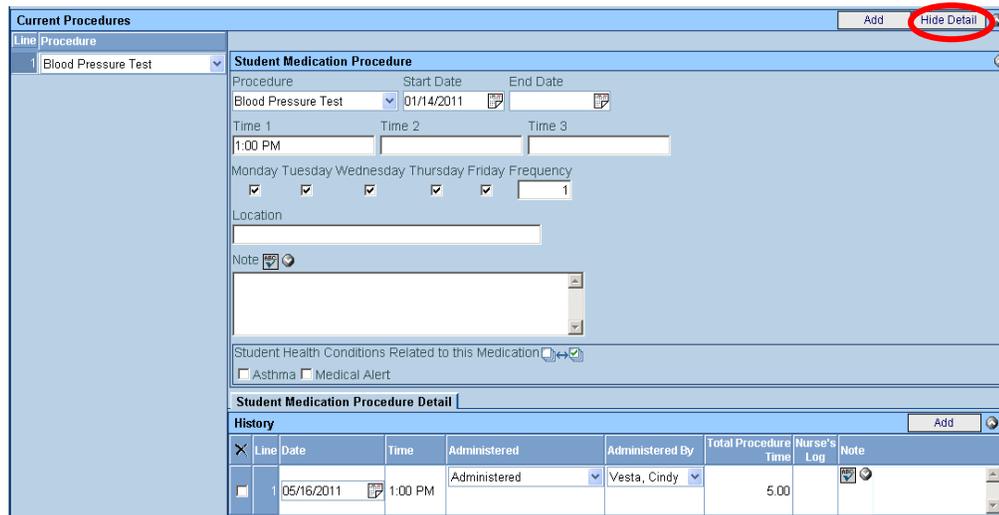


Figure 1.89 – Student Medication Procedure Detail

42. To return to the main screen, click the **Hide Detail** button.



Note – A list of required medication and procedures can be displayed on a daily basis on the Synergy SIS home page. The Medication and Service Monitor can also show the medications and procedures that must be administered on a given day.

Health History Tab

The **Health History tab** lists a record of all incidents in which the student was involved for both the current school year and any other schools and years. The Nurse's Log tab only lists incidents for the school and year in focus. It also lists any medications and procedures that are no longer actively administered and have an end date. The information displayed for each incident, medication and procedure is the same as on the Nurse's Log tab and Medications tab. To edit the historical records:

1. Click in the boxes and edit the data shown in each row. Dates must be entered in MM/DD/YY format or they can be selected by clicking on the Calendar  button.

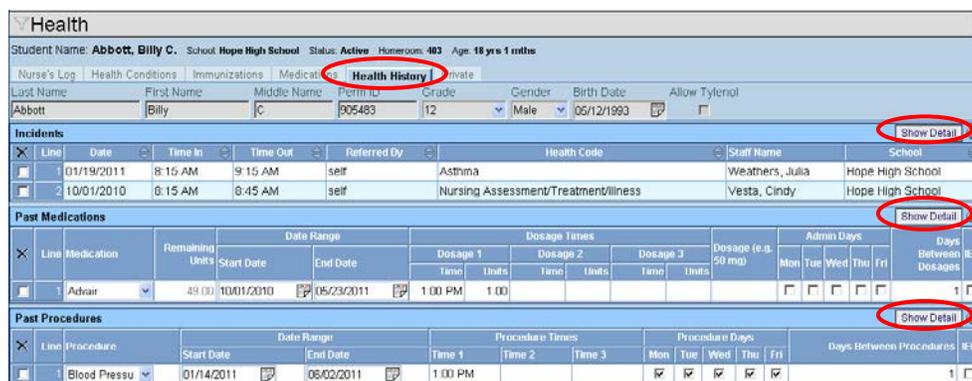


Figure 1.90 – Health Screen, Health History Tab

2. To delete a record, check the box in the **X** column.
3. Click the **Save** button at the top of the screen to save the changes.
4. To change any of the details of the records, click the **Show Detail** button, and edit the record as outlined for each of the tabs previously outlined in this chapter.

Private Tab

On the **Private tab**, staff may make comments regarding the student's health that are not displayed in the ParentVUE and StudentVUE software. Each comment is shown with the date and staff name of who entered the comment. To add or edit these comments:

1. To edit a comment, click in the boxes and edit the data shown in each row. Dates must be entered in MM/DD/YY format or they can be selected by clicking on the Calendar  button.

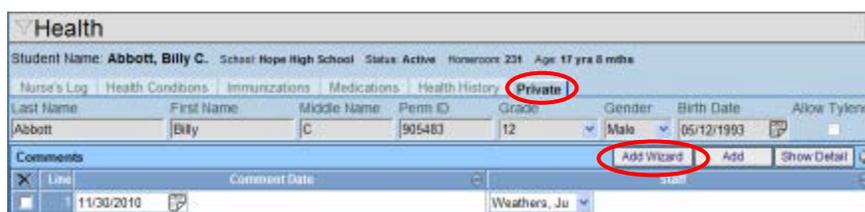


Figure 1.91 – Health Screen, Private Tab

2. To delete a comment, check the box in the **X** column.
3. Click the **Save** button at the top of the screen to save the changes.
4. To add a comment, click on either the **Add Wizard** button or the **Add** button. The Add button just adds an additional record on the main screen and additional details

must then be added by clicking the Show Detail button. The Add Wizard button allows both the information on the main screen and the detailed screen to be recorded.

5. To add a record using the Add Wizard button, click the **Add Wizard button**.
6. The Health Private Comment Detail Add screen pops-up in a separate window. Mandatory fields are highlighted in green.
7. By default, the **Comment Date** is today's date. Change the date by typing the date in MM/DD/YY format or it can be selected by clicking on the Calendar  button.

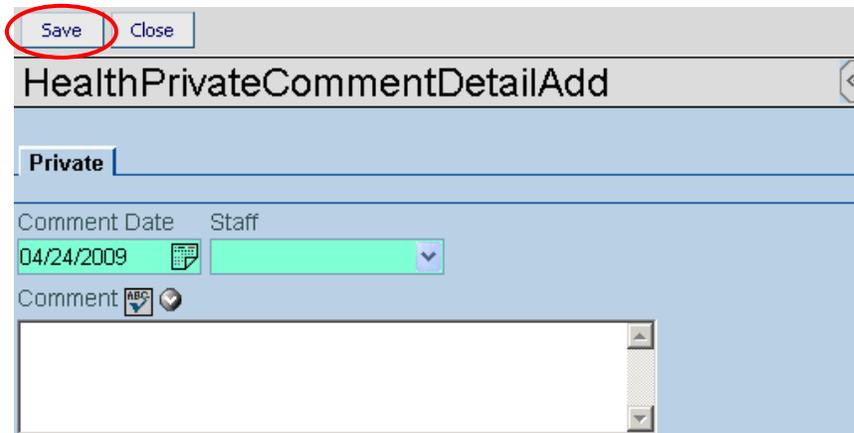


Figure 1.92 – Health Private Comment Detail Add Screen

8. Select the **Staff** making the comment from the drop-down list, and enter the comments in the **Comment** box. The comments can be checked for spelling by clicking the Spellcheck  button.
9. Click the **Save** button at the top of the screen to add the comment.
10. To add a record using the **Add button**, click the Add button and a new blank line is added to the Comments grid.

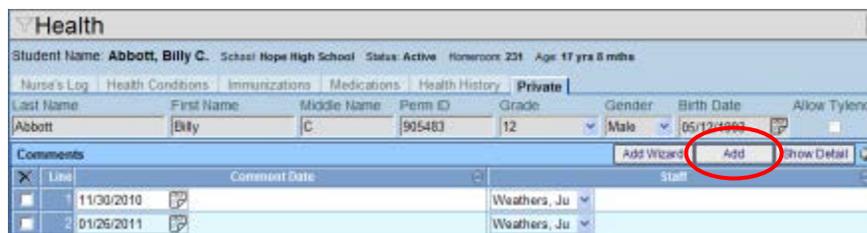


Figure 1.93 – Health Screen, Private Tab, Adding using the Add Button

11. By default, the **Comment Date** is today's date. Change the date by typing the date in MM/DD/YY format or it can be selected by clicking on the Calendar  button.
12. Select the **Staff** making the comment from the drop-down list, and click the **Save** button at the top of the screen to save the new comment.

13. To add or edit the details of each comment, click the **Show Detail** button.

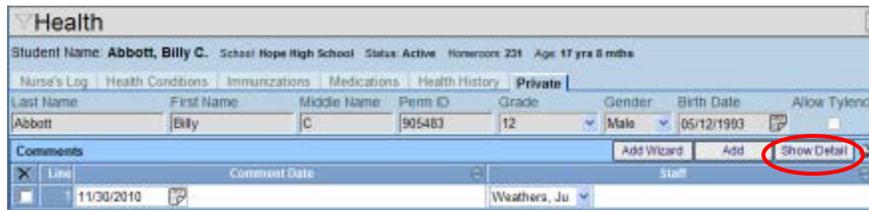


Figure 1.94 - Health Screen, Private Tab, Show Detail

14. Select the record to view by clicking on the Date of the record on the left side of the screen. The selected record is highlighted in green.

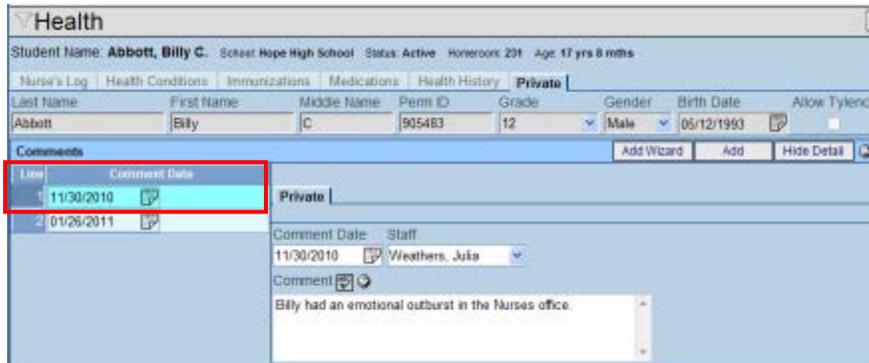


Figure 1.95 – Health Screen, Private Tab, Detailed Screen

15. Edit the **Comment** in the right side of the screen. The comment can be checked for spelling by clicking the Spellcheck  button.
16. Click the **Save** button at the top of the screen to save the changes. To return to the main screen, click the **Hide Detail** screen.

VIEWING HEALTH INCIDENTS BY THE DAY

In addition to logging health incidents by student, incidents may also be logged by for the entire day. To view the existing log:

1. Go to the **Health Log Student** screen, found under Synergy SIS > Health.

Super Title								
Line	Student Name	Gender	Perm ID	Time In	Time Out	Health Code	Staff Name	Totals
1	Abbott, Billy C.	M	905483	2:45 PM	3:00 PM	350 Diabetes	User, Admin	2

Figure 1.96 – Health Log Student Screen

2. By default, the Health Log shows the list of incidents that have happened today, and the incidents are displayed in alphabetical order by the student's last name. To view the incidents in another order, select the order in the **Sort Column** field and check the **Ascending** checkbox to list them in ascending order.

For each incident, it lists the time the person entered the nurse's office and the time they left. It also lists the patient's name, the health code assigned to the incident, and name of the staff that treated the patient.

3. To view additional detail about the incident, click the **Show Detail** button.

The details of the incident appear on the right side of the screen. Select the incident to view by clicking on the Student of the incident on the left side.

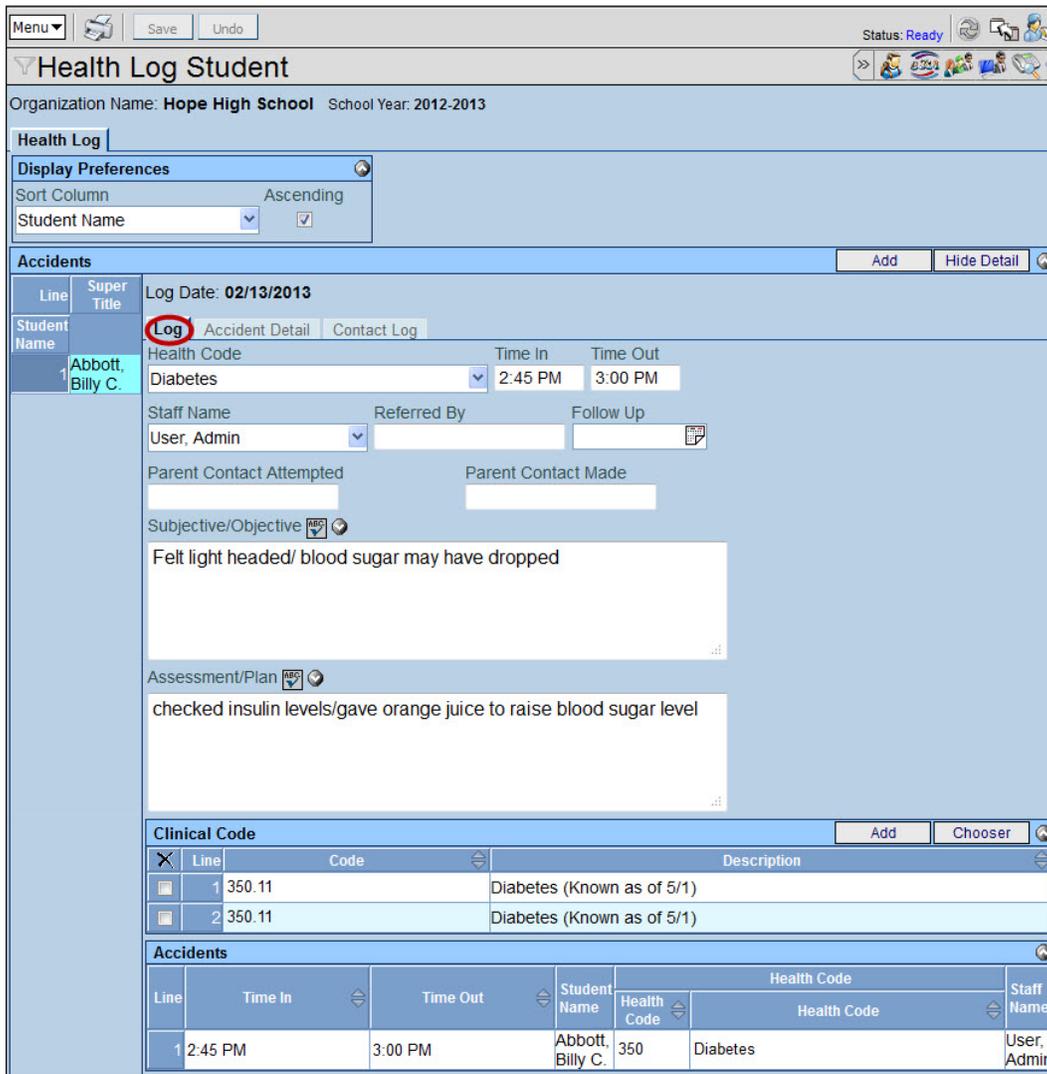


Figure 1.97 – Health Log Other Screen, Detailed Screen, Log Tab

In the detailed screen, the **Log tab** shows all of the information displayed on the main screen, as well as a subjective description of the person’s condition, and the assessment of the person’s condition and treatment plan. Additional clinical codes may also be listed.

The **Accident Detail tab** shows who initially cared for the person. It also records if additional medical care was recommended and if so, where the person was taken and who took them and when. It records why the person was at the location, any witnesses to the incident, the follow-up care needed by the person, and any preventative measures taken to prevent future incidents as well.

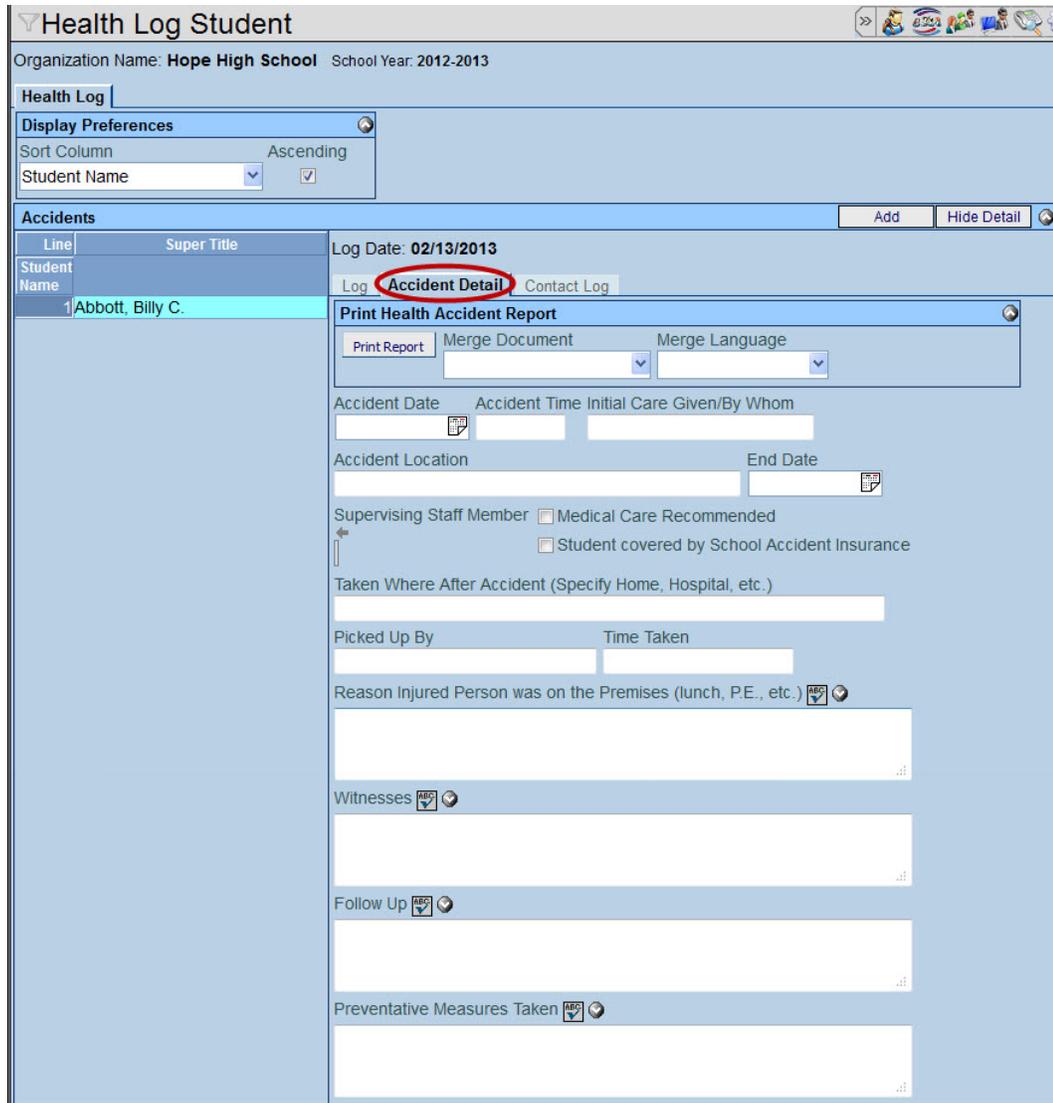


Figure 1.98 – Health Log Student Screen, Detailed Screen, Accident Detail Tab

On the **Contact Log tab** of the detailed screen, it records all contact with the parent and/or student regarding the health incident. For each contact, it can show how the contact was made, who made the contact, the date and time of contact, the type of outcome of the contact, and any notes regarding the contact.

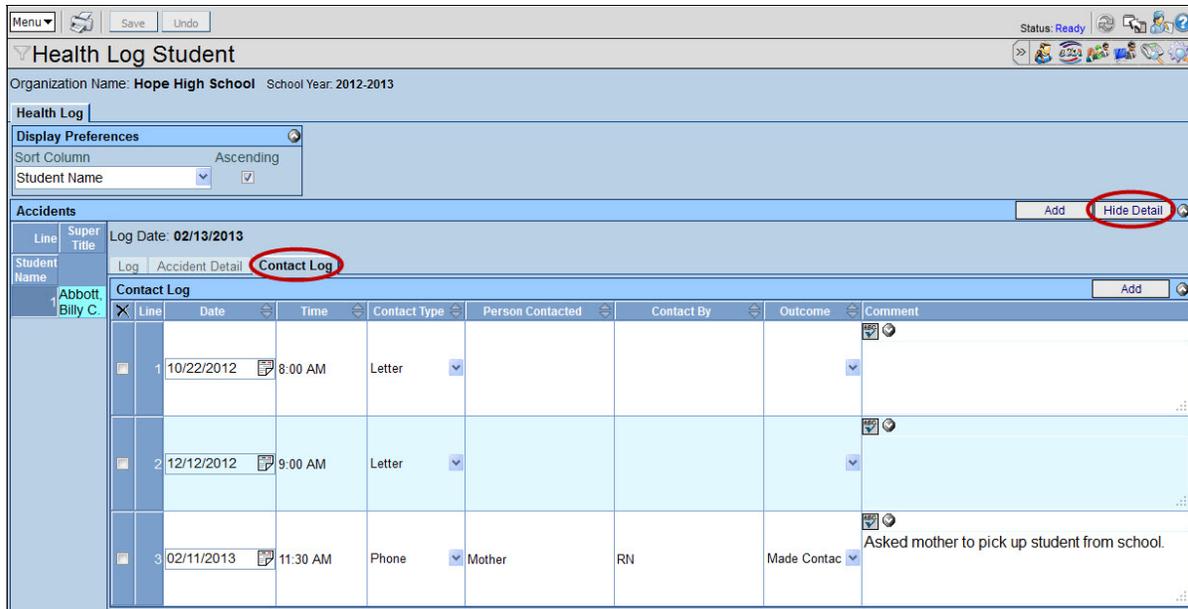


Figure 1.99 – Health Log Student Screen, Detailed Screen, Contact Log Tab

- To return to the main screen, click the **Hide Detail** button.

ADDING & EDITING HEALTH INCIDENTS BY DAY

To add or edit incidents for on the Health Log Student screen:

- Check to make sure the current **focus** is set to a school and not the district. The focus is indicated in the top right-hand corner of the screen.



Figure 1.100 – Checking Current Focus

- Change to Update mode by clicking the **Edit** button at the top of the screen. If the button is not available, Update mode is already turned on.



Figure 1.101 – Edit Button

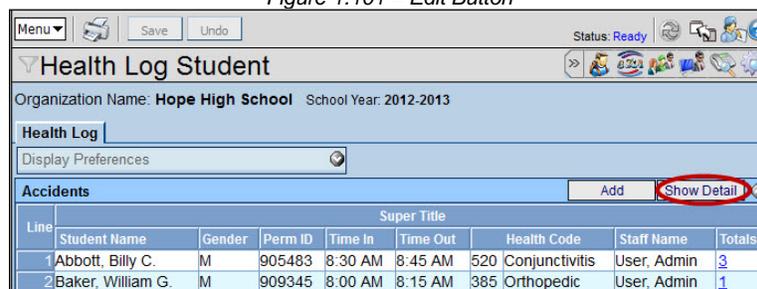


Figure 1.102 – Health Log Other Screen

In the detailed screen of each record, the **Log tab** shows all of the information displayed on the main screen, as well as the date set for follow-up, when parent contact was attempted and made, a subjective description of the student's condition,

and the assessment of the student’s condition and treatment plan. The **Subjective/Objective** description of the incident and the **Assessment/Plan** can be checked for spelling by clicking the **Spellcheck** button.

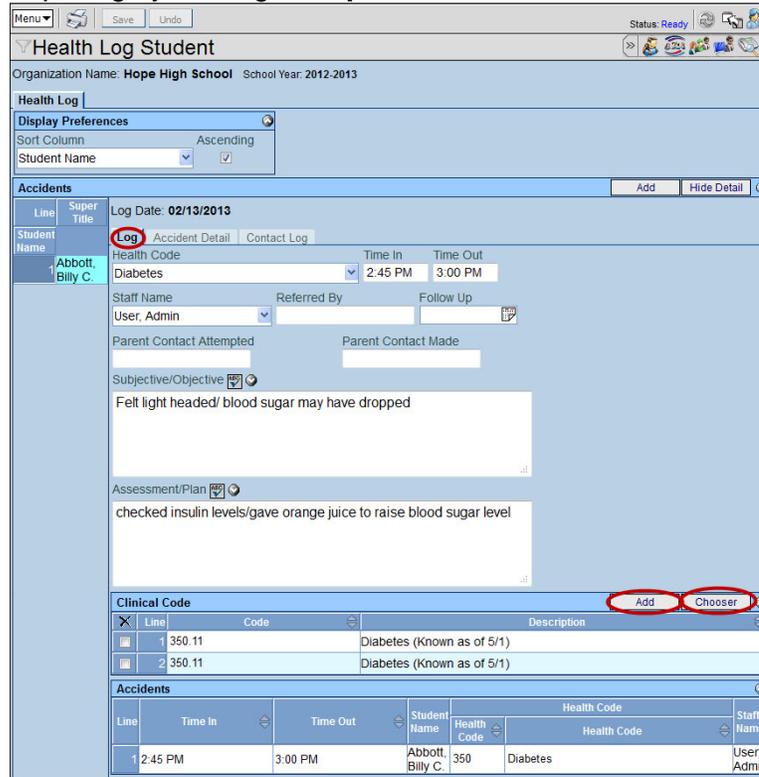


Figure 1.103 – Health Log Student screen – Detail Screen – Log tab

3. To add an individual **Clinical Code**, click the **Add** button. To select more than one code, click the **Chooser** button.
4. If the **Add button** is used, a new row is added for the clinical code. Enter the number of the code in the **Code** column. When a correct code is entered, the description is automatically filled in. To remove a code, check the box in the **X** column.

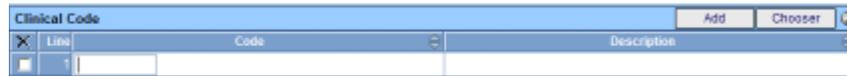


Figure 1.104 – Clinical Code, Add Button

5. If the **Chooser button** is used, the Chooser screen pops-up in a separate window. Enter all or part of the Code and/or Description and click the **Find** button.

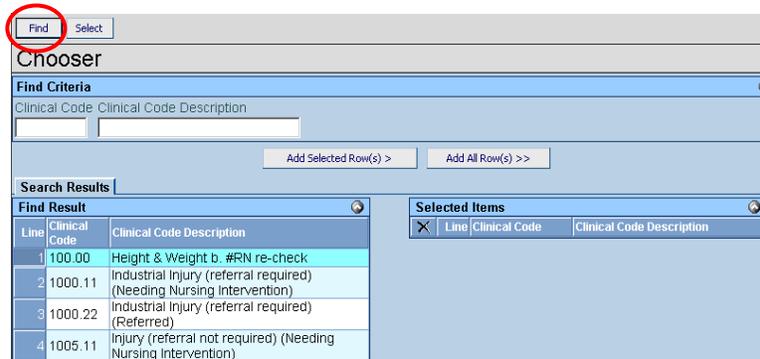


Figure 1.105 – Chooser Screen

- The clinical codes matching the criteria entered are displayed in the Find Result grid. Click on a code to select it, and then click the **Add Selected Row(s)>** button. To add multiple codes at a time, hold the CTRL button down while clicking on multiple codes to select them. To add all the codes matching the criteria, click the **Add All Row(s) >** button.

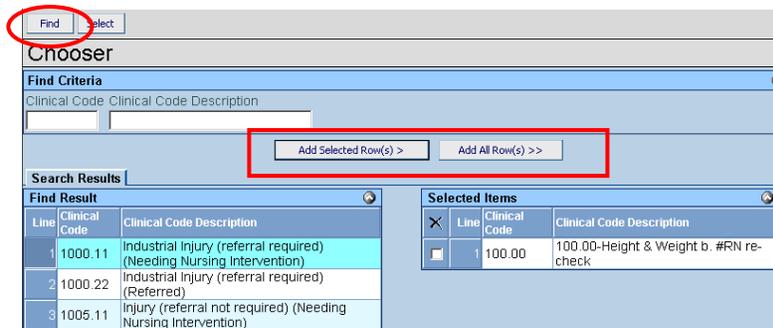


Figure 1.106 – Chooser Screen, Selecting

- The codes are moved to the Selected Items grid. To remove a code from the Selected Items grid, click the box in the X column. When all the codes needed are in the Selected Items grid, click the **Select** button to add them to the grid.

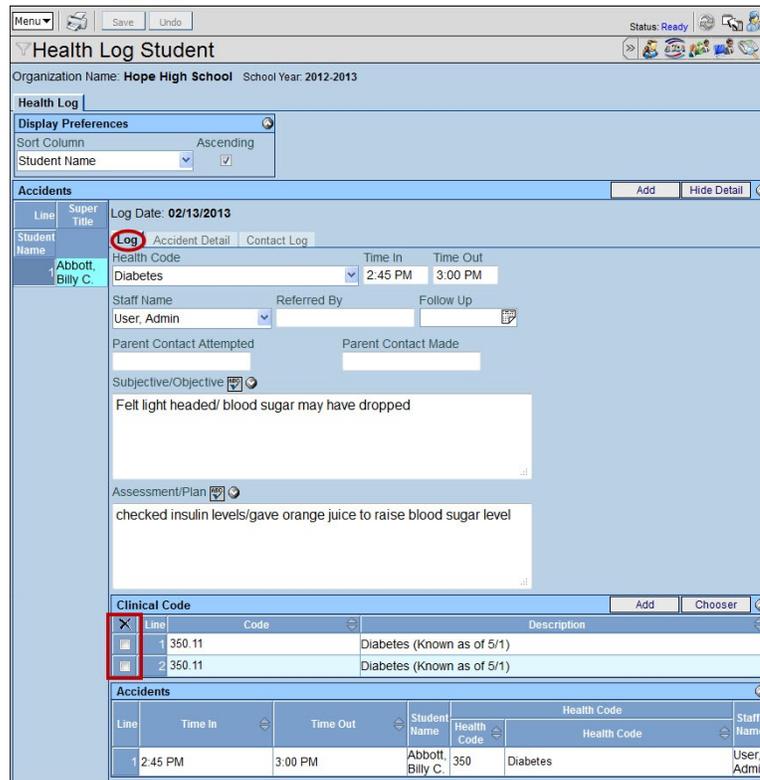


Figure 1.107 – Health Log Student, Detailed Screen, Log Tab

On the **Accident Detail** tab of the detailed screen, it records the date, time, and location of the accident and, if appropriate, an end date. It also shows who initially assisted the student and the staff member who supervised the medical treatment. Additional details that may be recorded include the status of the student’s accident insurance, if additional medical care was recommended and if so, where the student was taken and who picked up the student and when. It records why the student was at the location, any witnesses to the incident, the follow-up care needed by the student, and any preventative measures taken to prevent future incidents as well.

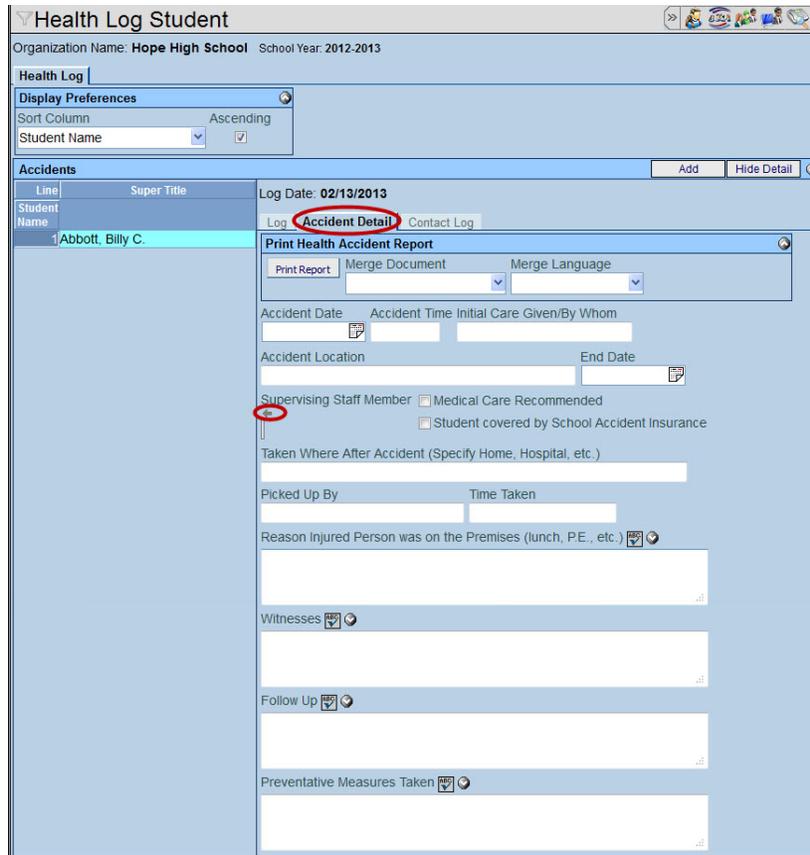


Figure 1.108 – Health Log Student Screen, Detailed Screen, Accident Detail Log

8. The dates on this tab must be entered in MM/DD/YY format or they can be selected by clicking on the Calendar  button on each field. To check the text entered for spelling, click the Spellcheck  button on each field.
9. To add a Supervising Staff Member, click the gray arrow. The Find Staff screen pops-up. Enter all or part of the **Last Name**, **First Name**, and/or **Middle Name** of the staff and click the **Find** button.



Figure 1.109 – Find Staff Screen

10. The staff matching the criteria entered is listed in the Search Results grid. Click on the **staff name** and it is then highlighted in green. Click the **Select** button at the top of the screen to enter the staff name in the group.

The screenshot shows a software interface for finding staff. At the top, there are buttons for 'Find', 'Close', 'Select', and 'Of Selection'. Below these is a search bar containing 'Find: Staff'. Underneath is a 'Find Criteria' section with three input fields: 'Last Name' (containing 'm'), 'First Name', and 'Middle Name'. Below the criteria is a 'Search Results' section containing a table with the following data:

Line	Last Name	First Name	Middle Name
1	McBride	Russ	
2	McGrew	Tom	
3	Media Center	Media Center	

Figure 1.110 – Find Staff Screen, Search Results

11. The staff member's name is entered in the Supervising Staff Member box.
12. A letter and form detailing the accident can also be printed to be sent home to the student's parents. To print the form, leave the **Merge Document** and **Merge Language** fields blank and click the **Print Report** button.

The screenshot shows a form titled 'Print Health Accident Report'. It contains three main fields: 'Print Report', 'Merge Document', and 'Merge Language'. The 'Print Report' button is circled in red. The 'Merge Document' and 'Merge Language' fields are dropdown menus, both of which are currently blank.

Figure 1.111 – Health Log Student Screen, Detailed Screen, Printing the Accident Report Form

13. The **Student Accident/Incident Report** form pops-up in a separate PDF window. This report can also be generated from the Reports folder using report HLT203.

Hope High School Student Accident/Incident Report						Year: 2008-2009 Report: HL1203
Student Information						
Student Name Abbott, Billy		Parm ID 905483	Gender M	Grade 12	Phone 480-555-1214	Homeroom 231
Address 1953 S Val Vista Dr			City Mesa	State AZ	Zip Code 85234	
Accident Information						
Accident Location: Gym				Accident Date: 03/20/2009	Time Accident Occured: 9:07 AM	
Reported by: McGrew, Tom		Date Reported: 01/14/2010	Parent Contact Attempted At: 9:08 AM	Parent Contacted At: 9:08 AM		
Describe Accident, Give Specific Location and Condition of Premises: Billy fell down in gym class and fractured his ankle.						
Medical Information						
Detailed Injury Description: His mother picked him up and took him to the hospital.						
Care Given/By Whom: Joe Coach				Medical Care Recommended: Yes		
Reason Injured Person was on the Premises(lunch, P.E., etc.): Gym class						
Persons Familiar with Circumstances(Name & Title): Joe Coach, Susie Student						
Staff Member Responsible for Student Supervision at Time of Incident:				Student Covered by School Accident Insurance: No		
Where Taken After Incident(Specify home, hospital, etc.): Hospital				By Whom: Mother	Time Taken: 10:15 AM	
Follow-Up:						
Preventative Measure Taken:						
Signatures						
Principal Signature: _____				Date Signed: _____		
Nurse Signature: _____				Date Signed: _____		
Printed by Admin User at 01/14/2010 8:39 AM Edupoint School District Page 1 of 1						

Figure 1.112 – Student Accident/Incident Report

- To print a cover letter to accompany the form, select Accident Report from the **Merge Document** drop-down list and select which language to use for the letter from the **Merge Language** drop-down list. Then click the **Print Report** button.



Figure 1.113 – Health Log Student Screen, Detailed Screen, Printing the Accident Report Letter

- The **Student Accident/Incident Letter** pops-up in a separate PDF window.

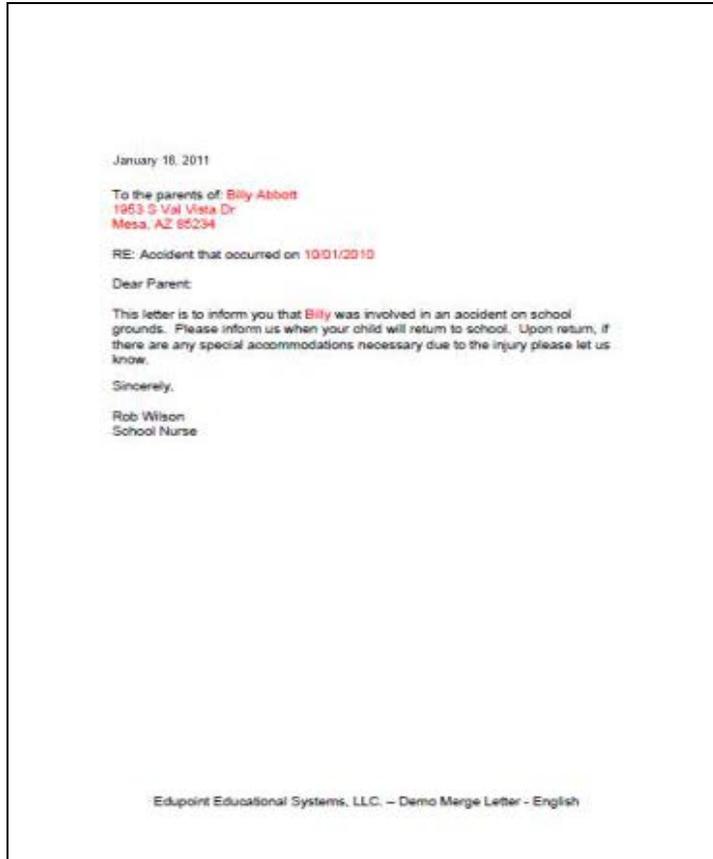


Figure 1.114 – Student Accident/Incident Letter

- To record any contact made with the student or parent regarding the incident, click on the **Contact Log** tab of the detailed screen.

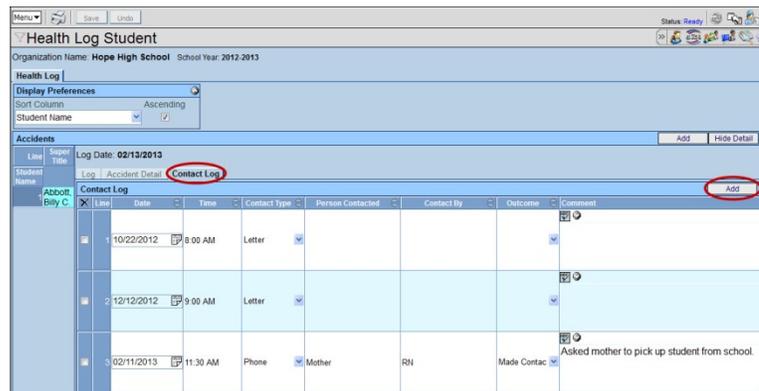


Figure 1.115 – Contact Log Tab, Detailed Screen

17. To add a new contact, click the **Add** button in the Contact Log grid.
18. A new blank line is then added to the grid. Enter the **Date** of contact by typing the date in MM/DD/YY format or it can be selected by clicking on the Calendar  button.

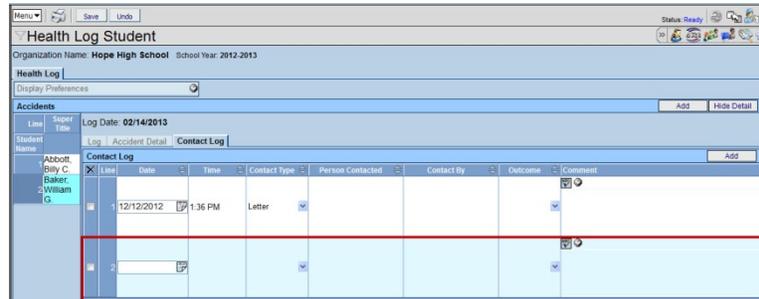


Figure 1.116 – Adding a Record of Contact

19. Enter the **Time** in HH:MM AM/PM format, and select how contact was made from the **Contact Type** drop-down list. Enter the name of the person who made contact in the **Contact By** column.
20. Select the type of **Outcome** from the drop-down list, and enter any notes or comments in the **Comment** column. The Comment can be checked for spelling by clicking the Spellcheck  button.
21. Click the **Save** button at the top of the screen to save any changes to the detail. To return to the main screen, click the **Hide Detail** button.

HEALTH MENU OPTIONS

At the top of the Health screen, a **Menu** button provides access to additional information regarding the student's health records.

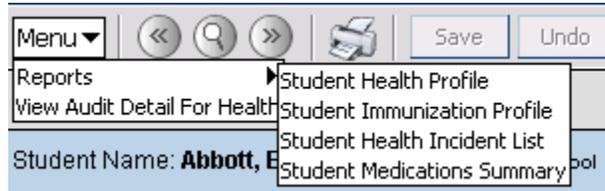


Figure 1.117 – Health Menu Options Screen

The options available under the Menu button are:

- **Reports** – the reports menu allows four reports to be easily generated for the student currently displayed in the screen. These reports are the **Student Health Profile**, the **Student Immunization Profile**, **Student Health Incident List**, and the **Student Medications Summary**. Samples of these reports can be seen in chapter 5.
- **View Audit Detail for Health** – the Audit Trail History screen lists all of the changes made to the health records, what was changed, who changed it, and the date and time the change was made

Audit Trail History							
Properties							
Line	Business Object	Property Name	Crud Action	New Value	Old Value	User Name	Date Time Stamp
1	StudentsOREnrollment	SchedTeam	Update	D		User, Admin	11/19/2009 22:06:05
2		SchedHouse	Update	ELL		User, Admin	11/19/2009 22:06:05
3		SchedLowPeriod	Update	6		User, Admin	11/19/2009 22:06:05
4		SchedHighPeriod	Update	9		User, Admin	11/19/2009 22:06:05
5	HealthIncident	Timeln	Insert	1000		User, Admin	11/16/2009 22:49:22
6		ReferredBy	Insert	two test		User, Admin	11/16/2009 22:49:22
7		StudentGU	Insert	<Link>		User, Admin	11/16/2009 22:49:22
8		TimeOut	Insert	1100		User, Admin	11/16/2009 22:49:22
9		EffectiveDate	Insert	20091116		User, Admin	11/16/2009 22:49:22
10		EnteredByGU	Insert	User, Teacher		User, Admin	11/16/2009 22:49:22
11		HealthCode	Insert	030		User, Admin	11/16/2009 22:49:22

Figure 1.118 – Health Audit Trail History Screen

MEDICATION AND SERVICE MONITOR

The Medication and Service Monitor lists all of the medications and/or procedures that have been scheduled using the Medications tab of the Health screen, and that have not been recorded as completed. It is a “to-do” list for the nursing staff at the school. To view the list of medications and procedure due:

1. Go to the **Medication and Service Monitor**, found under Synergy SIS > Health.

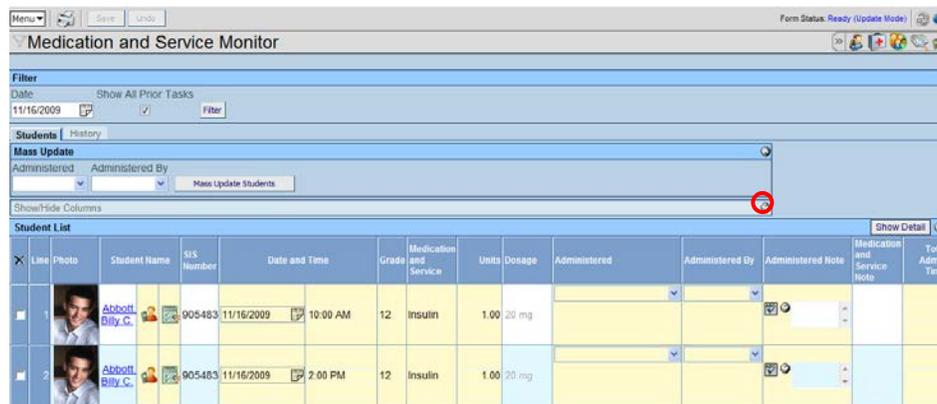


Figure 1.119 – Medication and Service Monitor Screen

2. By default, the screen lists the tasks due for today and any overdue tasks. To change the date of the tasks to view, edit the **Date** in the Filter section. The date must be entered in MM/DD/YY format or they can be selected by clicking on the Calendar button. To list all tasks prior to the date entered, check the box **Show All Prior Tasks**. Once the Date and Show All Prior Tasks have been modified, click the **Filter** button to change the list of tasks.
3. For each task, it shows the student’s photo, name, grade, and SIS number. If the **student’s name** is clicked, the student’s health records pop-up in a separate window to show the **Medications tab of the Health screen**. Clicking the icon pops-up the **Student Phone Numbers screen** in a separate window. Clicking the icon pops-up the student’s **Daily or Period Attendance** record in a separate window.
4. On each task, it shows the **Date and Time**, the task is due, and the name of the medication or procedure is shown in the **Medication and Service** column. If a medication is due, the **Units and Dosage** are displayed. Finally, if the medication or procedure has any notes attached, these are displayed in the **Medication and Service Note** column.
5. To modify the columns displayed for each task, expand the **Show/Hide Columns** section by clicking the **Maximize** button at the right-hand side of the section



Figure 1.120 – Show/Hide Columns Section

6. Check or uncheck the columns to be displayed, and then click the **Refresh Grid** button to update the task list. To hide this section, click the **Minimize** button.

7. To view the details of each task, click the **Show Detail** button.
8. The detailed screen shows on the right-hand side of the screen. To select which task's details to display, click on the Photo on the left side.



Figure 1.121 – Medication and Service Monitor Screen, Detailed Screen

9. The only additional detail available in this screen is the primary phone number of the student. All other details are also shown in the main screen.
10. Click the **Hide Detail** button to return to the main screen.
11. To record the administration of a medication or procedure, select **Absent**, **No Show**, or **Administered** from the **Administered** column. Select the staff who administered the task from the **Administered By** column.
12. A note regarding the task can be entered in the **Administered Note** column, and the time taken for the task in the **Total Admin Time** column. The note can be checked for spelling by clicking the Spellcheck  button.
13. Click the **Save** button at the top of the screen to save the changes. The records then no longer appear in the task list, but they can be screened from the History tab if needed.
14. To delete a task from the screen, check the box in the **X** column then click the **Save** button at the top of the screen.
15. To enter the same information for all task listed in the screen, select the value for the **Administered** column and the **Administered By** column in the Mass Update section. Then click the **Mass Update Students** button.



Figure 1.122 – Mass Update

16. To view the history of the tasks, click on the **History** tab. A list of all tasks that have been completed are shown, with the same columns are shown on the Students tab.

X	Line	Photo	Student Name	SIS Number	Date	Time	Grade	Medication and Service	Units	Administered	Administered By	Administered Note	Medication and Service Note	Total Admin Time
<input type="checkbox"/>			Abbott, Billy C.	905483	10/12/2009	10:52 PM	12	Insulin		Dosage Adjustment		Initial Dosages		

Figure 1.123 – Medication and Service Monitor Screen, History Tab

17. The information on the History tab can be modified by changing the text and then clicking the **Save** button at the top of the screen.

- To delete a task, check the box in the **X** column then click the **Save** button at the top of the screen.

TASK LIST

Tasks in Synergy SIS provide a “to-do” list on the home page of Synergy SIS. Currently, two types of health-related tasks may be displayed: Student Medication and Procedures as scheduled on the **Medications tab of the Health screen**, and follow-up to a student health incident as defined by the End Date on the Accident Detail tab of the **Nurse’s Log tab on the Health screen**. To go the related screen, click on the Icon in the task list.

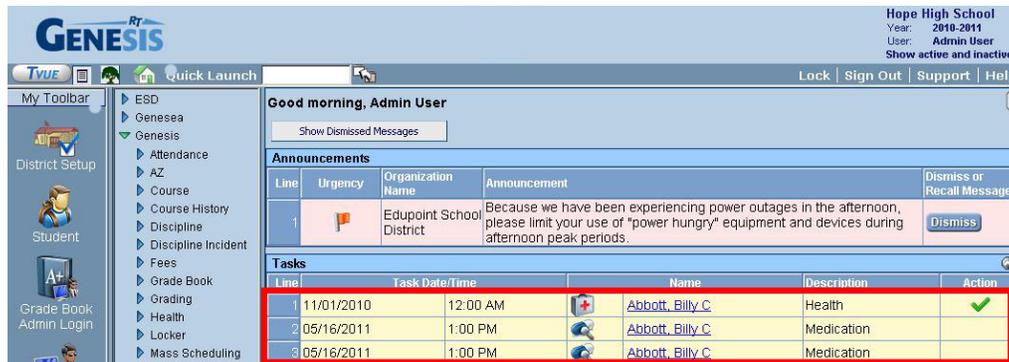


Figure 1.124 – Tasks Displayed on the Synergy SIS Home Page

The tasks are generated once a day. To turn on the task list,

- Go to the **User Profile screen**, found under Synergy SIS > User Preferences.
- Click on the **POV tab**.
- Check the **Show Task List** box.

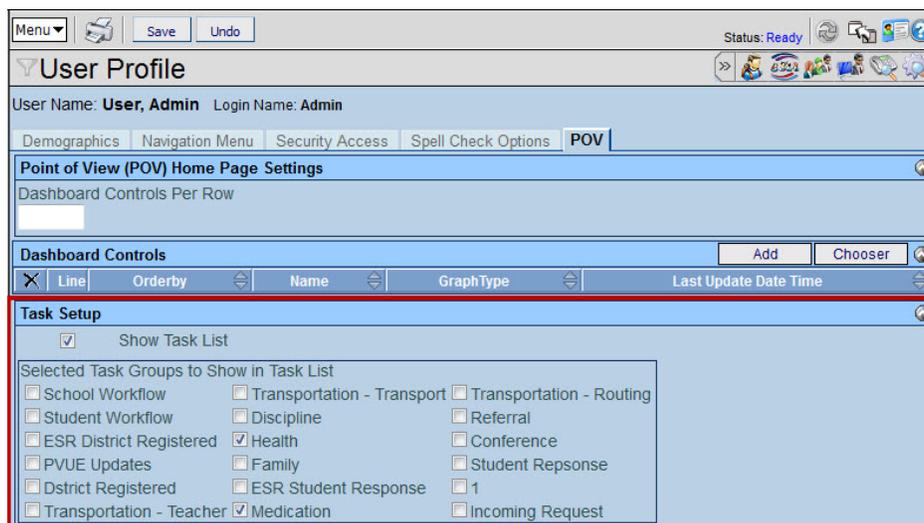


Figure 1.125 – POV Tab, User Profile Screen

- Select which tasks are displays by checking the **Selected Task Groups to Show in Task List** boxes. Check **Health** to show the follow-ups to the Nurse’s Log, and check **Medication** to show the medications and procedures due each day.

5. Click the **Save** button at the top of the screen to save the changes, or click the **Undo** button to reverse them.

Chapter Two: INCIDENTS FOR NON-STUDENTS

In this chapter, the following topics are covered:

- ▶ Viewing health incidents for non-students
- ▶ Adding & editing health incidents for non-students

VIEWING HEALTH INCIDENTS FOR NON-STUDENTS

In addition to logging health incidents for students, incidents may also be logged for non-students such as staff or visitors. To view the existing log:

1. Go to the **Health Log Other** screen, found under Synergy SIS > Health.

The screenshot shows the 'Health Log Other' interface for 'Hope High School' in the '2008-2009' school year. The 'Log Date' is set to '08/02/2009'. Below this is a table of incidents. The first incident is highlighted with a red box around the 'Show Detail' button.

Line	Time In	Time Out	Patient Name	Health Code	Staff Name
1	8:53 AM	9:12 AM	Scott Gordon	001 Nursing Assessment/Treatment/Illness	McGrew, Tom

Figure 2.1 – Health Log Other Screen

2. By default, the Health Log shows the list of incidents that have happened today. To view the incidents for another date, enter the date in the **Log Date** field. The data must be entered in MM/DD/YY format or they can be selected by clicking on the Calendar button.
3. Click the **Go To Date** button, and the list of incidents for the date selected appears.
4. For each incident, it lists the time the person entered the nurse's office and the time they left. It also lists the patient's name, the health code assigned to the incident, and name of the staff that treated the patient.
5. To view additional detail about the incident, click the **Show Detail** button.
6. The details of the incident appear on the right side of the screen. Select the incident to view by clicking on the Time of the incident on the left side.

The screenshot shows the 'Health Log Other' interface for 'Hope High School' in the '2010-2011' school year. The 'Log Date' is set to '10/01/2010'. The 'Accidents' table shows one incident at '8:15 AM'. The 'Log' tab is selected, showing detailed information for this incident.

Line	Time In	Time Out	Staff Name
1	8:15 AM	9:45 AM	Vesta, Cindy

The detailed view includes fields for Effective Date (10/01/2010), Health Code (Nursing Assessment/Treatment/Injury), Patient Name (Abbott, Billy), Patient Description, Subjective/Objective, and Assessment/Plan. A 'Clinical Codes' table is also visible at the bottom.

Figure 2.2 – Health Log Other Screen, Detailed Screen, Log Tab

7. In the detailed screen, the **Log tab** shows all of the information displayed on the main screen, as well as a subjective description of the person's condition, and the

assessment of the person's condition and treatment plan. Additional clinical codes may also be listed.

- The **Accident Detail tab** shows who initially cared for the person. It also records if additional medical care was recommended and if so, where the person was taken and who took them and when. It records why the person was at the location, any witnesses to the incident, the follow-up care needed by the person, and any preventative measures taken to prevent future incidents as well.

Figure 2.3 – Health Log Other Screen, Detailed Screen, Accident Detail Tab

- To return to the main screen, click the **Hide Detail** button.

ADDING & EDITING HEALTH INCIDENTS FOR NON-STUDENTS

To add or edit incidents for non-students:

- Check to make sure the current **focus** is set to a school and not the district. The focus is indicated in the top right-hand corner of the screen.



Figure 2.4 – Checking Current Focus

- Change to Update mode by clicking the **Edit** button at the top of the screen. If the button is not available, Update mode is already turned on.



Figure 2.5 – Edit Button

- To locate the incident to edit, enter the date of the incident in the **Log Date** field. The data must be entered in MM/DD/YY format or they can be selected by clicking on the Calendar button.
- Click the **Go To Date** button, and the list of incidents for the date selected appears.

Health Log Other

Organization Name: **Hope High School** School Year: **2008-2009**

Health Log

Log Date: 08/02/2009 Go To Date

Accidents Current Log Date: 8/2/2009 Add Wizard Add Show Detail

Line	Time In	Time Out	Patient Name	Health Code	Staff Name
1	8:53 AM	9:12 AM	Scott Gordon	001 Nursing Assessment/Treatment/Illness	McGrew, Tom

Figure 2.6 – Health Log Other Screen

5. To edit the records, click on the data to modify and change the information as desired. Boxes with a gray background cannot be changed.
6. The **Health Code** can be selected either by clicking on the drop-down arrow, or by entering the numeric code.
7. To delete a record, check the box in the **X** column.
8. Click the **Save** button at the top of the screen to save the changes.
9. To add a record, click on either the **Add Wizard** button or the **Add** button. The Add button just adds an additional record on the main screen and additional details must then be added by clicking the Show Detail button. The Add Wizard button allows both the information on the main screen and the detailed screen to be recorded.
10. To add a record using the Add Wizard button, click the **Add Wizard** button.

The Health Log Other Detail Add screen pops-up in a separate window. Mandatory fields are highlighted in green. The **Effective Date** will automatically be set to today's date and cannot be changed.

HealthLogOtherDetailAdd

Log Accident Detail

Effective Date: [Green] Health Code: [Drop-down]

Patient Name: [Green] Patient Description: [Text Area]

Time In: [Green] Time Out: [Text Area] Staff Name: [Green]

Subjective/Objective: [Text Area] [Spellcheck]

Assessment/Plan: [Text Area] [Spellcheck]

Clinical Codes: [Add] [Chooser]

Line	Clinical Code	Description
------	---------------	-------------

Figure 2.7 – Health Log Other Detail Add Screen, Log Tab

11. The **Health Code** can either be selected by clicking on the drop-down arrow.
12. Enter the **Patient Name**, **Patient Description**, **Time In**, **Time Out**, and **Staff Name**.
13. The **Subjective/Objective** description of the incident and the **Assessment/Plan** can be checked for spelling by clicking the **Spellcheck** button.
14. To add an individual **Clinical Code**, click the **Add** button. To select more than one code, click the **Chooser** button.

- If using the **Add button**, a new row is added for the clinical code. Enter the number of the code in the **Code** column. When a correct code is entered, the description is automatically filled in. To remove a code, check the box in the **X** column.



Figure 2.8 – Clinical Code, Add Button

- If the **Chooser button** is used, the Chooser screen pops-up in a separate window. Enter all or part of the Code and/or Description and click the **Find** button.

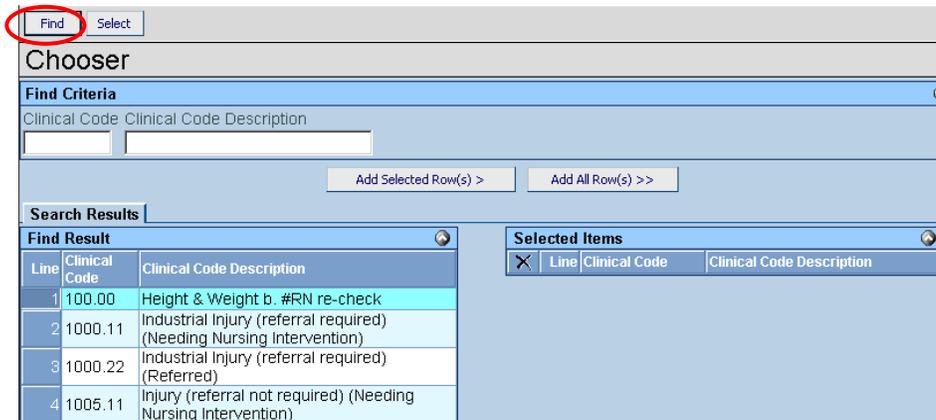


Figure 2.9 – Chooser Screen

- The clinical codes matching the criteria entered are displayed in the Find Result grid. Click on a code to select it, and then click the **Add Selected Row(s)>** button. To add multiple codes at a time, hold the CTRL button down while clicking on multiple codes to select them. To add all the codes matching the criteria, click the **Add All Row(s) >** button.

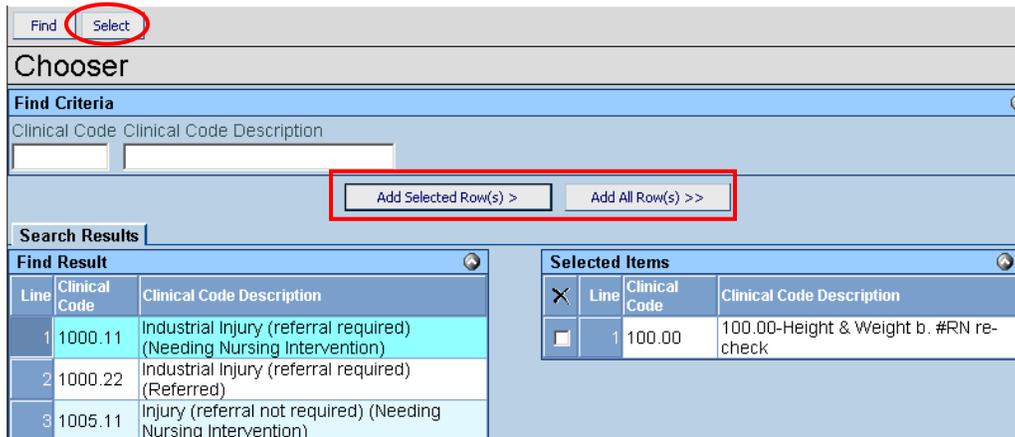


Figure 2.10 – Chooser Screen, Selecting

- The highlighted codes are moved to the Selected Items grid. To remove a code from the Selected Items grid, click the box in the **X** column. When all the codes needed are in the Selected Items grid, click the **Select** button to add them to the Clinical Codes grid.

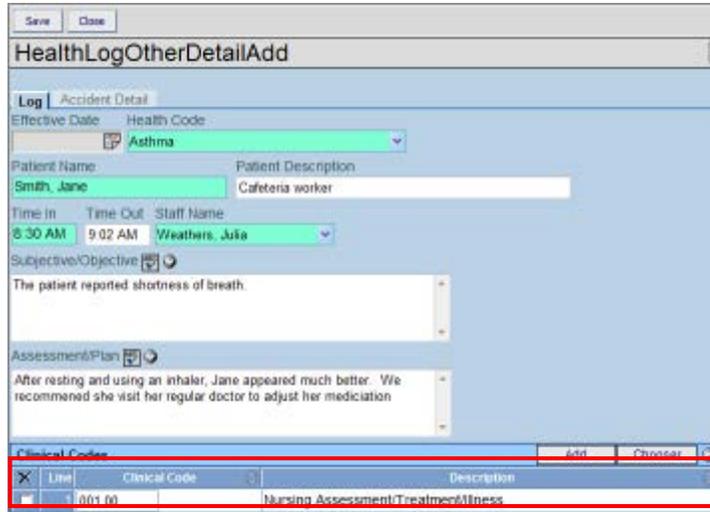


Figure 2.11 - Adding a Clinical Code

19. If the health incident is an accident, click on the **Accident Detail** tab to record additional information.

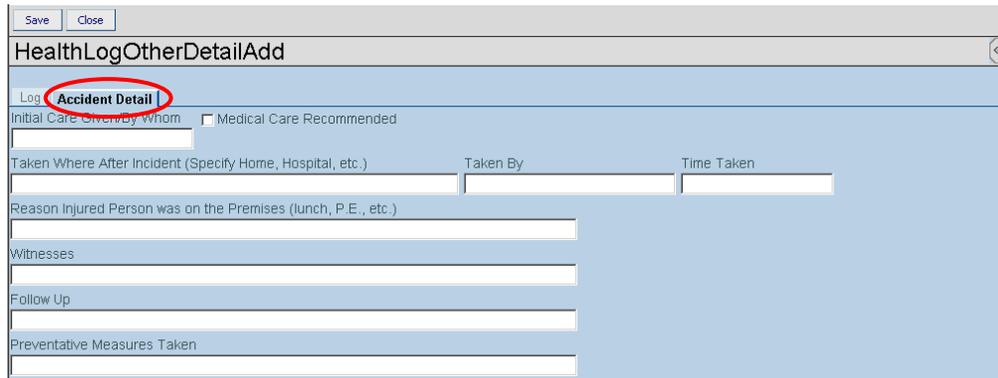


Figure 2.12 – Health Log Other Detail Add Screen, Accident Detail Tab

20. When all the information has been added for the incident, click the **Save** button at the top of the screen to save the record.

21. To edit or add details for each incident, click the **Show Detail** button.



Figure 2.13 – Health Log Other Screen

- Select the record to view by clicking on the **Time** of the record on the left side of the screen. The selected record is highlighted in green.

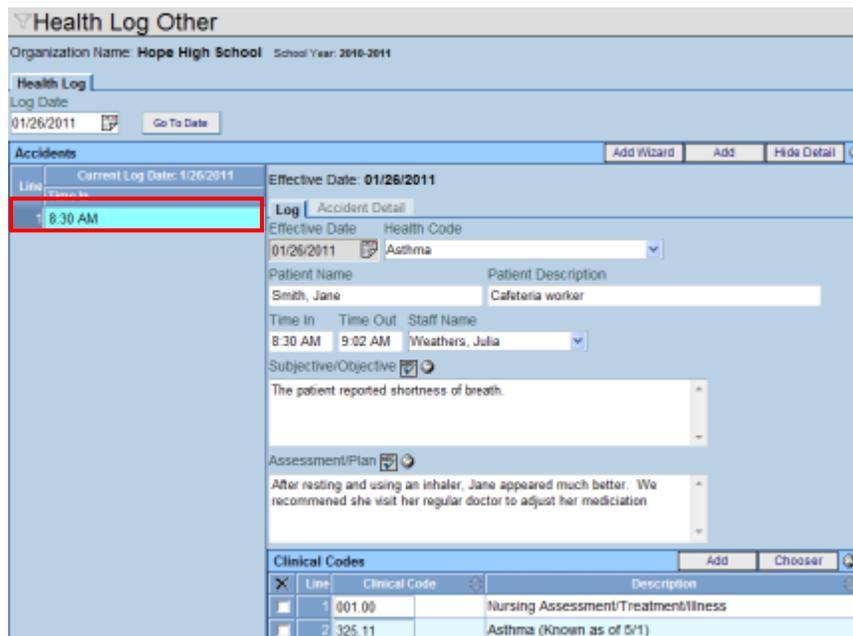


Figure 2.14 – Health Log Other Screen, Detailed Screen, Log Tab

In the detailed screen, the **Log tab** shows all of the information displayed on the main screen, as well as a subjective description of the person’s condition, and the treatment plan. Additional clinical codes may also be listed. The **Subjective/Objective** description of the incident and the **Assessment/Plan** can be checked for spelling by clicking the **Spellcheck** button.

- To add an individual **Clinical Code**, click the **Add** button. To select more than one code, click the **Chooser** button.
- If using the **Add button**, a new row is added for the clinical code. Enter the number of the code in the **Code** column. When a correct code is entered, the description is automatically filled in. To remove a code, check the box in the **X** column.



Figure 2.15 – Clinical Code, Add Button

- If the **Chooser button** is used, the Chooser screen pops-up in a separate window. Enter all or part of the Code and/or Description and click the **Find** button.

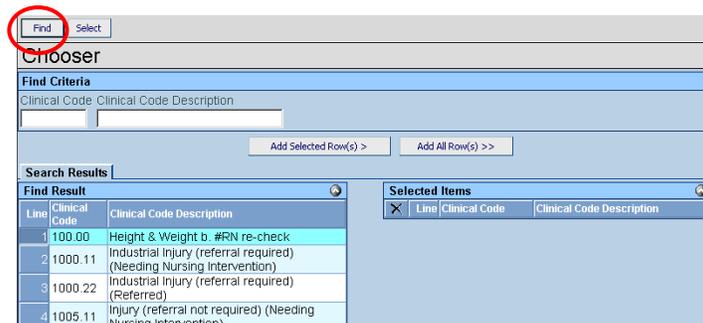


Figure 2.16 – Chooser Screen

- The clinical codes matching the criteria entered are displayed in the Find Result grid. Click on a code to select it, and then click the **Add Selected Row(s)>** button. To add multiple codes at a time, hold the CTRL button down while clicking on multiple codes to select them. To add all the codes matching the criteria, click the **Add All Row(s) >** button.

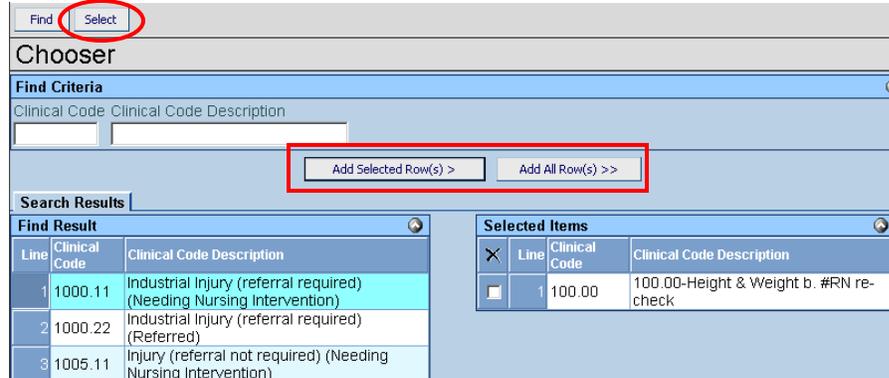


Figure 2.17 – Chooser Screen, Selecting

- The codes are moved to the Selected Items grid. To remove a code from the Selected Items grid, click the box in the X column. When all the codes needed are in the Selected Items grid, click the **Select** button to add them to the grid.

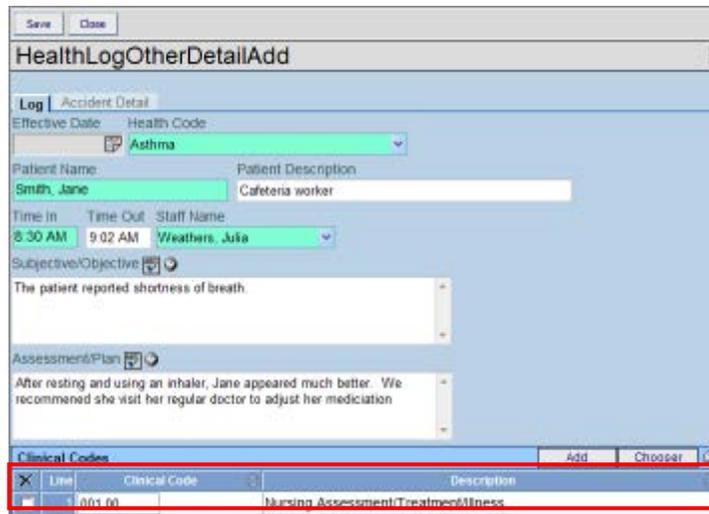


Figure 2.18 – Health Log Other Detail Add Screen

The **Accident Detail tab** shows who initially cared for the person. It also records if additional medical care was recommended and if so, where the person was taken and who took them and when. It records why the person was at the location, any witnesses to the incident, the follow-up care needed by the person, and any preventative measures taken to prevent future incidents as well.

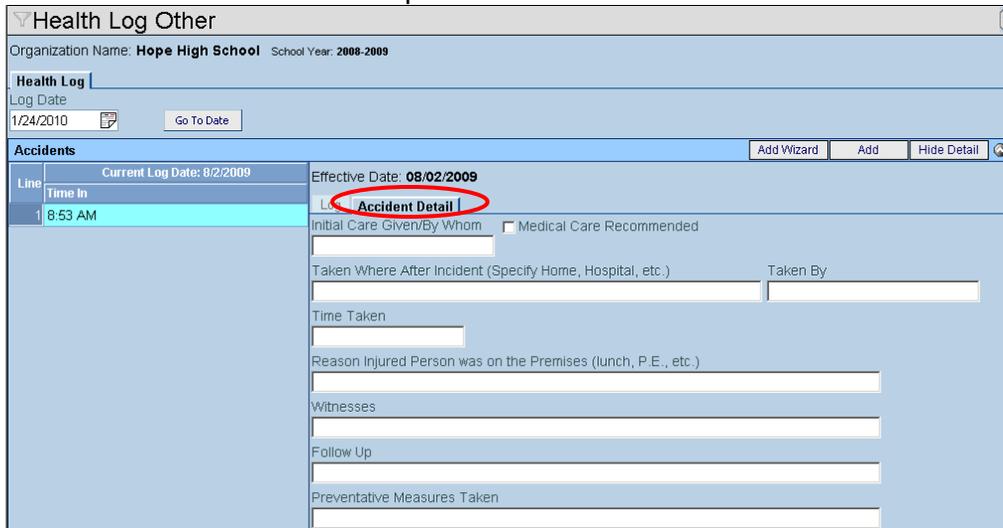


Figure 2.19 – Health Log Other Screen, Detailed Screen, Accident Detail Log

28. Click the **Save** button at the top of the screen to save any changes to the detail. To return to the main screen, click the **Hide Detail** button.

Chapter Three: HEALTH SCREENING

In this chapter, the following topics are covered:

- ▶ Viewing health screen records
- ▶ Adding & editing health screen records

VIEWING HEALTH SCREEN RECORDS

The Health Screen screen can record all of the screenings that take place, including Tuberculosis, Vision, Hearing, Scoliosis, General Health, and Dental. To view the student's health screening records:

1. Go to the **Health Screen** screen, found under Synergy SIS > Health > Health Screen.

Health Screen

Student Name: **Abbott, Billy** School: **Hope High School** Status: **Active** Room Name: **215**

Tuberculosis | Vision | Hearing | Scoliosis | General Health | Dental

Last Name: **Abbott** First Name: **Billy** Middle Name: Suffix: Perm ID: **905483** Grade: **12** Gender: **Male**

Tuberculosis Skin Test

Type	Date Given 1	Date Read 1	mm Induration 1	Impression 1
PPD-Mantoux	08/03/2006	08/06/2006	0	Negative
Type	Date Given 2	Date Read 2	mm Induration 2	Impression 2
PPD-Mantoux	08/01/2008	08/06/2008	8	Positive

Waiver: Waiver Date:

Tuberculosis Chest X-Ray

Xray Film Date: **02/12/2009** Xray Impression: **Abnormal**

Tuberculosis Medication

Medication Prescribed: Medication:

Medication Start Date: Medication End Date:

Free of communicable Tuberculosis: **Yes, Person is free of communicable Tuberculosis**

Figure 3.1 – Health Screen Screen

To find a **Health Screen** record, there are two methods: **Scroll or Find mode**. To scroll through the student records to find the student:

1. Click on the **right Scroll button** to advance to the first health record. Records are sorted alphabetically by student last name.



Figure 3.2 – Right Scroll Button

2. To scroll in reverse descending order, click the **left Scroll button**.

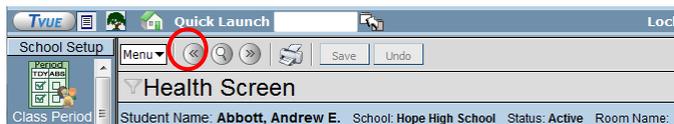


Figure 3.3 – Left Scroll Button

3. Continue clicking on the scroll button until the desired record appears.

To switch to the Find mode to look for a **Health Screen** record:

1. Click on the **Find Mode** button.



Figure 3.4 – Find Mode Button

2. Enter either the entire last name or the first part of the last name of the student in the **Last Name** box.

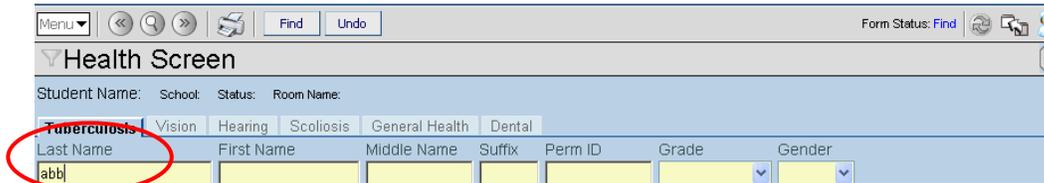


Figure 3.5 – Health Find Last Name Screen

3. Click the **Find** button or press the **Enter** key. The first student with the last name entered into the Find screen will appear. Then use the scroll buttons to find the exact student.



Note: In the Find Mode, student records can also be found by searching by any of the yellow fields on the screen. For example, a first name may be entered in addition to the last name. This will bring up a pop-up screen with a list of students matching the criteria entered when the Find button is clicked. To select a student, click on their name and the student record selected will appear in the Health Screen screen. For more about finding students in any screen, please refer to *Synergy SIS – Student Information User Guide*.

Once the desired record has been located, the information in the Health Screen screen is: On the **Tuberculosis** tab, the results of two different tuberculosis skin tests can be seen. For each test, it records the type of test, the date it was given, the date it was read, and the results of the test.

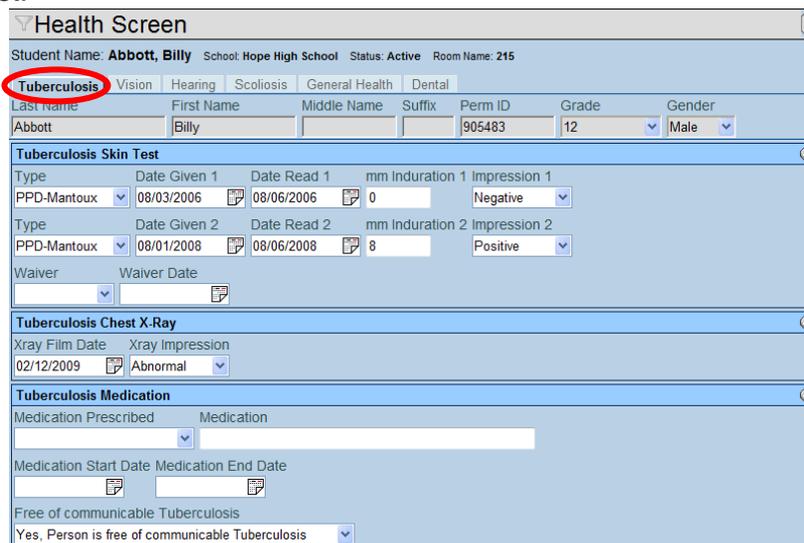


Figure 3.6 – Tuberculosis Tab, Health Screen Screen

4. If the student waived testing, the reason for the **Waiver** and the **Waiver Date** is shown.
5. If the student tests positive, the **X-ray Film Date** and **X-ray Impression** is shown.
6. If the x-ray shows an abnormal result, the **Medication Prescribed** to the student is listed as well as the **Start** and **End Date** of the medication.
7. The overall result of the testing or medication process is shown in the **Free of Communicable Tuberculosis** drop-down list.

On the **Vision tab**, each vision test the student has received is listed. For each test, it lists the date of the test and the grade level of the student when the test was taken. It also shows the results of the test for each eye, with and without glasses.

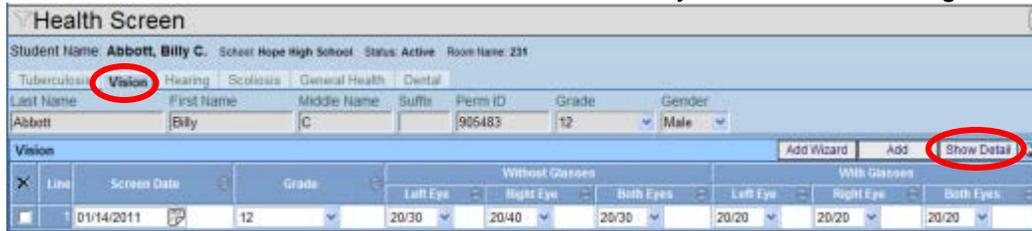


Figure 3.7 – Health Screen Screen, Vision Tab

8. To view the details of a test, click on the **Show Detail** button.
9. The details of the test appear on the right side of the screen. Select the test to view by clicking on the **Screen Date** of the test on the left side. The test selected is highlighted in green.

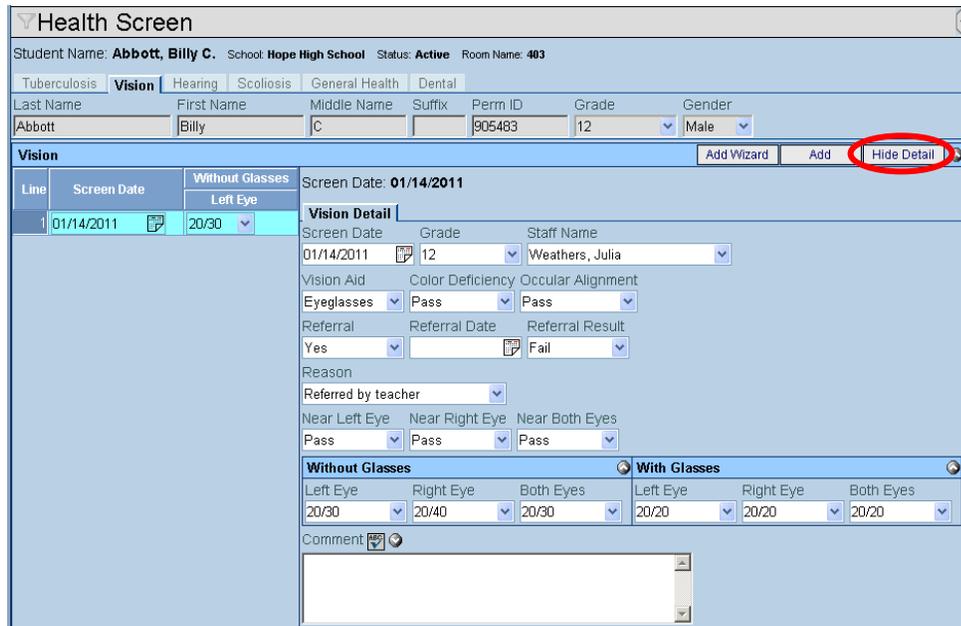


Figure 3.8 – Health Screen Screen, Vision Tab, Detailed Screen

For each test, it shows all of the information on the main screen as well as the name of the staff that performed the test. It also shows if the student uses contacts or glasses, if the student was referred, the referral date, the referral result, and the reason for the referral. It displays the results of the color deficiency, ocular alignment, near left eye and near right eye tests as well and the near both eyes test.

On the **Hearing** tab, the results of all of the student’s hearing tests are listed. At the top of the tab, it lists the overall status of the student’s hearing as well as other notes. For each test, it displays the date of the test and the grade level of the student when the test was taken. The reason for the testing and result of the test for each ear is displayed, as well as the clinic date, referral type and referral date.

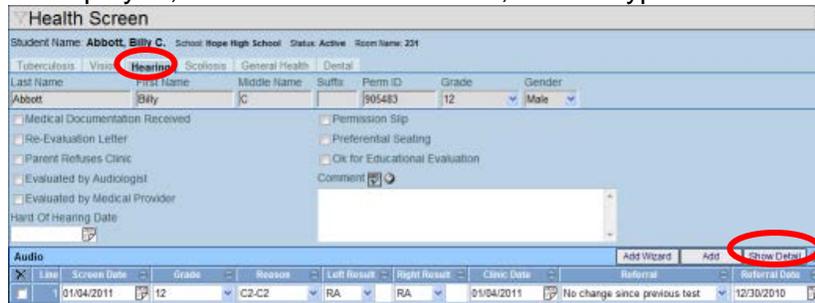


Figure 3.9 – Health Screen Screen, Hearing Tab

10. To view the details of each test, click the **Show Detail** button.
11. The details of the test appear on the right side of the screen. Select the test to view by clicking on the **Screen Date** of the test on the left side. The test selected is highlighted in green.

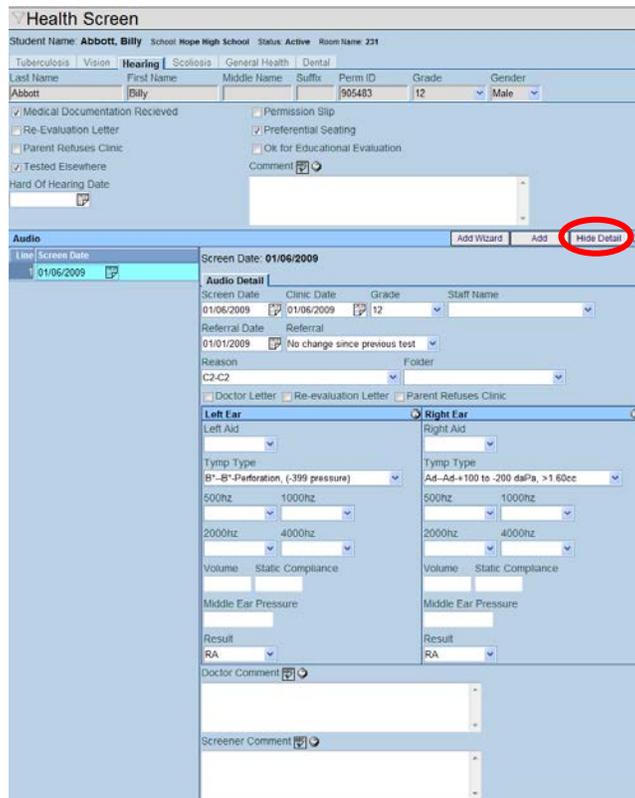


Figure 3.10 – Health Screen Screen, Hearing Tab, Detailed Screen

For each test, it shows all of the information on the main screen as well as any comments about the test. It lists if the student uses a hearing aid for either ear, and the details of each test used for each ear. Other information includes the folder, and if a doctor's letter or re-evaluation letter was received.

12. Click the **Hide Detail** button to return to the main screen.

On the **Scoliosis tab**, the date of the latest physical exam for scoliosis is shown with the result. If needed, the referral date is listed and the results and dates of the x-rays. Additional comments may also be displayed.

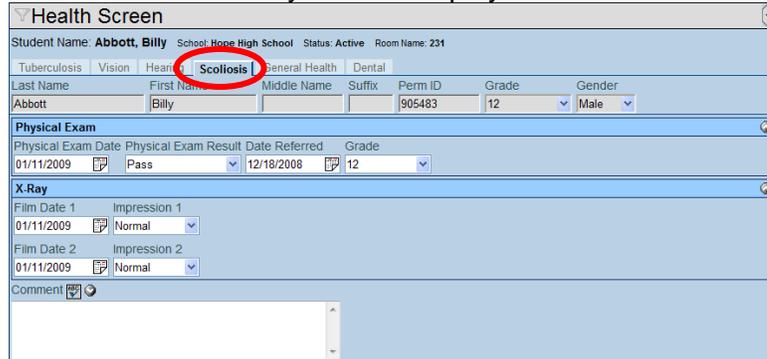


Figure 3.11 – Health Screen screen, Scoliosis Tab

On the **General Health tab**, a list of all the student’s physical examinations is shown. For each exam, it shows the date of the exam and the grade level of the student when the exam was performed. It also displays the student’s height & weight, body mass index (BMI), heart rate, and blood pressure. If the student is referred to a medical professional for follow-up, the date of the referral is shown. It also shows any health or drug tests performed for student group participation.

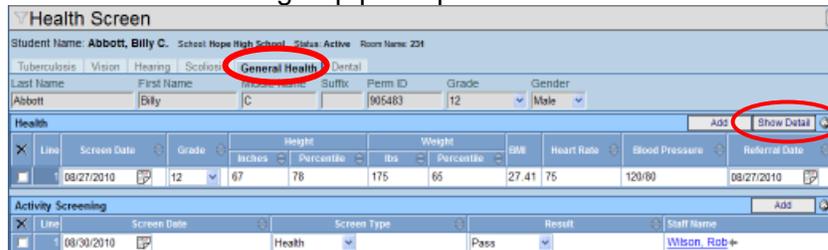


Figure 3.12 – Health Screen Screen, General Health Tab

13. To view the detail of an exam, click the **Show Detail** button.
14. The details of the test appear on the right side of the screen. Select the test to view by clicking on the **Screen Date** of the test on the left side. The test selected is highlighted in green.

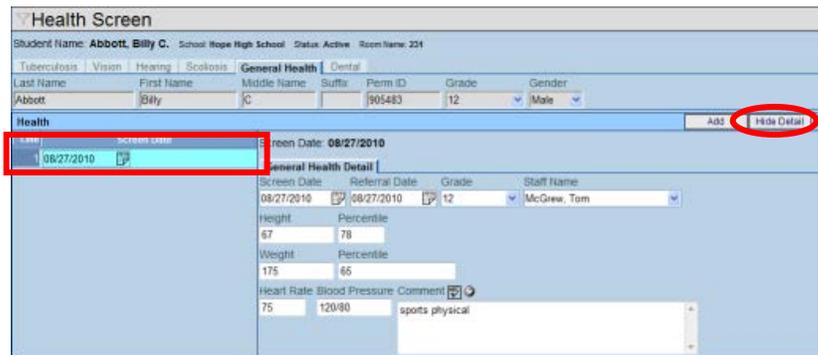


Figure 3.13 – Health Screen Screen, General Health Tab, Detailed Screen

For each exam, it shows all of the information on the main screen as well as any comments about the exam and the staff who administered it.

15. To return to the main screen, click the **Hide Detail** button.

On the **Dental tab**, a list of the student’s dental exams is shown. For each exam, it shows the date of the exam and the grade level of the student when the exam was

performed. It also lists the results of the exam, if the student has any cavities or fillings, the treatment recommended, the reason for an exam waiver, and the follow-up date if needed.

The screenshot shows the 'Health Screen' interface for student 'Abbott, Billy C.' at 'Hope High School'. The 'Dental' tab is selected and circled in red. Below the student information, there is a table with columns: Line, Screen Date, Grade, Pass/Fail, Visible Fillings, Usable Cavities, Treatment, Waiver, and Follow Up Date. The first row shows a screen date of 11/16/2010, grade 12, a 'Pass' result, and 'No obvious problem' as the treatment.

Figure 3.14 – Health Screen Screen, Dental Tab

ADDING & EDITING HEALTH SCREEN RECORDS

When editing the information about a student, **each tab must be edited separately and all changes saved before switching to a new tab.** To edit the health screening data:

1. Check to make sure the current **focus** is set to a school and not the district. The focus is indicated in the top right-hand corner of the screen.



Figure 3.15 – Checking Current Focus

2. Change to Update mode by clicking the **Edit** button at the top of the screen. If the button is not available, Update mode is already turned on.



Figure 3.16 – Edit Button

3. On the **Tuberculosis** tab, add or edit the records by clicking on the data to modify and change the information as desired. Boxes with a gray background cannot be changed. Dates must be entered in MM/DD/YY format or they can be selected by clicking on the Calendar button.

The screenshot shows the 'Health Screen' interface for student 'Abbott, Billy' at 'Hope High School'. The 'Tuberculosis' tab is selected and circled in red. The 'Tuberculosis Skin Test' section is expanded, showing two PPD-Mantoux tests. The first test was given on 08/03/2006 and read on 08/06/2006, resulting in a 'Negative' impression. The second test was given on 08/01/2008 and read on 08/06/2008, resulting in a 'Positive' impression. Other sections like 'Tuberculosis Chest X-Ray' and 'Tuberculosis Medication' are also visible.

Figure 3.17 – Tuberculosis Tab, Health Screen Screen

- On the **Vision tab**, each vision test the student has received is listed. Edit the records by clicking on the data to modify and change the information as desired. Boxes with a gray background cannot be changed. Dates must be entered in MM/DD/YY format or they can be selected by clicking on the Calendar  button.

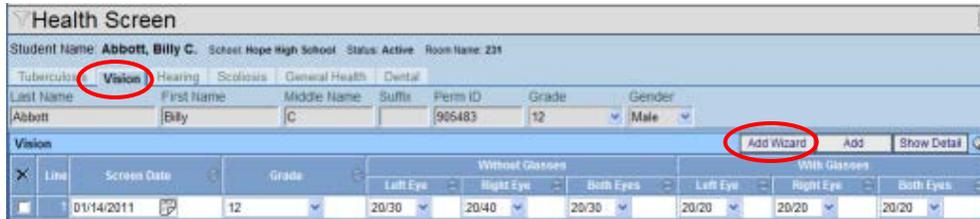


Figure 3.18 – Health Screen Screen, Vision Tab

- To delete a test record, check the box in the **X** column.
- Click the **Save** button at the top of the screen to save any changes.
- To add a test record, click on either the **Add Wizard** button or the **Add** button. The Add button just adds an additional record on the main screen and additional details must then be added by clicking the Show Detail button. The Add Wizard button allows both the information on the main screen and the detailed screen to be recorded.
- To add a record using the Add Wizard button, click the **Add Wizard** button.
- The Health Screen Vision Detail Add screen pops-up in a separate window. Mandatory fields are highlighted in green.

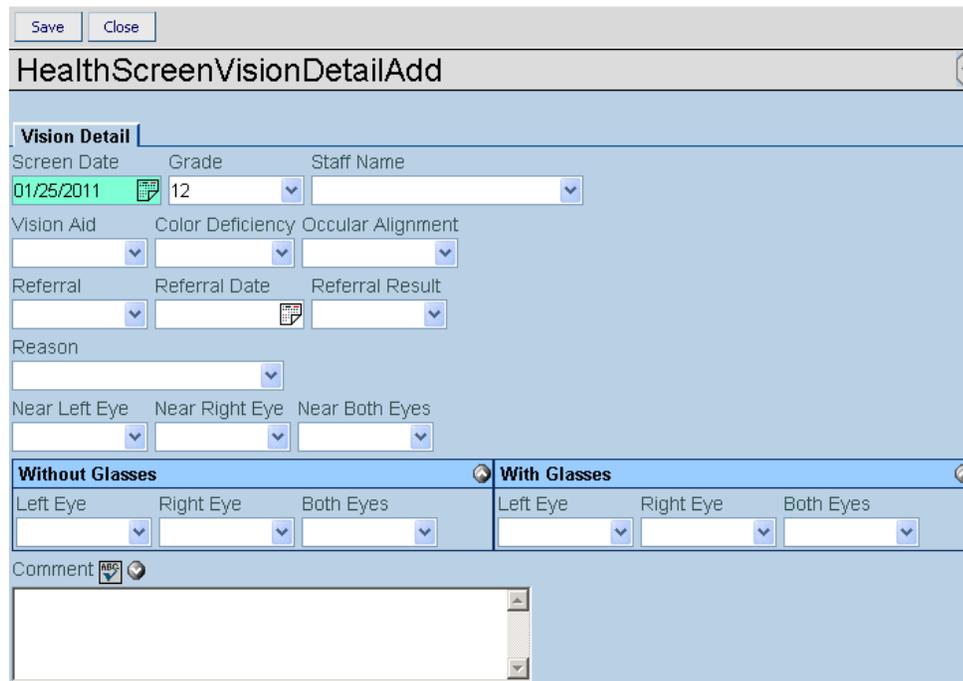


Figure 3.19 – Health Screen Vision Detail Add Screen

- By default, the **Screen Date** is set to today's date. To change the date, enter the date in MM/DD/YY format or it can be selected by clicking on the Calendar  button.

11. Enter the results of the test by selecting the values from the drop-down lists. Notes regarding the test can also be added to the **Comment** box. This text can also be checked for spelling by clicking the Spellcheck  button.
12. Click the **Save** button at the top of the screen to save the new test record.
13. To add a record using the Add button, click the **Add button** and a new blank record is added to the grid.

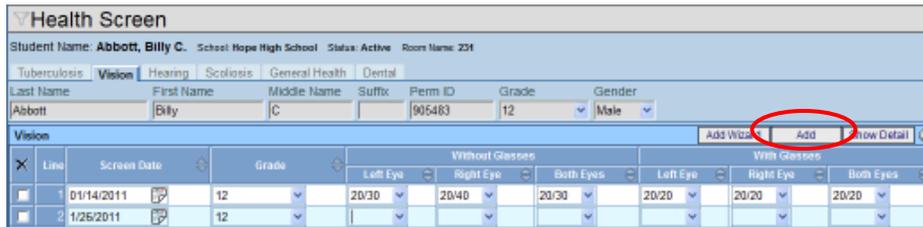


Figure 3.20 – Health Screen Screen, Vision Tab, Adding

14. By default, the **Screen Date** is set to today’s date. To change the date, enter the date in MM/DD/YY format or it can be selected by clicking on the Calendar  button.
15. Enter the results of the test by selecting the values from the drop-down lists. When everything has been entered, click the **Save** button at the top of the screen.
16. To add or edit the details of a test, click on the **Show Detail** button.
17. The details of the test appear on the right side of the screen. Select the test to edit by clicking on the **Screen Date** of the test on the left side. The test selected is highlighted in green.

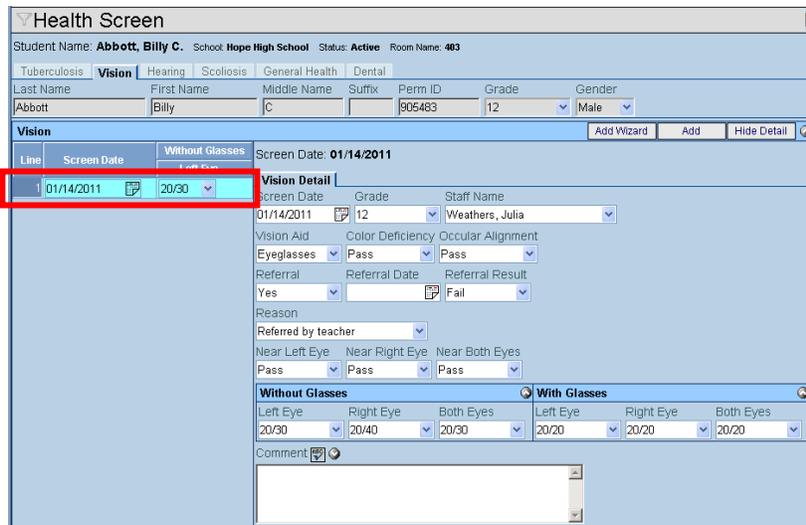


Figure 3.21 – Health Screen Screen, Vision Tab, Detailed Screen

18. For each test, it shows all of the information on the main screen as well as the name of the staff who performed the test, the near eye tests, vision aid, referral information, color deficiency, ocular alignment, and comments. To edit or add information, enter the information in the boxes provided. Dates must be entered in MM/DD/YY format or they can be selected by clicking on the Calendar  button. The Comment information can be checked for spelling by clicking the Spellcheck  button.

19. Click the **Save** button at the top of the screen to save the changes.

On the **Hearing tab**, the results of all of the student's hearing tests are listed. At the top of the tab, it lists the overall status of the student's hearing as well as other notes. For each test, it displays the date of the test and the grade level of the student when the test was taken. The reason for the testing and result of the test for each ear is displayed, as well as the clinic date, referral type and referral date.

The screenshot shows the 'Health Screen' interface for a student named Abbott, Billy C. The 'Hearing' tab is active. At the top, there are tabs for Tuberculosis, Vision, Hearing, Scoliosis, General Health, and Dental. Below these are fields for student information: Last Name (Abbott), First Name (Billy), Middle Name (C), Suffix, Perm ID (905483), Grade (12), and Gender (Male). There are several checkboxes for medical documentation and evaluation status. A 'Hard Of Hearing Date' field is present. Below this is a 'Comment' field with a spellcheck icon. At the bottom, there is an 'Audio' section with a table of test results. The 'Add Wizard' button is circled in red.

X	Line	Screen Date	Grade	Reason	Left Result	Right Result	Clinic Date	Referral Date
	1	01/04/2011	12	C2-C2	RA	RA	01/04/2011	No change since previous test

Figure 3.22 – Health Screen Screen, Hearing Tab

20. To edit the information at the top of the tab, check or uncheck the boxes as needed. The **Hard of Hearing Date** must be entered in MM/DD/YY format or it can be selected by clicking on the Calendar button. The **Comment** text can be checked for spelling by clicking the Spellcheck button.
21. To delete a test record, check the box in the **X** column.
22. Click the **Save** button at the top of the screen to save any changes.
23. To add a test record, click on either the **Add Wizard** button or the **Add** button. The Add button just adds an additional record on the main screen and additional details must then be added by clicking the Show Detail button. The Add Wizard button allows both the information on the main screen and the detailed screen to be recorded.
24. To add a record using the Add Wizard button, click the **Add Wizard** button.

25. The Health Screen Audio Detail Add screen pops-up in a separate window. Mandatory fields are highlighted in green.

Figure 3.23 – Health Screen Audio Detail Add Screen

26. By default, the **Screen Date** is set to today's date. To change the date, enter the date in MM/DD/YY format or it can be selected by clicking on the Calendar button. Enter the rest of the dates in the same fashion.
27. Enter the results of the tests for both ears, and comment can be added from the Doctor and/or Screener/Audiologist. The comments can be checked for spelling by clicking the Spellcheck button.
28. Once all of the information has been added, click the **Save** button at the top of the screen to add the new test record.
29. To add a record using the Add button, click the **Add button**. A new blank line is added where the test results can be recorded.

Line	Screen Date	Grade	Reason	Left Result	Right Result	Clinic Date	Referral	Referral Date
1	01/04/2011	12	C2-C2	RA	RA	01/04/2011	No change since previous test	12/30/2010
2	1/26/2011	12						

Figure 3.24 – Adding an Audio Record using the Add Button

30. By default, the **Screen Date** is set to today's date. To change the date, enter the date in MM/DD/YY format or it can be selected by clicking on the Calendar button. Enter the rest of the dates in the same fashion.
31. Enter the rest of the results of the tests, and click the Save button at the top of the screen to add the record.
32. To add or edit the details of each test, click the **Show Detail** button.

33. The details of the test appear on the right side of the screen. Select the test to edit by clicking on the **Screen Date** of the test on the left side. The test selected is highlighted in green.

The screenshot displays the 'Health Screen' interface for a student named Billy Abbott. The 'Hearing' tab is selected, and the 'Detailed Screen' is shown. The 'Audio' section is expanded, showing a table with one entry for a hearing test on 01/06/2009. The details for this test are visible on the right side of the screen, including 'Screen Date', 'Clinic Date', 'Grade', 'Staff Name', 'Referral Date', 'Referral', 'Reason', 'Folder', and 'Doctor Letter'. The 'Left Ear' and 'Right Ear' sections are also expanded, showing 'Left Aid', 'Right Aid', 'Tymp Type', '500hz', '1000hz', '2000hz', '4000hz', 'Volume', 'Static Compliance', 'Middle Ear Pressure', and 'Result' for both ears. The 'Doctor Comment' and 'Screener Comment' fields are also visible at the bottom.

Figure 3.25 – Health Screen Screen, Hearing Tab, Detailed Screen

34. For each test, all of the information on the main screen as well as any comments about the test can be edited. Edit or add the information as needed. Dates can be changes by entering the date in MM/DD/YY format or they can be selected by clicking on the Calendar  button. The comments can be checked for spelling by clicking the Spellcheck  button.
35. Click the **Save** button at the top of the screen to save any changes.
36. Click the **Hide Detail** button to return to the main screen.

37. On the **Scoliosis** tab, add or edit the records by clicking on the data to modify and change the information as desired. Boxes with a gray background cannot be changed. Dates must be entered in MM/DD/YY format or they can be selected by clicking on the Calendar button. The comments can be checked for spelling by clicking the Spellcheck button.

The screenshot shows the 'Health Screen' interface for student 'Abbott, Billy'. The 'Scoliosis' tab is selected and circled in red. Below the student information, there are sections for 'Physical Exam' and 'X-Ray'. The Physical Exam section has a table with columns: Physical Exam Date, Physical Exam Result, Date Referred, and Grade. One record is shown: 01/11/2009, Pass, 12/18/2008, 12. The X-Ray section has a table with columns: Film Date and Impression. Two records are shown: 01/11/2009, Normal. A 'Comment' field is at the bottom.

Figure 3.26 – Health Screen screen, Scoliosis Tab

38. Click the **Save** button at the top of the screen to save the changes.

On the **General Health** tab, a list of all the student's physical examinations is shown. For each exam, it shows the date of the exam and the grade level of the student when the exam was performed. It also displays the student's height & weight, body mass index (BMI), heart rate, and blood pressure. If the student is referred to a medical professional for follow-up, the date of the referral is shown. In the Activity Screening section, it also shows the results of any health or drug tests taken for eligibility for participating in a student group.

The screenshot shows the 'Health Screen' interface for student 'Abbott, Billy C.'. The 'General Health' tab is selected and circled in red. Below the student information, there are sections for 'Health' and 'Activity Screening'. The Health section has a table with columns: Line, Screen Date, Grade, Height (Inches, Percentile), Weight (lbs, Percentile), BMI, Heart Rate, Blood Pressure, and Referral Date. One record is shown: 08/27/2010, 12, 67, 78, 175, 65, 27.41, 75, 120/80, 08/27/2010. The Activity Screening section has a table with columns: Line, Screen Date, Screen Type, Result, and Staff Name. One record is shown: 08/30/2010, Health, Pass, Wilson, Rob.

Figure 3.27 – Health Screen Screen, General Health Tab

39. Edit the records by clicking on the data to modify and change the information as desired. Boxes with a gray background cannot be changed. Dates must be entered in MM/DD/YY format or they can be selected by clicking on the Calendar button.
40. To delete a test record, check the box in the **X** column.
41. Click the **Save** button at the top of the screen to save any changes.

42. To add a health exam record, click the **Add** button in the Health section. A new blank line is added at the bottom of the Health grid.

The screenshot shows the 'Health Screen' interface for student Abbott, Billy C. at Hope High School. The 'General Health' tab is selected. The 'Health' section contains a table with columns for Line, Screen Date, Grade, Height (Inches and Percentile), Weight (lbs and Percentile), BMI, Heart Rate, Blood Pressure, and Referral Date. Two records are shown: one from 08/27/2010 and another from 1/26/2011. An 'Add' button is circled in red in the top right corner of the Health section.

Line	Screen Date	Grade	Height (Inches)	Height (Percentile)	Weight (lbs)	Weight (Percentile)	BMI	Heart Rate	Blood Pressure	Referral Date
1	08/27/2010	12	67	78	175	65	27.41	75	120/80	08/27/2010
2	1/26/2011	12								

Figure 3.28 – Health Screen screen, General Health Tab, Adding Records

43. By default, the **Screen Date** is set to today's date. To change the date, enter the date in MM/DD/YY format or it can be selected by clicking on the Calendar button. Enter the rest of the dates in the same fashion.
44. Enter the rest of the test results, and then click the **Save** button at the top of the screen to save the new record.
45. To delete a test record, check the box in the **X** column.
46. To add or edit the detail of an exam, click the **Show Detail** button.
47. The details of the test appear on the right side of the screen. Select the test to edit by clicking on the **Screen Date** of the test on the left side. The test selected is highlighted in green.

The screenshot shows the 'Health Screen' interface with the 'General Health Detail' section expanded. The 'Screen Date' 01/11/2009 is highlighted in green in the table. The 'Hide Detail' button is circled in red. The detailed view shows fields for Screen Date, Referral Date, Grade, Staff Name, Height, Weight, Heart Rate, and Blood Pressure.

Line	Screen Date	Screen Date	Referral Date	Grade	Staff Name
1	01/11/2009	01/11/2009	01/11/2009	12	Weathers, Julia

Figure 3.29 – Health Screen Screen, General Health Tab, Detailed Screen

48. For each exam, all of the same information on the main screen can be edited. Any comments about the exam can also be added or edited, as well as the name of the staff who administered the test. The comment can be checked for spelling by clicking the Spellcheck button.
49. Click the **Save** button at the top of the screen to save the changes.
50. To return to the main screen, click the **Hide Detail** button.

- To add a new Activity Screening record, click on the **Add** button. A new blank line is shown.

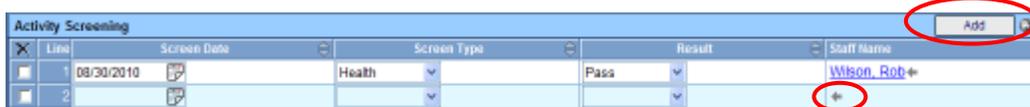


Figure 3.30 – Health Screen Screen, General Health Tab, Activity Screening Screen

- By default, the **Screen Date** is set to today’s date. To change the date, enter the date in MM/DD/YY format or it can be selected by clicking on the Calendar button. Enter the rest of the dates in the same fashion.
- To enter the **Staff Name**, click the **gray arrow** and select the staff from the Find: Staff screen.
- Enter the rest of the test results, and then click the **Save** button at the top of the screen to save the record. To delete a test record, check the box in the **X** column.
- On the **Dental tab**, a list of the student’s dental exams is shown. For each exam, it shows the date of the exam and the grade level of the student when the exam was performed. It also lists the results of the exam, if the student has any cavities or fillings, the treatment recommended, the reason for an exam waiver, and the follow-up date if needed.

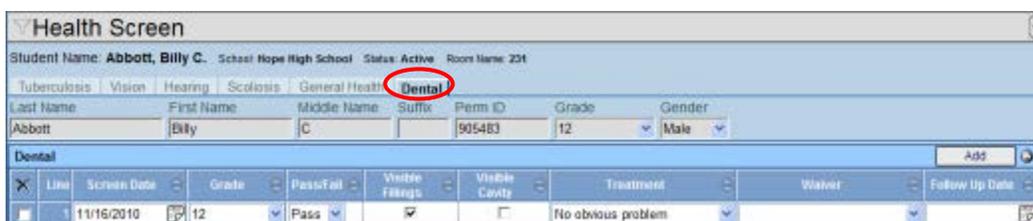


Figure 3.31 – Health Screen Screen, Dental Tab

- Edit the records by clicking on the data to modify and change the information as desired. Boxes with a gray background cannot be changed. Dates must be entered in MM/DD/YY format or they can be selected by clicking on the Calendar button.
- To delete a test record, check the box in the **X** column.
- Click the **Save** button at the top of the screen to save any changes.
- To add an exam record, click the **Add** button in the Dental section. A new blank line is added at the bottom of the Dental grid.

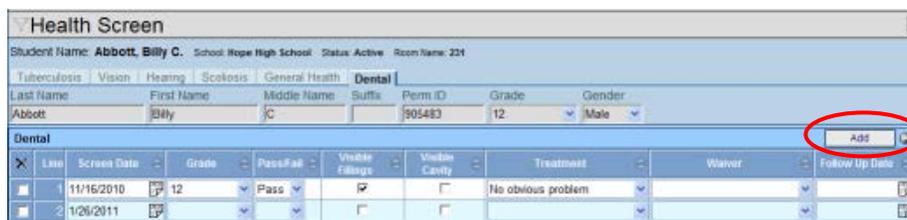


Figure 3.32 – Health Screen Screen, Dental Tab, Adding Records

- By default, the **Screen Date** is set to today’s date. To change the date, enter the date in MM/DD/YY format or it can be selected by clicking on the Calendar button. Enter the rest of the dates in the same fashion.
- Enter the rest of the test results, and then click the **Save** button at the top of the screen to save the new record.

HEALTH SCREENING BY SECTION

Since most health screening is completed by class, the screening results may also be entered by section instead of by student. To enter the screening results by section:

1. Go to the **Health Screen By Section** screen, found under Synergy SIS > Health.
2. Enter all or part of the Section ID in the **Section ID** box and click **Find**.

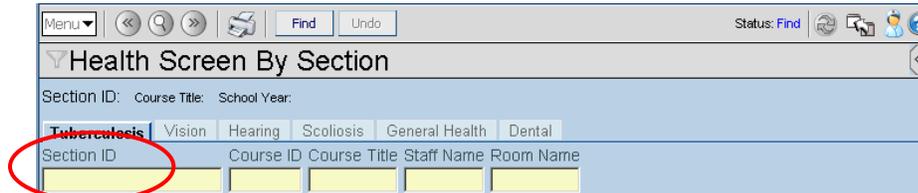


Figure 3.33 – Health Screen By Section Find Screen

3. On the **Tuberculosis** tab, only the first test results may be entered. Dates must be entered in MM/DD/YY format or they can be selected by clicking on the Calendar button. To see only the students needing screening, checking the box **Hide Students With Tuberculosis Records**. To see the student's demographic records, click on the student name. Click the **Save** button at the top of the screen.

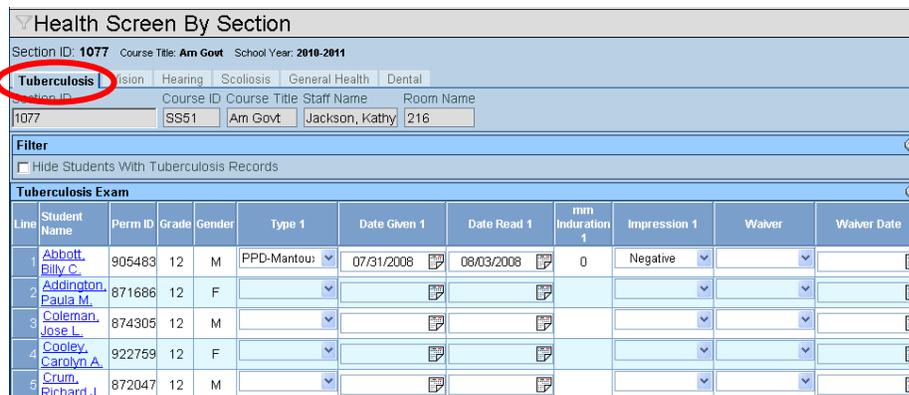


Figure 3.34 – Health Screen By Section Screen

4. On the **Vision** tab, enter the date for vision screening in the **Screen Date**. Multiple screening dates may take place throughout the year. Dates must be entered in MM/DD/YY format or they can be selected by clicking on the Calendar button. To see the student's demographic records, click on the student name.

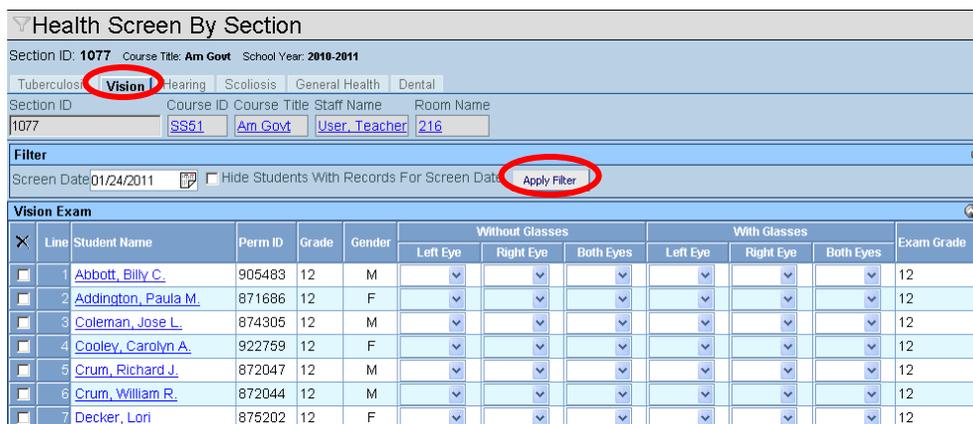


Figure 3.35 – Health Screen By Section Screen, Vision Tab

5. To show only the records of students that were not screened on that date, check the box **Hide Students With Records For Screen Date**.
6. Click **Apply Filter**.
7. Enter the test results for each student Without Glasses and With Glasses, then click the **Save** button at the top of the screen.
8. On the **Hearing** tab, enter the date for hearing screening in the **Screen Date**. Multiple screening dates may take place throughout the year. Dates must be entered in MM/DD/YY format or they can be selected by clicking on the Calendar button. To see the student's demographic records, click on the student name underlined in blue.

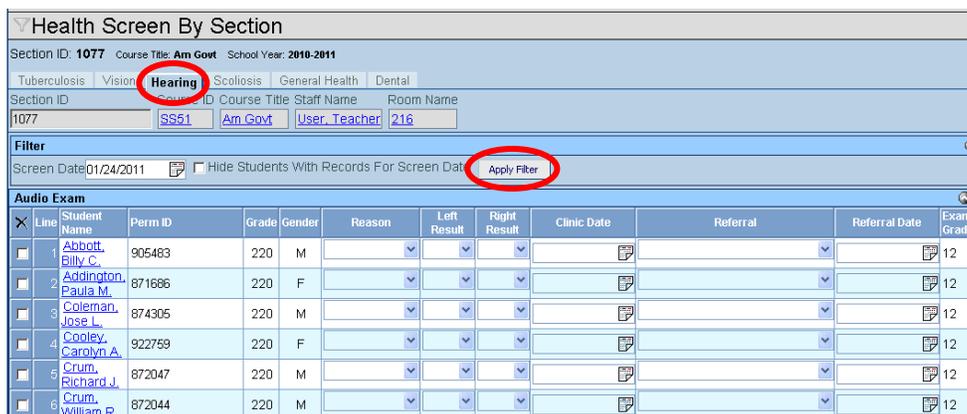


Figure 3.36 – Health Screen By Section Screen, Hearing Tab

9. To show only the records of students that were not screened on that date, check the box **Hide Students With Records For Screen Date**.
10. Click **Apply Filter**.
11. Enter the test results and referral information for each student, then click the **Save** button at the top of the screen.
12. On the **Scoliosis** tab, enter the X-Ray results. Dates must be entered in MM/DD/YY format or they can be selected by clicking on the Calendar button. To see only the students needing screening, checking the box **Hide Students With Scoliosis Records**. To see the student's demographic records, click on the student name underlined in blue. Click the **Save** button at the top of the screen.

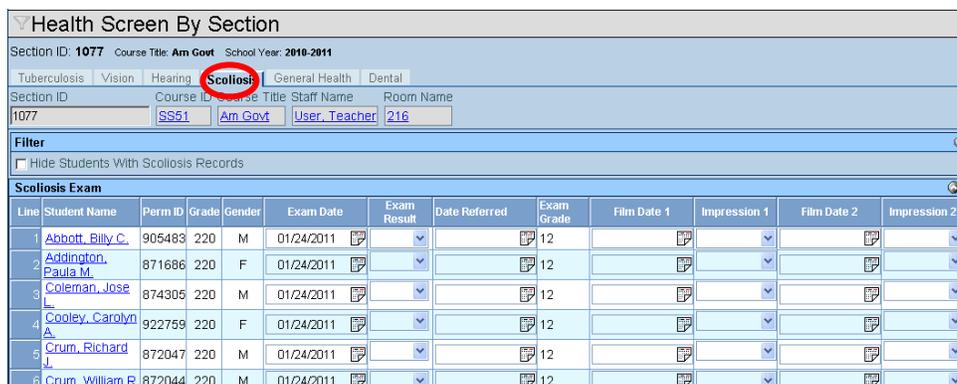
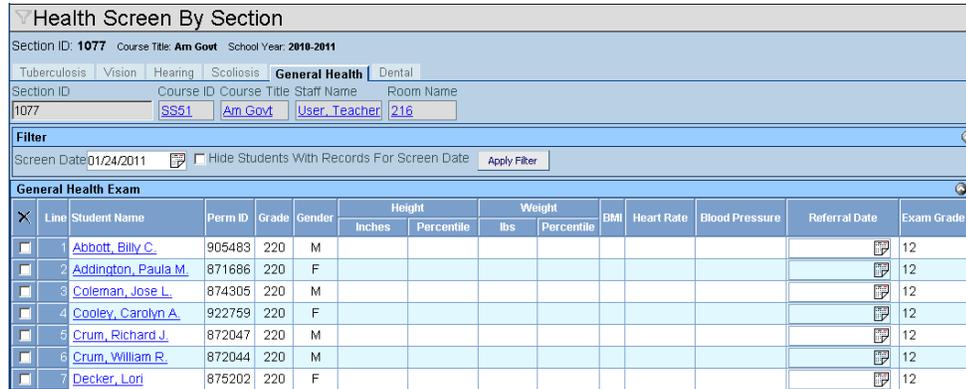


Figure 3.37 – Health Screen By Section Screen, Scoliosis Tab

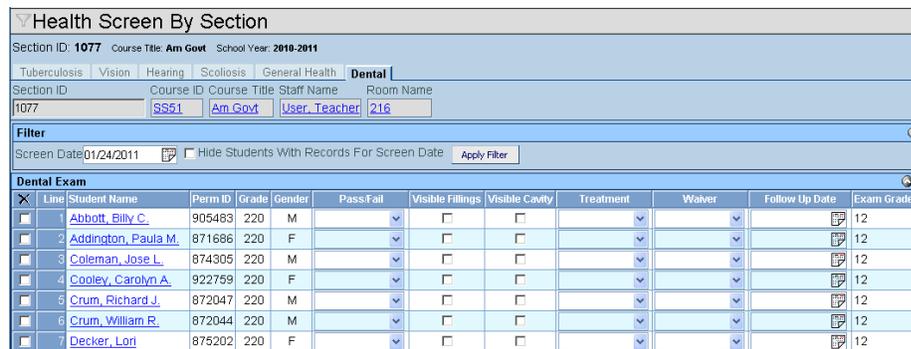
- On the **General Health tab**, enter the date for health screening in the **Screen Date**. Multiple screening dates may take place throughout the year. Dates must be entered in MM/DD/YY format or they can be selected by clicking on the Calendar  button. To see the student's demographic records, click on the student name underlined in blue.



Line	Student Name	Perm ID	Grade	Gender	Height		Weight		BMI	Heart Rate	Blood Pressure	Referral Date	Exam Grade
					Inches	Percentile	lbs	Percentile					
1	Abbott, Billy C.	905483	220	M									12
2	Addington, Paula M.	871686	220	F									12
3	Coleman, Jose L.	874305	220	M									12
4	Cooley, Carolyn A.	922759	220	F									12
5	Crum, Richard J.	872047	220	M									12
6	Crum, William R.	872044	220	M									12
7	Decker, Lori	875202	220	F									12

Figure 3.38 – Health Screen By Section Screen, General Health Tab

- To show only the records of students that were not screened on that date, check the box **Hide Students With Records For Screen Date**.
- Click **Apply Filter**.
- Enter the test results and referral information for each student, then click the **Save** button at the top of the screen.
- On the **Dental tab**, enter the date for dental screening in the **Screen Date**. Multiple screening dates may take place throughout the year. Dates must be entered in MM/DD/YY format or they can be selected by clicking on the Calendar  button. To see the student's demographic records, click on the student name underlined in blue.



Line	Student Name	Perm ID	Grade	Gender	Pass/Fail	Visible Fillings	Visible Cavity	Treatment	Waiver	Follow Up Date	Exam Grade
2	Addington, Paula M.	871686	220	F							12
3	Coleman, Jose L.	874305	220	M							12
4	Cooley, Carolyn A.	922759	220	F							12
5	Crum, Richard J.	872047	220	M							12
6	Crum, William R.	872044	220	M							12
7	Decker, Lori	875202	220	F							12

Figure 3.39 – Health Screen By Section Screen, Dental Tab

- To show only the records of students that were not screened on that date, check the box **Hide Students With Records For Screen Date**.
- Click **Apply Filter**.
- Enter the test results, waiver, and follow-up information for each student, then click the **Save** button at the top of the screen.

Chapter Four: HEALTHCARE PLANS

In this chapter, the following topics are covered:

- ▶ Viewing healthcare plans
- ▶ Adding & editing healthcare plans

VIEWING INDIVIDUAL HEALTHCARE PLANS

The Individual Healthcare Plan screen can record all of the individual healthcare plans created for students with serious or chronic healthcare needs. To view the student's healthcare plans:

1. Go to the **Individual Healthcare Plan** screen, found under Synergy SIS > Health.

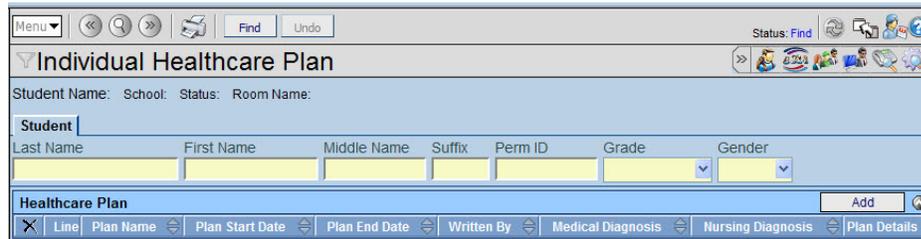


Figure 4.1 – Individual Healthcare Plan Screen

To find an **Individual Healthcare Plan** record, there are two methods: **Scroll or Find mode**. To scroll through the student records to find the student:

2. Click on the **right Scroll button** to advance to the first health record. Records are sorted alphabetically by student last name.



Figure 4.2 – Right Scroll Button

3. To scroll in reverse descending order, click the **left Scroll button**.



Figure 4.3 – Left Scroll Button

4. Continue clicking on the scroll button until the desired record appears.

To switch to the Find mode to look for a **Health Screen** record:

- Click on the **Find Mode** button.



Figure 4.4 – Find Mode Button

- Enter either the entire last name or the first part of the last name of the student in the **Last Name** box.



Figure 4.5 – Individual Healthcare Plan Find Last Name Screen

- Click the **Find** button or press the **Enter** key. The first student with the last name entered into the Find screen will appear. Then use the scroll buttons to find the exact student.



Note: In the Find Mode, student records can also be found by searching by any of the yellow fields on the screen. For example, a first name may be entered in addition to the last name. This will bring up a pop-up screen with a list of students matching the criteria entered when the Find button is clicked. To select a student, click on their name and the student record selected will appear in the Individual Healthcare Plan screen. For more about finding students in any screen, please refer to *Synergy SIS – Student Information User Guide*.

Once the desired record has been located, the Individual Healthcare Plans screen displays any Individual Healthcare Plans for the student. For each plan, it records the plan name, the date it started, the date it ends, who wrote it, the Medical Diagnosis, the Nursing Diagnosis, and a link to the plan details.

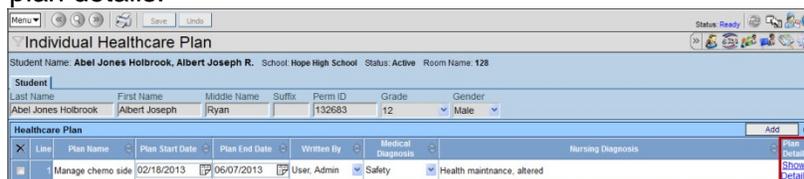


Figure 4.6 – Individual Healthcare Plan Screen

- To view additional detail about the healthcare plan, click the **Show Detail** link.

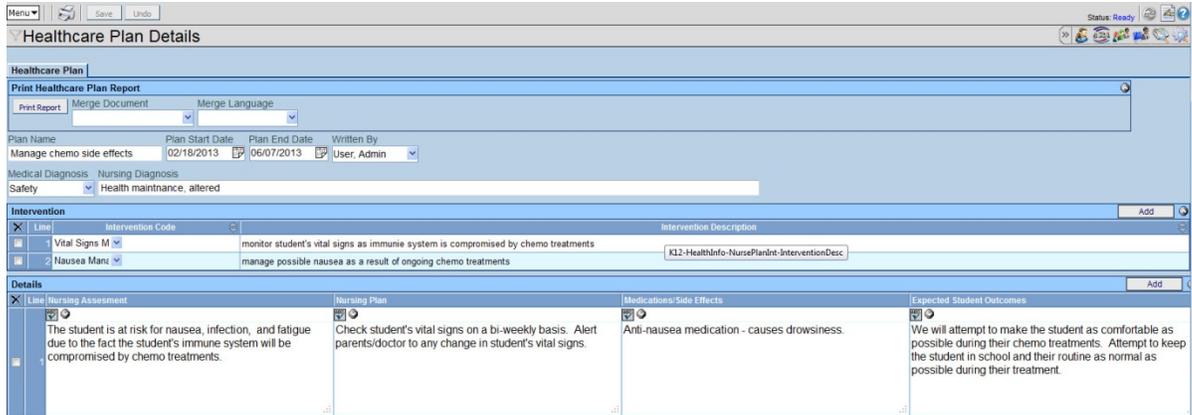


Figure 4.7 –Healthcare Plan Details Screen

9. The Healthcare Plan Details screen opens and shows all of the information on the main screen as well as the interventions for the plan. It also shows the nurse’s assessment of the health issue, their plan, any medications associated with the health issue and their possible side effects, and the expected outcome of the plan.
10. Close the Healthcare Plan Details screen to return to the main screen.

ADDING & EDITING HEALTHCARE PLANS

To add or edit healthcare plans:

1. Check to make sure the current **focus** is set to a school and not the district. The focus is indicated in the top right-hand corner of the screen.



Figure 4.8 – Checking Current Focus

2. Change to Update mode by clicking the **Edit** button at the top of the screen. If the button is not available, Update mode is already turned on.



Figure 4.9 – Edit Button

3. To edit the records, click on the data to modify and change the information as desired. Boxes with a gray background cannot be changed.

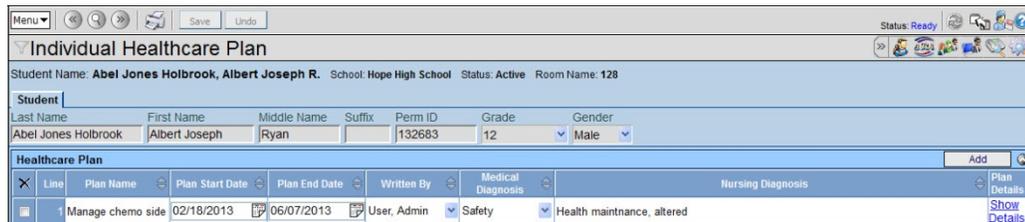


Figure 4.10 – Individual Healthcare Plan Screen

4. To delete a record, check the box in the **X** column.
5. Click the **Save** button at the top of the screen to save the changes.

- To change the plan details, click on the Show Details link. On the Healthcare Plan Details screen modify and change the information as desired.

The screenshot shows the 'Healthcare Plan Details' window. At the top, there are 'Save' and 'Undo' buttons. Below that is a 'Print Healthcare Plan Report' section with a 'Print Report' button and a 'Merge Language' dropdown. The main form contains the following fields:

- Plan Name: Manage chemo side effects
- Plan Start Date: 02/18/2013
- Plan End Date: 06/07/2013
- Written By: User, Admin
- Medical Diagnosis: Safety
- Nursing Diagnosis: Health maintenance, altered
- Safety:

Below the form is an 'Intervention' table with columns: Line, Intervention Code, and Intervention Description. It contains two rows:

Line	Intervention Code	Intervention Description
1	Vital Signs M	monitor student's vital signs as immune system is compromised by chemo treatments
2	Nausea Mani	manage possible nausea as a result of ongoing chemo treatments

At the bottom is a 'Details' section with columns: Line, Nursing Assessment, Nursing Plan, Medications/Side Effects, and Expected Student Outcomes. It contains one row:

Line	Nursing Assessment	Nursing Plan	Medications/Side Effects	Expected Student Outcomes
1	The student is at risk for nausea, infection, and fatigue due to the fact the student's immune system will be compromised by chemo treatments.	Check student's vital signs on a bi-weekly basis. Alert parents/doctor to any change in student's vital signs.	Anti-nausea medication - causes drowsiness.	We will attempt to make the student as comfortable as possible during their chemo treatments. Attempt to keep the student in school and their routine as normal as possible during their treatment.

Figure 4.11 – Healthcare Plan Details Screen

- To delete an Intervention or Detail record, check the box in the **X** column.
- Click the **Save** button at the top of the screen to save any changes.
- To add an Individual Healthcare Plan, click the **Add** button on the **Individual Healthcare Plan** screen.
- The **Healthcare Plan Details** screen pops-up in a separate window. Mandatory fields are highlighted in green.

The screenshot shows the 'Healthcare Plan Details' window with 'Save' and 'Close' buttons at the top. The form fields are highlighted in green:

- Plan Name:
- Plan Start Date: (with calendar icon)
- Plan End Date: (with calendar icon)
- Written By: (with dropdown arrow)
- Medical Diagnosis: (with dropdown arrow)
- Nursing Diagnosis:

Below the form is an 'Intervention' table with columns: Line, Intervention Code, and Intervention Description. It contains one row:

Line	Intervention Code	Intervention Description
<input checked="" type="checkbox"/>		

At the bottom is a 'Details' section with columns: Line, Nursing Assessment, Nursing Plan, Medications/Side Effects, and Expected Student Outcomes. It contains one row:

Line	Nursing Assessment	Nursing Plan	Medications/Side Effects	Expected Student Outcomes
<input checked="" type="checkbox"/>				

Figure 4.12 – Healthcare Plan Details Screen

- Enter the **Plan Start Date** and **Plan End Date** in MM/DD/YY format or they can be selected by clicking on the Calendar buttons.
- Enter the **Medical Diagnosis** by selecting the value from the drop-down list. The description of the diagnosis can be entered in the **Nursing Diagnosis** field.
- Click the **Save** button at the top of the screen to save the new plan.
- To add an intervention, click the **Add** button and a new blank record is added to the **Interventions** grid.

The screenshot shows the 'Healthcare Plan Details' window. At the top, there are 'Save' and 'Undo' buttons. Below that is the 'Print Healthcare Plan Report' section with a 'Print Report' button, 'Merge Document' dropdown, and 'Merge Language' dropdown. The 'Plan Name' is 'Manage chemo side effects', 'Plan Start Date' is '02/18/2013', 'Plan End Date' is '06/07/2013', and 'Written By' is 'User, Admin'. The 'Medical Diagnosis' is 'Nursing Diagnosis' and 'Safety' is 'Health maintenance, altered'. The 'Intervention' table has two rows: 'Vital Signs M' with description 'monitor student's vital signs as immune system is compromised by chemo treatments' and 'Nausea Manu' with description 'manage possible nausea as a result of ongoing chemo treatments'. The 'Details' section has four columns: 'Nursing Assessment' (The student is at risk for nausea, infection, and fatigue due to the fact the student's immune system will be compromised by chemo treatments.), 'Nursing Plan' (Check student's vital signs on a bi-weekly basis. Alert parents/doctor to any change in student's vital signs.), 'Medications/Side Effects' (Anti-nausea medication - causes drowsiness.), and 'Expected Student Outcomes' (We will attempt to make the student as comfortable as possible during their chemo treatments. Attempt to keep the student in school and their routine as normal as possible during their treatment.).

Figure 4.13 – Healthcare Plan Details Screen, Adding

15. Enter the **Intervention Code** by selecting the value from the drop-down list. The description of the intervention can be entered in the **Intervention Description** field.
16. To add details, click the **Add** button and a new blank record is added to the **Details** grid.
17. Enter the **Nursing Assessment**, **Nursing Plan**, **Medications/Side Effects**, and **Expected Student Outcomes** in the fields. by selecting the value from the drop-down list. The description of the intervention can be entered in the **Intervention Description** field. The **Comment** text can be checked for spelling by clicking the Spellcheck  button.
18. To delete a detail or intervention, check the box in the **X** column.
19. Click the **Save** button at the top of the screen to save any changes.
20. A letter and form detailing the healthcare plan can also be printed to be sent home to the student's parents. To print the form, leave the **Merge Document** and **Merge Language** fields blank and click the **Print Report** button.

This close-up shows the 'Print Healthcare Plan Report' section. It includes a 'Print Report' button (highlighted with a red box), a 'Merge Document' dropdown menu, and a 'Merge Language' dropdown menu.

Figure 4.14 – Healthcare Plan Details Screen, Printing the Healthcare Plan Report Form

21. The **Healthcare Detail Plan** form pops-up in a separate PDF window. This report can also be generated from the Reports folder using report HLT213.

Hope High School Healthcare Detail Plan					Year: 2012-2013 Report: HLT213
Student Information					
Student Name Abel Jones Holbrook, Albert Jos	Perm ID 132683	Gender M	Grade 12	Birth Date 04/30/1996	
Healthcare Plan					
Plan Name Manage chemo side effects	Plan Start Date 02/18/2013	Plan End Date 06/07/2013	Medical Diagnosis Safety		
Nursing Diagnosis Health maintenance, altered					
Intervention					
Intervention Code Vital Signs Monitoring	Intervention Description monitor student's vital signs as immune system is compromised by chemo treatments				
Intervention Code Nausea Management	Intervention Description manage possible nausea as a result of ongoing chemo treatments				
Plan Details					
Nursing Assessment The student is at risk for nausea, infection, and fatigue due to the fact the student's immune system will be compromised by chemo treatments.	Nursing Plan Check student's vital signs on a bi-weekly basis. Alert parents/doctor to any change in student's vital signs.	Medications/Side Effects Anti-nausea medication - causes drowsiness.	Expected Student Outcome We will attempt to make the student as comfortable as possible during their chemo treatments. Attempt to keep the student in school and their routine as normal as possible during their treatment.		
Signature Nurse/Staff _____		Date _____			
Signature Parent/Guardian _____		Date _____			
Printed by Admin User at 02/14/2013 11:49 AM			Edupoint School District		Page 1 of 1

Figure 4.15 – Healthcare Detail Plan

22. To print a cover letter to accompany the form, select a Report from the **Merge Document** drop-down list and select which language to use for the letter from the **Merge Language** drop-down list. Then click the **Print Report** button.

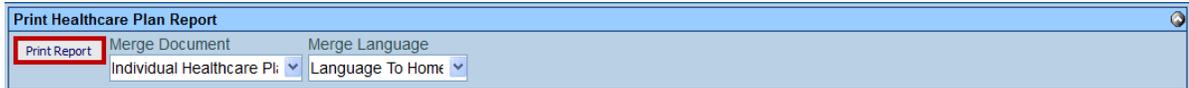


Figure 4.16 – Healthcare Plan Details Screen, Printing the Healthcare Plan Report Letter

23. The **Individualized Healthcare Plan Letter** pops-up in a separate PDF window.

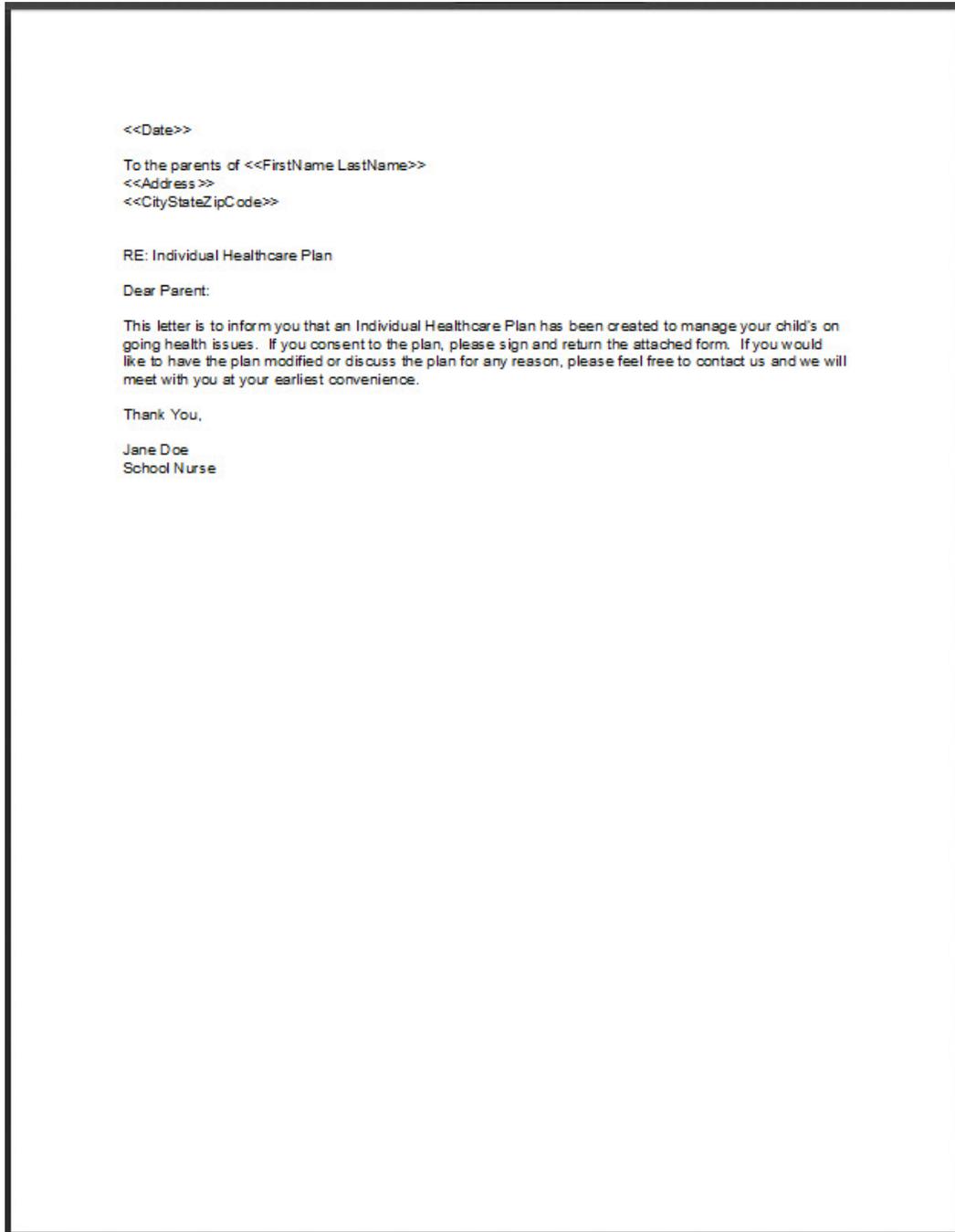


Figure 4.17 – Sample Individual Healthcare Plan Letter

Chapter Five: REPORTS

In this chapter, the following topics are covered:

- ▶ What reports are available through Health
- ▶ How to customize the reports prior to printing

The available reports for Health are found under the Synergy SIS Health menu. Individual reports print out information about a single student per page, but can be printed for multiple students at one time. List reports generate a list of all the students and their information as specified by the description of the list report. Summary reports generate summaries for multiple students.

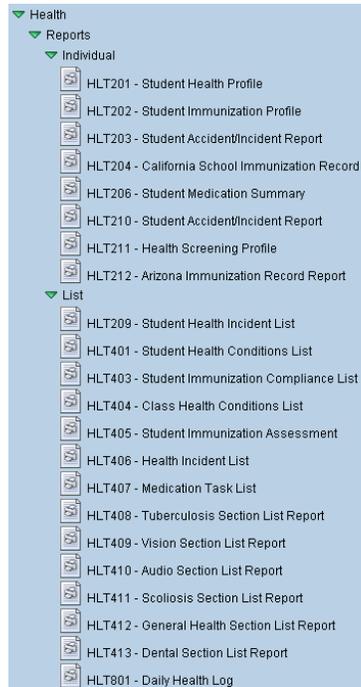


Figure 5.1 – List of Health Individual & List Reports

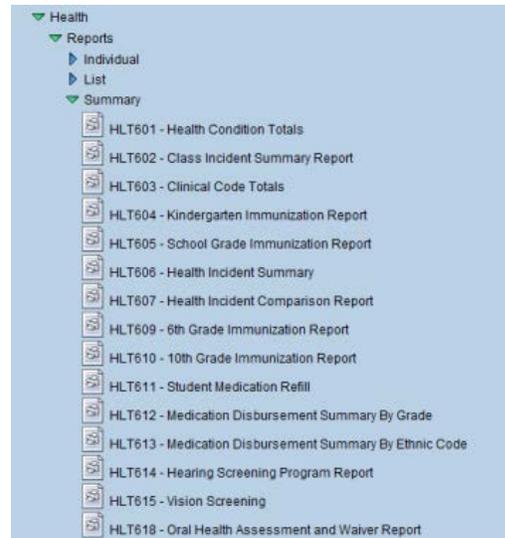


Figure 5.2 – List of Health Summary Reports

To access the available Health reports:

1. Open the **Synergy SIS Navigation Tree** by clicking on the Tree button.

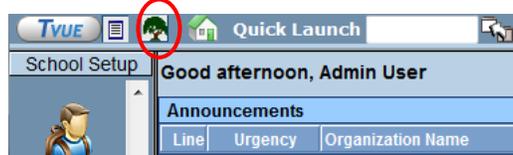


Figure 5.3 – Synergy SIS Navigation Tree

2. Expand the **Synergy SIS** folder by clicking on the blue triangle pointing right, next to the word Synergy SIS. Once clicked, the triangle will turn green and point downward.

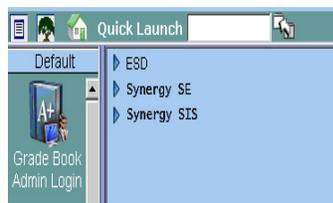


Figure 5.4 – Synergy SIS Folder



Figure 5.5 – Synergy SIS Folder Expanded

- Under the Synergy SIS folder, open the **Health** folder by clicking on the blue triangle pointing right, next to the words Health. Once clicked, the triangle will turn green and point downward.



Figure 5.6 – Health Folder



Figure 5.7 – Health Folder Expanded

- Under the Health folder, open the **Reports** folder by clicking on the blue triangle pointing right, next to the word Reports. Once clicked, the triangle will turn green and point downward.



Figure 5.8 – Health Reports Folder



Figure 5.9 – Health Reports Folder Expanded

- To access the **Individual** reports, click on the blue triangle next to the word Individual.

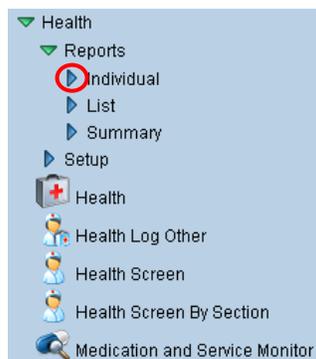


Figure 5.10 – Health Individual Folders

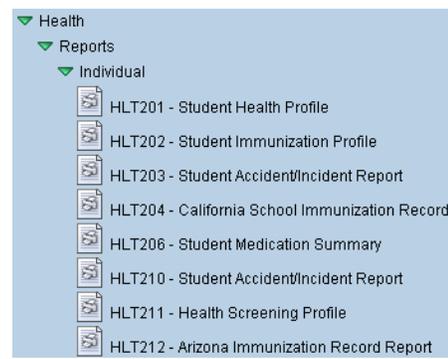


Figure 5.11 – Health Individual Folders Expanded

- To access the **List** reports, click on the blue triangle next to the word List.

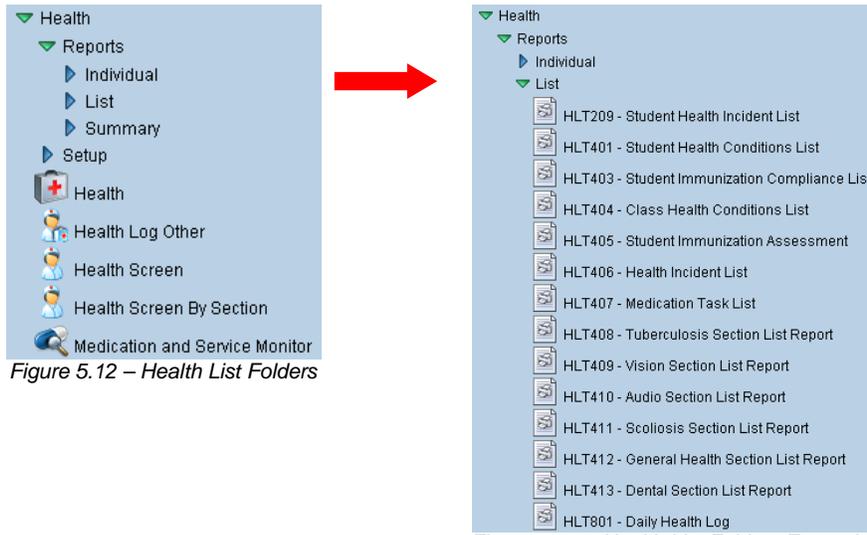


Figure 5.12 – Health List Folders

Figure 5.13 – Health List Folders Expanded

- To access the **Summary** reports, click on the blue triangle next to the word Summary.

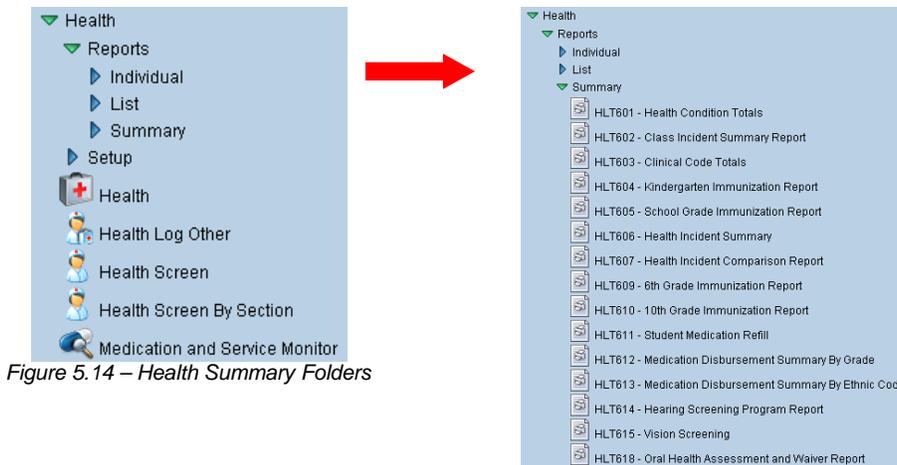


Figure 5.14 – Health Summary Folders

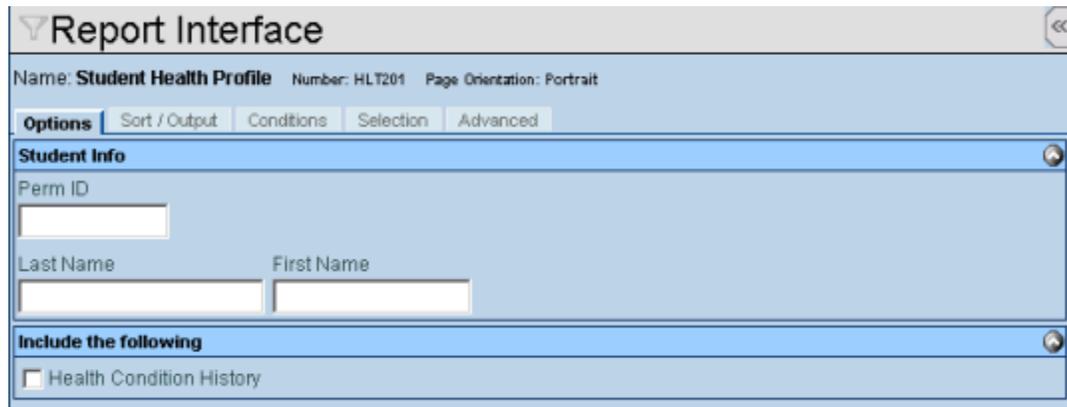
Figure 5.15 – Health Summary Folders Expanded

- Click on the name of the report to open the report and select the options to be used in printing the report.
- Once the report options have been set, click on the **Print** button to print the report. The report will be printed as a PDF file to the screen, which can then be sent to the printer.

HLT201 – Student Health Profile

The Student Health Profile report provides a complete listing of all of a student's health-related records. The report includes the student's basic demographic and contact information, their emergency contact information, their health conditions, any health incidents, and their immunization information.

This report can be customized using the following options:



The screenshot displays the 'Report Interface' for the 'Student Health Profile' report. The interface includes a title bar, a header section with report details, a tabbed menu, and two main sections for configuration: 'Student Info' and 'Include the following'. The 'Student Info' section contains input fields for 'Perm ID', 'Last Name', and 'First Name'. The 'Include the following' section contains a checkbox for 'Health Condition History'.

Figure 5.16 – Student Health Profile Report Interface

- An individual student or group of students can be selected by filtering on the **Last Name**, **First Name**, or **Perm ID**. For example, if a last name of Smith is entered, the report prints an individual report for each student with a last name of Smith.
- To include the **Health Condition History**, check the box.



Hope High School Student Health Profile

Year: 2010-2011
Report: HLT201

Student Information

Student Name Abbott, Billy C.		Perm ID 905483	Gender M	Grade 12	Track Tra	Address 1954 S Val Vista Dr Mesa, AZ 85234
Last Name Goes By	Nick Name		Birth Date 05/12/1993			
Phone 480-555-1214	Home Language Spanish	Resolved Race/Ethnicity White	Enter Date 08/31/2010	Leave Date		

IN CASE OF EMERGENCY: Names of persons who can assume temporary responsibility

Name Lauretta Jones	Relationship Aunt	Home Phone 480-555-1545	Work Phone	Other Phone
Name Darryl King	Relationship Friend	Home Phone 480-555-1962	Work Phone	Other Phone
Physician Mesa Peds		Phone 949-555-0831		

Health Conditions

Condition Code Medical Alert	Start Date 08/15/2007
Comment ADHD	
Condition Code Medical Alert	Start Date
Comment OCCASIONAL ASTHMA, SCOLIOSIS, ADHD	
Condition Code Medical Alert	Start Date 08/20/2007
Comment ASTHMA	

Health Incidents

Health Code Nursing Assessment/Treatment/Illness	Accident Date	Accident Time
Subjective/Objective Student complained of stomach pains.		
Assessment/Plan Provided place for student to lay down; after 20 minutes, student felt better and returned to class.		

Immunization Information

Immunization Name	Student Compliance Status
Polio	Compliant (0 valid dosage(s))
DTP/DTaP/DT	Compliant (0 valid dosage(s))
Td	Compliant (0 valid dosage(s))
MMR	Compliant (0 valid dosage(s))
HIB	Compliant (0 valid dosage(s))

Abbott, Billy C.

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Figure 5.17 – Student Health Profile Report

HLT202 – Student Immunization

The Student Immunization report lists all of a student's vaccinations, the date they received the vaccination, and if they are compliant with the immunization requirement.

This report can be customized using the following options:

Figure 5.18 – Student Immunization Profile Report Interface

- An individual student or group of students can be selected by filtering on the **Last Name**, **First Name**, **Perm ID**, or **Grade**. For example, if grade 12 is selected the report prints an individual report for each student in grade 12.
- To show only the students and immunizations that have not met the requirements, check the **Only Non-Compliant** box.
- Several areas of the report can be removed by checking **Hide Footer Text**, **Hide Documentation and Requirement Status**, **Hide TB/Scoliosis Section**, or **Hide Compliance Notes**.



Reference: To modify the text at the bottom of the report, go to the Immunization Definition screen found under Synergy SIS > Health > Setup. For more information, please refer to the manual titled *Synergy SIS – Health Administrator Guide*.

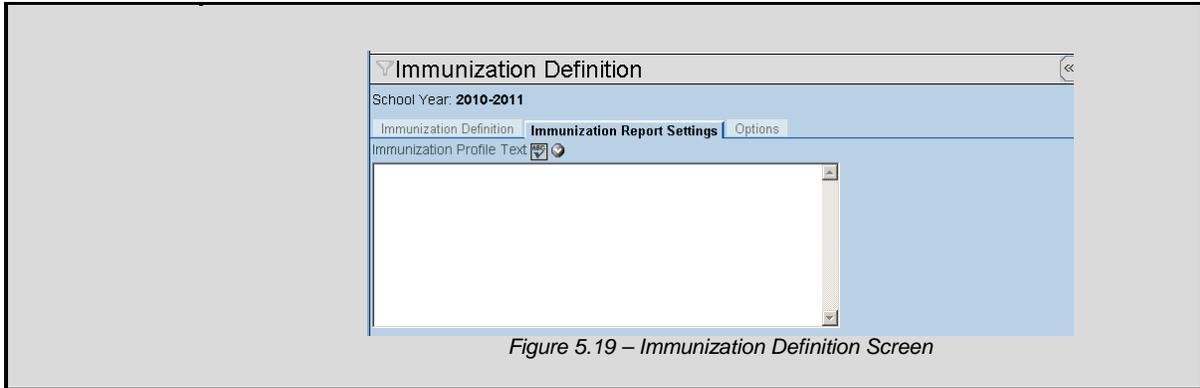


Figure 5.19 – Immunization Definition Screen



Hope High School
Student Immunization Profile

Year: 2010-2011
Report: HLT202

1. Identification Information							
Student Name	Perm ID	Grade	Gender	Birth Date			
Abbott, Billy C.	905483	12	Male	05/12/1993			
2. Immunizations							
	1st Date	2nd Date	3rd Date	4th Date	5th Date	6th Date	Compliance
Polio	02/02/2004	01/28/2006	03/03/2007	04/04/2008	05/06/2009		
DTP/DTaP/DT	02/02/2004	01/28/2006	03/03/2007	04/04/2008	05/06/2009		
Td	09/10/2010						
MMR	05/06/2009						
HIB	02/02/2004	01/28/2006	04/04/2008	05/06/2009			
HBV 2 DOSE	11/27/2008	02/28/2009					
HBV							
Varicella (History of Disease)	02/26/2011						
Varicella 13 + (History of Disease)							
HEP A	07/28/1997	07/29/1997					
3. Documentation				4. Status of requirements			
I certify that I reviewed this student's immunization record and it has been transcribed accurately. Date: _____ Admitting Official: _____ Documentation presented: <input type="checkbox"/> Official State Record <input type="checkbox"/> Foreign country (name) _____ <input type="checkbox"/> Out-of-State record (Name) _____				<input type="checkbox"/> A. Immunization Complete Date: _____ Date: _____ <input type="checkbox"/> B. Currently up-to-date; more doses are due later. <input type="checkbox"/> C. Laboratory evidence of immunity to: _____ Exemption for: <input type="checkbox"/> D. Medical Reasons - Permanent Date: _____ <input type="checkbox"/> E. Medical Reasons - Temporary until: Date: _____ <input type="checkbox"/> F. Personal Beliefs Date: _____			
Tuberculosis							
First Tuberculosis Skin Test		Second Tuberculosis Skin Test		Tuberculosis Chest X-Ray			
Impression	Date Given	mm Induration	Impression	Date Given	mm Induration	Impression	Date Given

Printed by Admin User at 04/22/2011 9:52 AM Edupoint School District Part 1 of 1 / Page 1 of 2

Figure 5.20 – Student Immunization Profile Report

HLT203 – Student Accident/Incident Report

The Student Accident/Incident Report lists the details of an accident or health-related incident involving a student. This is also the same report that prints when the Print Report button is clicked from the Accident Detail tab of the detailed screen of an incident on the Nurse's Log tab of the Health screen.

This report can be customized using the following options:

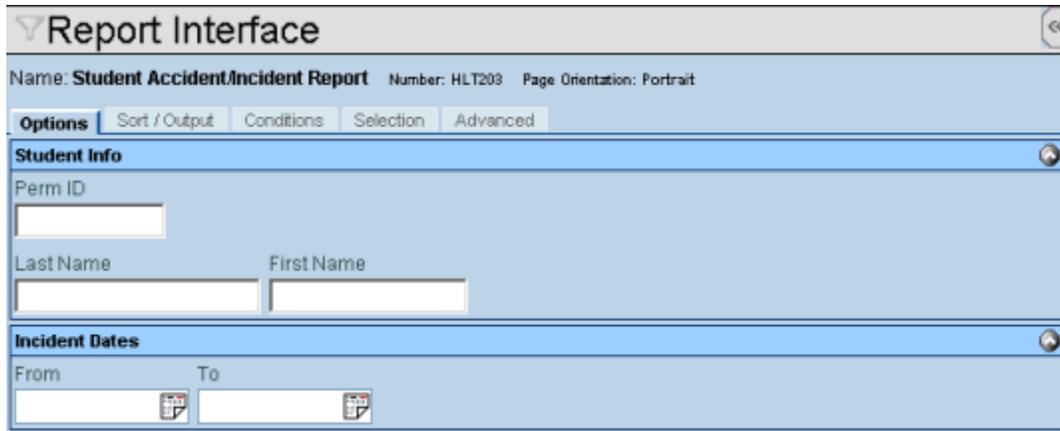


Figure 5.21 – Student Accident/Incident Report Interface

- An individual student or group of students can be selected by filtering on the **Last Name**, **First Name**, or **Perm ID**. For example, if a last name of Smith is entered, the report prints an individual report for each student with a last name of Smith.
- To only print the incidents that occurred during a specific period, enter the range of **Incident Dates** in the **From** and **To** boxes. Dates must be entered in MM/DD/YY format or they can be selected by clicking on the Calendar  button.

		Hope High School Student Accident/Incident Report 08/30/2010 - 06/03/2011			Year: 2010-2011 Report: HLT203	
Student Information						
Student Name Abbott, Billy C.		Perm ID 905483	Gender M	Grade 12	Phone 480-555-1214	Homeroom 230
Address 1954 S Val Vista Dr		City Mesa	State AZ	Zip Code 85234		
Accident Information						
Accident Location:			Accident Date:	Time Accident Occurred:		
Reported by: Vesta, Cindy		Date Reported: 12/15/2008	Parent Contact Attempted At:	Parent Contacted At:		
Describe Accident, Give Specific Location and Condition of Premises: Student complained of stomach pains.						
Medical Information						
Detailed Injury Description: Provided place for student to lay down; after 20 minutes, student felt better and returned to class.						
Care Given/By Whom:				Medical Care Recommended: No		
Reason Injured Person was on the Premises(lunch, P.E., etc.):						
Persons Familiar with Circumstances(Name & Title):						
Staff Member Responsible for Student Supervision at Time of Incident:			Student Covered by School Accident Insurance: No			
Where Taken After Incident(Specify home, hospital, etc.):			By Whom:	Time Taken:		
Follow-Up:						
Preventative Measure Taken:						
Signatures						
Principal Signature: _____			Date Signed: _____			
Nurse Signature: _____			Date Signed: _____			
Printed by Admin User at 04/22/2011 9:52 AM		Edupoint School District			Page 1 of 1	

Figure 5.22 – Student Accident/Incident Report

HLT204 – California Immunization Record

The California Immunization Record report lists all of a student's vaccination information in the format specified by the state of California.

This report can be customized using the following options:

Figure 5.23 – California Immunization Record Report Interface

- An individual student or group of students can be selected by filtering on the **Last Name**, **First Name**, **Perm ID**, or **Grade**. For example, if grade 12 is selected the report prints an individual report for each student in grade 12.
- To show the student's birth state and country on the report, check the **Display Birth State and Country** box.
- To identify a parent on the immunization record, select the **Parent/Guardian Selection Criteria**. The options are based on the flags set on the **Parent/Guardian** tab of the **Student** screen. Options include:
 - **Lives With,**
 - **Contact Allowed,**
 - **Ed. Rights,**
 - **Has Custody, or**
 - **Mailings Allowed.**

Tdap (Pertussis Booster) Requirement
Date of Tdap immunization: MM DD YYYY

Decision: Tdap case given on state's 7th birthday (7th birthday requirement)
 Medical exemption from physician on file
 Tdap personal belief exemption entered from parent/guardian on file

School Staff Name: Mary Smith (Health)
 Tdap's Date: 02/20/2013 PH 10443

CALIFORNIA SCHOOL IMMUNIZATION RECORD

This record is part of the student's permanent record (cumulative folder) as defined in Section 49069 of the Education Code and shall transfer with that record. Local health departments shall have access to this record in schools, child care facilities and family day care homes.

This record must be completed by school and child care personnel from an immunization record provided by parent or guardian. See reverse side for instructions.



Student Name: Abbott, Billy C. Sex: M F Birthdate: 07/31/2002 Place of Birth: Mesa

Name of Parent or Guardian: Aaron, Kathleen Race/Ethnicity:
 White, not His panic
 His panic
 Black
 Other: _____

Address: 1950 S mesa Dr
 City: Mesa ZIP: 85234

Telephone: ###-###-#### / ###-###-####
 Daytime Nighttime

VACCINE	DATE EACH DOSE WAS GIVEN				
	1st	2nd	3rd	4th	5th
POLIO (OPV or IPV)	01/30/2008	01/28/2008	02/28/2009	04/02/2010	
DTP/DTaP/DT/d (Diphtheria, tetanus and [acellular] pertussis OR tetanus and diphtheria only)	01/30/2008	01/28/2008	02/28/2009	04/02/2010	
MMR (Measles, mumps and rubella)					
HIB (Required only for child care and preschool)					
HEPATITIS B	02/23/2013				
VARICELLA (Chickenpox)					
HEPATITIS A (Not Required)					

TB SKIN TESTS	Type*	Date Given	Date Read	mm indur	Impression
	<input checked="" type="checkbox"/> PPD-Mantoux	07/29/2010	08/01/2010	0	<input type="checkbox"/> Pos <input checked="" type="checkbox"/> Neg
	<input type="checkbox"/> Other				
	<input checked="" type="checkbox"/> PPD-Mantoux	07/27/2012	08/01/2012	8	<input checked="" type="checkbox"/> Pos <input type="checkbox"/> Neg
	<input type="checkbox"/> Other				

Td or Tdap Booster: 04/02/2010

* If required for school entry, must be Mantoux unless exemption granted by local health department.

CHEST X-RAY (Necessary if skin test positive.) Film date: 02 / 07 / 2013 Impression: normal abnormal
 Person is free of communicable tuberculosis is: yes no

I. DOCUMENTATION
 I certify that I reviewed a record of this child's immunizations and transcribed it accurately.
 Date: 08/27/2012
 Staff Signature: Mary Smith (Health Clerk)

Record presented as:
 Yellow California Immunization Record
 Out-of-state school record
 Other immunization record

Specify:
II. STATUS OF REQUIREMENTS
 A. All requirements are met. Date: 05 / 04 / 2011
 B. Currently up-to-date, but more doses are due later. Needs follow-up.

Exemption was granted for:
 C. Medical Reasons - Permanent
 D. Medical Reasons - Temporary
 E. Personal Beliefs

III. 7th GRADE ENTRY
 A. All requirements are met. Name: Donna Jones (registr) Date: 09/10/2012
 B. Currently up-to-date, but more doses are due later. Needs follow-up. Name: _____ Date: _____

STATE OF CALIFORNIA-DEPARTMENT OF HEALTH SERVICES
IMMUNIZATION BRANCH

PM 286B (1.02)

Figure 5.24 – California Immunization Record Report

HLT206 – Student Medication Summary

The Student Medication Summary report lists of all of the medications that the school nurse has been asked to administer to the student. For each medication, it lists the name of the medication, the type, the date range during which the medication is to be given, and the times the medication should be administered. It also shows how many units of the medication are left in the school infirmary and how the medication should be administered (orally, injected, etc.).

This report can be customized using the following options:

Figure 5.25 – Student Medication Summary Report Interface

- An individual student or group of students can be selected by filtering on the **Last Name**, **First Name**, **Perm ID**, **Gender**, or **Grade**. For example, if grade 12 is selected the report prints an individual report for each student in grade 12.
- To show all of the medications administered, click the **Show Medication History** button
- To show previous medications that were given to the student as well as current medications, click the **Show Past Medications** box.
- To filter the report to show only the medications that may need to be refilled, enter the number of **Remaining Units**. The report will only list those medications with that number of units remaining or less.

HLT210 – Student Accident/Incident Report

The Student Accident/Incident Report provides information regarding those students involved in either an accident or a health-related incident, similar to HLT203. However, this report can be filtered to list only incidents with specific clinical codes..

This report can be customized using the following options:

Report Interface

Name: **Student Accident/Incident Report** Number: **HLT210** Page Orientation: **Portrait**

Options | Sort / Output | Conditions | Selection | Advanced

Student Info

Perm ID

Last Name First Name

Incident Dates

From To
 09/01/2008 05/29/2009

Health Codes

Exclude Selected Health Codes

Health Codes

<input type="checkbox"/> Nursing Assessment/Treatment/Illness	<input type="checkbox"/> Nursing Assessment/Treatment/Injury	<input type="checkbox"/> Health Conference/ Counseling
<input type="checkbox"/> Medication # Doses given	<input type="checkbox"/> Personal Feminine Needs	<input type="checkbox"/> Medication : TYL
<input type="checkbox"/> Nursing Procedures	<input type="checkbox"/> Parent Contact	<input type="checkbox"/> Home Visits
<input type="checkbox"/> Student Health Record [Enrollment]	<input type="checkbox"/> Student Health Records[Withdrawal]	<input type="checkbox"/> Immunization Records
<input type="checkbox"/> Immunization Administration a. #adults	<input type="checkbox"/> Immunization Administration-b.#students	<input type="checkbox"/> Vision a. #screened
<input type="checkbox"/> Vision b. #RN re-check	<input type="checkbox"/> Hearing a. #screened	<input type="checkbox"/> Hearing b. #RN re-check
<input type="checkbox"/> Scoliosis a. #screened	<input type="checkbox"/> Scoliosis b. #RN re-check	<input type="checkbox"/> Height & Weight a. #screened
<input type="checkbox"/> Staff - Industrial Injury (referral required)	<input type="checkbox"/> Height & Weight b. #RN re-check	<input type="checkbox"/> Staff - Injury (referral not required)
<input type="checkbox"/> Staff - Illness/Counseling	<input type="checkbox"/> B/P a. #screened	<input type="checkbox"/> B/P b. #RN re-check
<input type="checkbox"/> Dental a. #screened	<input type="checkbox"/> Dental b. #RN re-check	<input type="checkbox"/> Pediculosis a. #screened
<input type="checkbox"/> Pediculosis b. #RN re-check	<input type="checkbox"/> TB Skin Test a. #administered	<input type="checkbox"/> TB Skin Test b. #Read by Rn
<input type="checkbox"/> Sickle Cell a. #screened	<input type="checkbox"/> Sickle Cell b. #RN Counseling	<input type="checkbox"/> Anemia a. #screened

Figure 5.27 – Student Accident/Incident Report Interface

- An individual student or group of students can be selected by filtering on the **Last Name**, **First Name**, or **Perm ID**. For example, if a last name of Smith is entered, the report prints an individual report for each student with a last name of Smith.
- To only print the incidents that occurred during a specific period, enter the range of **Incident Dates** in the **From** and **To** boxes. Dates must be entered in MM/DD/YY format or they can be selected by clicking on the Calendar button.
- To specify which types of incidents are included in the report, check the **Health Codes** to be included. To exclude the codes checked instead of including them, check the **Exclude Selected Health Codes** box. To check or uncheck all of the codes, click on the Uncheck/Check All buttons.

		Hope High School Student Accident/Incident Report 08/30/2010 - 06/03/2011			Year: 2010-2011 Report: HLT210	
		Student Information				
Student Name Abbott, Billy C.		Perm ID 905483	Gender M	Birth Date 05/12/1993	Age 17	
School Name Hope High School			Grade 12	Homeroom 230	Phone 480-555-1214	
Address 1954 S Val Vista Dr		City Mesa	State AZ	Zip Code 85234		
Accident Information						
Date Occurred:	Time Occurred:	Name of Person Completing Report: Vesta, Cindy			Date Reported: 12/15/2008	
Location:		Injury:		Activity:		
Witnesses:						
Accident/Incident Description: Student complained of stomach pains.						
Assessment/Treatment Plan: Provided place for student to lay down; after 20 minutes, student felt better and returned to class.						
Action Taken:		Care Given By Whom:			Medical Care Recommended: No	
Parent/Other Notified:		Notified By Whom:		Notified How:		Notified Time:
Where Taken After Accident/Incident:				Taken By Whom:		Time Taken:
Other Persons Notified: <input type="checkbox"/> Superintendent Notified <input type="checkbox"/> Regional R.N. Notified <input type="checkbox"/> Parent/Guardian Notified						
Follow Up Information						
Date	Time	Staff Name	Follow Up			
(Empty table for follow-up entries)						
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Figure 5.28 – Student Accident/Incident Report

HLT211 – Health Screening Profile

The Health Screening Profile report lists the results of all of the screening tests for a student.

This report can be customized using the following options:

Report Interface

Name: **Health Screening Profile** Number: **HLT211** Page Orientation: **Portrait**

Options | Sort / Output | Conditions | Selection | Advanced

Student Info

Perm ID: 905483 Gender: Male

Last Name: Abbott First Name: Billy

Grade: -

Date Range

Start: 08/31/2009 End: 04/26/2010

Include the following

Dental Screening

General Health Information

Hearing Screening

Scoliosis Screening

Tuberculosis Skin Test

Vision Screening

- An individual student or group of students can be selected by filtering on the **Last Name**, **First Name**, **Perm ID**, **Gender**, or **Grade**. For example, if grade 12 is selected the report prints an individual report for each student in grade 12.
- The screening results included on the report can be filtered to include only results with a specific date range by entering the **Start** and **End** dates. Dates must be entered in MM/DD/YY format or they can be selected by clicking on the Calendar button.
- Check the box in front of each screening type to be included on the report in the **Include the Following** section.



Hope High School Health Screening Profile

From 08/30/2010 to 04/29/2011

Year: 2010-2011
Report: HLT211

Abbott, Billy C.

Student Information

Student Name Abbott, Billy C.		Perm ID 905483	Gender M	Grade 12	Address	
Last Name Goes By		Nick Name	Birth Date 05/12/1993		1954 S Val Vista Dr Mesa, AZ 85234	
Phone 480-555-1214	Home Language Spanish	Resolved Race/Ethnicity White	Enter Date 08/31/2010	Leave Date		

Hearing

<input type="checkbox"/> Medical Documentation Received	<input type="checkbox"/> Permission Slip
<input type="checkbox"/> Re-Evaluation Letter	<input type="checkbox"/> Preferential Seating
<input type="checkbox"/> Parent Refuses Clinic	<input type="checkbox"/> Ok for Educational Evaluation
<input type="checkbox"/> Evaluated by Audiologist	<input type="checkbox"/> Evaluated by Medical Provider
Comment	

Screen Date 01/04/2011	Clinic Date 01/04/2011	Grade 12	Staff Name	Referral Date 12/30/2010	Referral No change since previous test
Reason C2	Folder	Doctor Letter No	Reevaluation Letter No	Parent Refuses Clinic No	
Left Ear			Right Ear		
Left Aid		Left Tympanic Type B*-Perforation, (-399 pressure)		Right Aid	
				Right Tympanic Type Ad+100 to -200 daPa, >1.60cc	
500hz	1000hz	2000hz	4000hz	Volume	Static Compl
500hz	1000hz	2000hz	4000hz	Volume	Static Compl
Middle Ear Pressure		Left Result Risk Audio		Middle Ear Pressure	
				Right Result Risk Audio	
Doctor Comment					
Screener Comment					

Vision

Screen Date 04/22/2011	Grade 12	Staff Name		Vision Aid	Color Deficiency	Occular Alignment
Referral	Referral Date	Referral Result	Left Eye Near	Right Eye Near		
Without Glasses			With Glasses			
Left Eye 20/20	Right Eye 20/20	Both Eyes 20/20	Left Eye Glasses	Right Eye Glasses	Both Eyes Glasses	

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Figure 5.29 – Health Screening Profile Report

HLT212 – Arizona Immunization Record Report

The Arizona Immunization Record report prints each student's immunization record on the official state of Arizona immunization record format.

This report can be customized using the following options:

Figure 5.30 – Arizona Immunization Record Report Interface

- An individual student or group of students can be selected by filtering on the **Last Name**, **First Name**, **Perm ID**, or **Grade**. For example, if grade 12 is selected the report prints an individual report for each student in grade 12.



Caution: For the HLT212 report to work correctly, the **Vaccination State Cod** table must be setup with the following values. Once the lookup table is setup, the codes must be mapped to each vaccination definition as outlined in the *Synergy SIS – Health Administrator Guide* in the section on Immunization Definition Setup.

Code	Description	State Code
01	Polio	01
02	Diphth	02
03	DTTD	03
04	MMR	04
05	HIB	05
06	HEP B	06
07	HEP A	07
08	Varicella	08
09	PCV7	09
10	TDAP	10
11	MCV	11
12	TB Skin Test	12
13	HPV	13

ARIZONA SCHOOL IMMUNIZATION RECORD						
This form must be completed from an immunization record provided by the parent or guardian. See reverse side for instructions.						
I. IDENTIFICATION INFORMATION						
CHILD'S NAME NOMBRE DE NIÑO			BIRTH DATE FECHA DE NACIMIENTO			
Abbott, Billy C.			05/12/1993			
ENTRY GRADE (circle) GRADO (marque con circulo)		SEX SEXO		Male Niño		
Pre-K K 1 2 3 4 5 6 7 8 9 10 11 12				Female Niña		
II. IMMUNIZATIONS						
	1st	2nd	3rd	4th	5th	6th
	MO/DA/YR	MO/DA/YR	MO/DA/YR	MO/DA/YR	MO/DA/YR	MO/DA/YR
(DTaP/DTP) Diphtheria, Tetanus & Pertussis Difteria, Tetano y Tos Ferina	02/02/2004	01/28/2006	03/03/2007	04/04/2008	05/06/2009	
(DT) Diphtheria & Tetanus Difteria y Tetano						
(Td) Tetanus & Diphtheria Tetano y Difteria	09/10/2010					
(Tdap) Tetanus, Diphtheria, acellular Pertussis Tetano, Difteria y Tos Ferina						
(IPV/OPV) Polio Vaccine Vacuna Antipoliomielitica	02/02/2004	01/28/2006	03/03/2007	04/04/2008	05/06/2009	
(MMR) Measles, Mumps & Rubella Sarampión, y Paperas, y Rubola (Month, Day & year required)	05/06/2009					
(Hib) Haemophilus influenzae b Required for Pre-K program, children age 2 months to age 5 years. Influenzae Haemophilus tipo B Los Niños 2 meses de edad a 5 años de edad necesitan tener la vacuna para poder atender la programa de pre-jardín de infantes.	02/02/2004	01/28/2006	04/04/2008	05/06/2009		
(Hep B) Hepatitis B La Vacuna Hepatitis B	11/27/2008					
(Hep A) Hepatitis A La Vacuna Hepatitis A	07/28/1997	07/28/1997				
Variella (Chickenpox) Check box if history of disease: <input type="checkbox"/>	02/26/2011					
Meningococcal Meningococcos						
HPV (Human Papilloma Virus) Virus Papilloma Humano						
Other (Including Influenza Vaccine)						
TB Skin Test: (optional) List most recent test Prueba de tuberculosis del pie: (opcion) Liste la m's reciente prueba	07/31/2008	07/30/2010				
ADR109R - revised 06/05/10						

This record is part of the mandatory permanent pupil records as defined in the Arizona Revised Statute 15-674 and shall transfer with that record. Local health departments shall have access to this record.

FOR SCHOOL USE ONLY:						
Enrollment Date: 08/10/2010						
Schedule for Completion (Check dose(s) needed)						
VACCINE	1ST	2ND	3RD	4TH	5TH	6TH
DTap/DTP/DT/Td						
Tdap						
OVP/IPV						
MMR						
Hib						
Hep A						
Hep B						
Mening						
VAR						

III. Documentation

I certify that I reviewed this student's immunization record and it has been transcribed accurately.
 Date 08 / 30 / 2010
 Admitting Official Mary Smith (Health Clerk)

Documentation presented:
 Arizona Lifetime Record
 Foreign country (name) _____
 Out-of-State record (name) _____
 Other (name) _____

IV. Status of Requirements

A. Immunization complete Date 05 / 06 / 2009
 B. Currently up-to-date; more doses are due later. Needs follow-up
 C. Laboratory evidence of immunity to: _____

Exemption for:
 D. Medical Reasons-Permanent
 Date / /
 E. Medical Reasons-Temporary until
 Date / /
 F. Personal Beliefs
 Date / /

Figure 5.31 – Arizona Immunization Record Report

HLT213 – Healthcare Detail Plan

The Healthcare Detail Plan lists the individual healthcare plans on file for a student.

This report can be customized using the following options:

The screenshot displays the 'Report Interface' for the 'Healthcare Detail Plan' (HLT213). The interface includes a top navigation bar with 'Print', 'Save Default', 'Reset Default', and 'Email Me' buttons. Below this, the report title 'Report Interface' is shown with a status of 'Ready'. The main content area displays the report name 'Healthcare Detail Plan', the number 'HLT213', and the page orientation 'Portrait'. The 'Options' section is expanded to show 'Student Info' and 'Date Range' sections. The 'Student Info' section includes fields for 'Perm ID' (905483), 'Gender' (Male), 'Last Name' (Abbott), 'First Name' (Billy), and 'Grade'. The 'Date Range' section includes 'Start' (08/24/2012) and 'End' (02/20/2013) fields, each with a calendar icon.

Figure 5.32 – Healthcare Detail Plan Report Interface

- An individual student or group of students can be selected by filtering on the **Last Name**, **First Name**, **Perm ID**, or **Grade**. For example, if grade 12 is selected the report prints an individual report for each student in grade 12.
- The screening results included on the report can be filtered to include only results with a specific date range by entering the **Start** and **End** dates. Dates must be entered in MM/DD/YY format or they can be selected by clicking on the Calendar  button.

Hope High School Healthcare Detail Plan				Year: 2012-2013 Report: HLT213
Student Information				
Student Name Abel Jones Holbrook, Albert Jos	Perm ID 132683	Gender M	Grade 12	Birth Date 04/30/1996
Healthcare Plan				
Plan Name Manage chemo side effects	Plan Start Date 02/18/2013	Plan End Date 06/07/2013	Medical Diagnosis Safety	
Nursing Diagnosis Health maintenance, altered				
Intervention				
Intervention Code Vital Signs Monitoring	Intervention Description monitor student's vital signs as immune system is compromised by chemo treatments			
Intervention Code Nausea Management	Intervention Description manage possible nausea as a result of ongoing chemo treatments			
Plan Details				
Nursing Assessment The student is at risk for nausea, infection, and fatigue due to the fact the student's immune system will be compromised by chemo treatments.	Nursing Plan Check student's vital signs on a bi-weekly basis. Alert parents/doctor to any change in student's vital signs.	Medications/Side Effects Anti-nausea medication - causes drowsiness.	Expected Student Outcome We will attempt to make the student as comfortable as possible during their chemo treatments. Attempt to keep the student in school and their routine as normal as possible during their treatment.	
Signature Nurse/Staff _____		Date _____		
Signature Parent/Guardian _____		Date _____		
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Figure 5.33 – Healthcare Detail Plan

HLT209 – Student Health Incident List

The Student Health Incident List report lists all of the incidents in which a student was involved in a shortened format. For each incident, it lists the time in, time out, the date and time of the incident, the staff involved, the health code, a brief description of the incident, and the assessment plan.

This report can be customized using the following options:

Figure 5.34 – Student Health Incident List Report Interface

- An individual student or group of students can be selected by filtering on the **Last Name**, **First Name**, or **Perm ID**. For example, if a last name of Smith is entered, the report prints an individual report for each student with a last name of Smith.
- To list only one student's records on a page, check the box **Show One Student Per Page**.
- To list only students that have been involved in a health-related incident, check the box **Show Only Students with Incidents**.
- To only print the incidents that occurred during a specific period, enter the range of **Incident Dates** in the **From** and **To** boxes. Dates must be entered in MM/DD/YY format or they can be selected by clicking on the Calendar  button.
- To list only incidents with **Specific Health Codes**, select the codes from the **Health Code Selection** drop-down lists.

HLT401 – Student Health Conditions List

The Student Health Conditions List report lists all the students at the school in focus and shows if they have a health condition recorded.

This report can be customized using the following options:

Figure 5.36 – Student Health Conditions List Report Interface

- An individual student or group of students can be selected by filtering on the **Last Name**, **First Name**, **Perm ID**, or **Grade**. For example, if grade 12 is selected the report prints an individual report for each student in grade 12.
- To select what information to show about the health condition, select **Code**, **Comments** or **Both** from the **Information Options** drop-down list.
- To list only students with specific conditions, check the conditions to be listed in the **Condition Code** section. To check or uncheck all of the condition codes, click on the Uncheck/Check All  buttons. The **Show Only Selected Codes** box must also be checked.
- To list only students with a health condition, check the **Show Only Students with Conditions** box.
- To hide health conditions that have expired, click the **Suppress Expired Conditions** box.

- To hide any health conditions that have an expiration date, click the **Suppress Conditions with Any Expiration Date** box.
- To have health conditions that have expired appear in the report with parentheses around them, click the **Mark Expired Conditions with Parentheses** box.

Student Name	Perm ID	Gen	Grd	Room	Condition Code	Comment
Abbott, Billy C.	905483	M	12	230	Medical Alert	ADHD
					Medical Alert	OCCASIONAL ASTHMA, SCOLIOSIS, ADHD
					Medical Alert	ASTHMA

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Figure 5.37 – Student Health Conditions List Report

HLT403 – Student Immunization Compliance List

The Student Immunization Compliance List report lists all of the students at the school in focus, and shows the number of doses (in parenthesis) of each vaccination the student has received. Students that are not compliant show an N in the column for the vaccine. If an exemption has been recorded for the student, an E is shown in the column.

This report requires that at least one of the vaccination boxes to be checked before the report will run. This report can be further customized with the following options:

Figure 5.38 – Student Immunization Compliance List Report Interface

- Select the date in the **As Of Date** field to show all vaccinations received on or before that date. The date must be entered in MM/DD/YY format or they can be selected by clicking on the Calendar button.
- To filter by a range of grades, select the **Grade** from the drop-down list.
- Select which **Vaccinations** should be included on the report by checking the boxes next to each vaccination. To check or uncheck all of the vaccinations, click on the Uncheck/Check All buttons.

- To display an N in the box for vaccinations that have not been completed, check the box **Show Non-Compliant Students**.
- To display an E in the box for students that have an exemption, check the **Show Student Exemptions** box.
- To show the number of dosages completed by each student for each vaccination (the number in parentheses), check the **Show Dosage Count** box.
- To list the student's birth date, check the **Show Birth Date** box.
- Select the vaccination requirements to apply from the **Apply Rules For Year** drop-down list.
- To include mailing information in order to do a Mail Merge, click the **Include for Mail Merge** box.
- To list only students that will be in a specific school or grade level in the following school year, select the **Next School** and **Next Grade Level** from the drop-down lists.
- To either use the student's or parent's address when creating a mail merge, select from the **Address to Use** drop down. For parents, the **Parent Options** identifies the parent or guardian to whom the mail merge letter will be sent. The options are based on the flags set on the **Parent/Guardian** tab of the **Student** screen. Options include:
 - **Lives With,**
 - **Contact Allowed,**
 - **Ed. Rights,**
 - **Has Custody, or**
 - **Mailings Allowed.**



Hope High School

Student Immunization Compliance List

As of 04/22/2011, Show Non-Compliant, Show Exemptions

Year: 2010-2011
Report: HLT403

Student Name	Grade	Perm ID	Polio	DTP/DTap/DTd	MMR	Hib	HBV 2 DOSE	HBV	Varicella	Varicella 13 + HEP A
Abbott, Billy C.	12	905483	(5)	(5)	(1)	(1)	(4)	(2)	(0)	E (1) E (0) (2)
(Abernethy, Anne E.)	10	902870	(4)	(4)	(1)	(2)	(1)	(0)	(4)	E (0) E (0) (0)
Acevedo, Andrew	11	886630	(4)	(5)	(1)	(2)	N (0)	(0)	(3)	(0) (0) (0)
Ackley, Brian R.	12	913948	(5)	(5)	(1)	(2)	(1)	N (0)	N (0)	(0) (0) (0)
Acosta, Eugene A.	12	873921	E (3)	E (4)	E (2)	E (1)	E (1)	N (0)	N (0)	(0) (0) (0)
Acosta, John A.	11	150265	(4)	(5)	(1)	(3)	N (0)	(0)	(3)	(0) (0) (0)
Acunia, Kenneth O.	10	110412	N (5)	(5)	(1)	N (2)	(2)	(0)	(3)	(0) (0) (2)
Adair, Timothy S.	11	888621	N (5)	(5)	(1)	N (2)	(1)	(0)	(3)	(0) (0) (0)
Adams, Howard T.	12	873985	N (3)	(4)	(1)	N (1)	(1)	N (0)	N (0)	(0) (0) (1)
Adams, Larry A.	11	889314	(5)	(5)	(1)	(2)	N (0)	(0)	(3)	(0) (0) (0)
Adams, Martin C.	11	887623	E (3)	E (3)	E (0)	E (1)	E (1)	E (0)	E (1)	(0) (0) (0)
Adams, Scott M.	12	939208	N (0)	E (0)	E (0)	N (0)	N (0)	N (0)	N (0)	(0) (0) (0)
(Adams, Sean B.)	12	877340	(5)	(5)	(1)	(2)	(1)	N (0)	N (1)	(0) (0) (1)
Adamski, Alan M.	10	872035	N (5)	N (5)	N (1)	N (2)	N (0)	(0)	(3)	(0) (0) (0)
Addington, Paula M.	12	871686	(4)	(5)	(1)	(2)	(1)	N (0)	N (0)	(0) (0) (0)
Aelvoet, Jesse J.	12	944233	(4)	(5)	(0)	N (1)	N (0)	N (0)	N (0)	(0) (0) (0)
Aguado, Bobby J.	10	943822	(5)	(5)	(1)	(3)	N (0)	(0)	(3)	(0) (0) (0)
Aguado, Karen C.	12	135319	(4)	(5)	(1)	(2)	N (0)	N (0)	N (0)	(0) (0) (0)
Aguilar, Carolyn C.	10	902692	N (4)	N (5)	N (1)	N (2)	N (0)	(0)	(3)	(0) (0) (0)
(Aguilar, Kathleen G.)	10	132888	(3)	(0)	(3)	(2)	N (0)	(0)	(3)	(0) (0) (0)
Aguilar, Roger F.	12	991071	(3)	(0)	(3)	(2)	N (0)	(0)	(3)	(0) (0) (0)
Aguilar, Stephen A.	11	108367	(5)	(4)	(1)	(2)	N (0)	(0)	(3)	(1) (0) (1)
Aguirre, Jason K.	12	952357	N (4)	(5)	(1)	(3)	N (0)	(0)	(3)	(0) (0) (0)
Ahlstrom, Linda K.	10	120451	(4)	(4)	(1)	(2)	N (0)	(0)	(3)	(0) (0) (0)
Aitchison, Alice E.	12	871731	N (5)	(5)	(1)	N (2)	(1)	(0)	(3)	(0) (0) (0)
Akagawa, Adam H.	11	165923	N (5)	N (5)	N (1)	N (2)	N (0)	(0)	(3)	(0) (0) (2)
Akin, Andrea E.	10	902875	N (4)	(4)	(1)	(3)	(1)	(0)	(3)	(0) (0) (0)
(Akpan, Tina N.)	10	165110	N (3)	(4)	(1)	(2)	(1)	(0)	(3)	(1) (0) (0)
Alcazar, Eugene	10	141666	N (5)	N (5)	N (1)	(2)	N (0)	(0)	(3)	(0) (0) (0)
Alcazar, Eugene A.	10	141517	(5)	(5)	(1)	(2)	N (0)	(0)	(3)	(0) (0) (2)
(Alcorn, Donald A.)	11	929994	N (4)	N (5)	N (1)	N (2)	(1)	(0)	(3)	(0) (0) (0)
Alder, Lawrence S.	12	910024	N (5)	(5)	(1)	N (1)	N (0)	N (0)	N (0)	(0) (0) (0)
Alder, Sarah C.	12	968416	(4)	(5)	(1)	(2)	N (0)	(0)	(3)	(0) (0) (0)
Alexander, George M.	12	975141	N (5)	N (5)	N (1)	N (2)	(1)	(0)	(3)	(0) (0) (0)
(Alexander, Victor I.)	11	169473	N (5)	N (5)	N (1)	N (2)	(1)	(0)	(3)	(0) (0) (0)
Alger, Nicole C.	12	874433	N (4)	(5)	(1)	N (1)	(1)	N (0)	N (0)	(0) (0) (0)
Alger, Phyllis A.	10	149884	N (4)	(5)	(1)	N (2)	(1)	(0)	(3)	(0) (0) (0)
(Allen, Cheryl L.)	12	980882	(5)	(5)	(1)	(2)	(1)	N (0)	N (0)	(0) (0) (0)
Allen, Cynthia	12	874997	(5)	(5)	(1)	(2)	(1)	N (0)	N (2)	(0) (0) (0)
Allen, Diane B.	10	901507	(4)	(4)	(1)	(2)	(1)	N (0)	N (2)	(0) (0) (0)
Allen, Donald J.	10	883223	E (4)	E (5)	E (0)	E (2)	E (1)	N (0)	N (0)	(0) (0) (0)
(Allen, Douglas S.)	10	905926	N (0)	N (0)	N (0)	N (0)	N (0)	N (0)	N (0)	(0) (0) (0)
Allen, Jeremy S.	10	879216	N (5)	(5)	(1)	(3)	N (1)	(0)	(3)	(0) (0) (0)
Allen, Karen	11	891989	N (4)	(5)	(1)	N (2)	N (0)	(0)	(3)	(0) (0) (0)
Allen, Karen T.	12	871328	(5)	(5)	(1)	(3)	N (0)	N (0)	N (2)	(0) (0) (0)

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Figure 5.39 – Student Immunization Compliance List Report

HLT404 – Class Health Conditions List

The Class Health Conditions List report provides a list of all students by class and displays any health conditions they may have.

This report can be customized using the following options:

Figure 5.40 – Class Health Conditions List Report Interface

- To filter by a range of grades, select the **Grade** from the drop-down list.
- To filter by the period of the class, select the **Begin Period** and **End Period** from the drop-down list.
- To select what information to show about the health condition, select **Code**, **Comments** or **Both** from the **Information Options** drop-down list.
- Select the sections to print by entering the beginning and ending **Section ID**.
- To list only students with specific conditions, check the conditions to be listed in the **Condition Code** section. To check or uncheck all of the condition codes, click on the Uncheck/Check All  buttons. The **Show Only Selected Codes** box must also be checked.
- To list only students with a health condition, check the **Show Only Students with Conditions** box.
- To hide health conditions that have expired, click the **Suppress Expired Conditions** box.
- To hide any health conditions that have an expiration date, click the **Suppress Conditions with Any Expiration Date** box.

- To have health conditions that have expired appear in the report with parentheses around them, click the **Mark Expired Conditions with Parentheses** box.

Section ID		Course ID	Course Title	Teacher	Room	Grade	Period
0002		SC422	Life Science	Tofft, Robert	120	10	1

Student Name	Perm ID	Gender	Condition Code	Comment
Araujo, Daniel J.	120700	Male		
Bailey, Terry W.	901518	Male	Medical Alert	ASTHMA
			Medical Alert	CONCERTA DAILY
			Medical Alert	Asthma
			Medical Alert	ASTHMA
Barnette, Richard N.	904593	Male	Medical Alert	BIPOLAR ON MEDS
			Medical Alert	ADHD ON MEDS
Chavez, Wanda	909375	Female		
Childs, Lawrence C.	902878	Male	Medical Alert	ADD
			Medical Alert	ADHD.
			Medical Alert	Vision
Gale, Heather S.	103202	Female	Medical Alert	ALLERGY; TAVIST D
Green, Kimberly	877362	Female		
Johnson, Albert T.	887842	Male		
Kirby, Anthony O.	952382	Male		
Larios, Jeffrey F.	832781	Male	Medical Alert	ADHD
Leto, Charles A.	928213	Male	Medical Alert	Asthma
			Medical Alert	ASTHMA; ALLERGIES
			Medical Alert	ASTHMA
Martinez, Heather M.	904932	Female	Medical Alert	OBSESSIVE COMPULSIVE DISORDER.
Meadows, Benjamin J.	102705	Male	Medical Alert	ADHD
Miles, Michelle M.	901553	Female		
Nava-Rodriguez, Douglas A.	954140	Male	Medical Alert	ASTHMA
			Medical Alert	ASTHMA
Oliver, Angela L.	142112	Female		
Packer, Janice S.	889221	Female	Medical Alert	ASTHMA
			Medical Alert	ASTHMA
Patino, Amy M.	894666	Female	Medical Alert	ASTHMA
			Medical Alert	PETIT MAL SEIZURES
Rhoton, Lawrence A.	869042	Male	Medical Alert	HYDROCEPHALIC-SHUNT
			Medical Alert	CRUTCHES/INTERMITTENT CATH/SPINA BIFIDA
			Medical Alert	SELF CATHETERIZATION
			Medical Alert	ALLERGY LATEX, PCN
			Medical Alert	SPINA BIFIDA,WHEELCHAIR
Rivas, Clarence E.	157820	Male		
Rivera-Quintana, Aaron M.	158976	Male		
Rodriguez, Willie R.	110076	Male		

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Figure 5.41 – Class Health Conditions List Report

HLT405 – Student Immunization Assessment

The Student Immunization Assessment report is designed for pre-schools and kindergartens to assess the immunization status of their students or their incoming students.

This report requires the age group and birth date range to be filled in before the report will run. This report can be further customized with the following options:

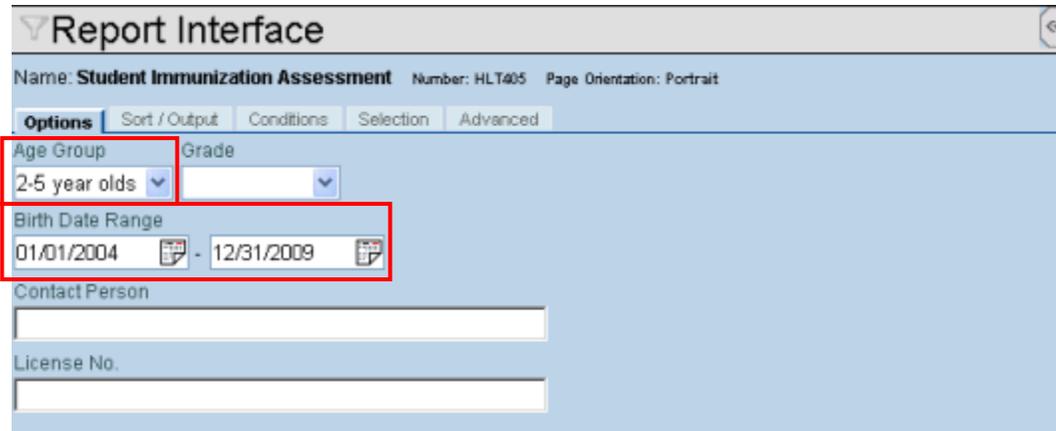


Figure 5.42 – Student Immunization Assessment Report Interface

- Select either **0-2 year olds** or **2-5 years olds** for the **Age Group** to be listed on the report.
- The report can be generated for a specific grade by selecting it from the **Grade** drop-down list.
- Enter the **Birth Date Range** by entering the dates in MM/DD/YY format, or they can be selected by clicking on the Calendar  button.
- To display the person who should be contacted and their license number, enter their information in the **Contact Person** and **License No.** fields. This information will display on the report.



Adams Elementary Student Immunization Assessment

As of: 04/22/2011

Year: 2010-2011
Report: HLT405

License # _____ Contact _____ Address 125 Robinson Av
 Child Care Head Start Phone 949-555-2425 Fountain Valley, AZ 85101
 Fax _____

Age Group
2-5 year olds (Children born on/after 01/01/2006 to 01/01/2011)

CHILD or I.D.	Birth Date	DTaP/DTP/DT			Polio			MMR			HIB			PCV7			Hepatitis A		Hepatitis B		Varicella	Had Chicken Pox	Religious Medical Exempt	Lab
		1	2	3	1	2	3	Date of 1st Dose	Date of 2nd Dose		1	2	3	1	2	3	Date of 1st Dose	Date of 2nd Dose	1	2				
Acoela, John	02/12/2006		X		X							X												
Adams, Aaron E.	05/03/2006																							
Adams, Paul	08/06/2006																							
Alicia, Nicole A.	02/03/2006		X		X						X									X				
Almanza, Jonathan	05/23/2006		X		X						X								X					
Alvarado, Janet	07/01/2006		X		X						X								X					
Appleton, Jerry	07/26/2006																							
Arcos, Nancy	01/23/2006		X		X						X								X					
Armas Dei Campo, Daniel D.	11/17/2006		X		X						X								X					
Armas Rueda, Walter	05/14/2006		X		X						X								X					
Armenta, Sandra	10/08/2006																							
Berrieault, Kathleen	05/03/2006																							
Betancourt, Michael L.	05/10/2006		X		X														X					
Betancourt, Roger J.	05/10/2006		X		X						X								X					
Bustamante, Angela M.	07/21/2006		X		X						X								X					
Castaneda Mares, Daniel I.	12/12/2006		X		X						X								X					
Cortes, Marilyn	06/01/2006																							
Cota, Virginia L.	05/31/2006		X		X						X								X					
Damacio, Jose	04/15/2006		X		X						X								X					
Diaz Tapia, George	06/23/2006		X		X						X								X					
Donald, Edward B.	01/21/2006		X		X						X								X					
Dunnuck, Henry J.	12/03/2006		X		X						X								X					
Encarnacion Baut, Frank	06/26/2006		X		X						X								X					
Enriquez, Thomas	08/26/2006																							
Escarcega, Gregory	05/07/2006																							
Espinoza, Cynthia C.	04/27/2006		X		X						X								X					
Flores, David S.	07/31/2006		X		X						X								X					
Gallo Perez, Katherine R.	10/13/2006		X		X						X								X					
Garcia Ramirez, Nancy	10/13/2006		X		X						X								X					
Garduño, Jose	10/05/2006																							

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Figure 5.43 – Student Immunization Assessment Report

HLT406 – Health Incident List

The Health Incident List report provides a list of students with a health incident.

This report can be customized using the following options:

Report Interface

Name: **Health Incident List** Number: **HLT406** Page Orientation: **Portrait**

Options | Sort / Output | Conditions | Selection | Advanced

Incident Dates

From: 09/01/2008 To: 06/05/2009

Health Codes

Exclude Selected Health Codes

Health Code Selection

<input type="checkbox"/> Nursing Assessment/Treatment/Illness	<input type="checkbox"/> Nursing Assessment/Treatment/Injury	<input type="checkbox"/> Health Conference/ Counseling
<input type="checkbox"/> Medication # Doses given	<input type="checkbox"/> Personal Feminine Needs	<input type="checkbox"/> Medication : TYL.
<input type="checkbox"/> Nursing Procedures	<input type="checkbox"/> Parent Contact	<input type="checkbox"/> Home Visits
<input type="checkbox"/> Student Health Record [Enrollment]	<input type="checkbox"/> Student Health Records[Withdrawal]	<input type="checkbox"/> Immunization Records
<input type="checkbox"/> Immunization Administration a. #adults	<input type="checkbox"/> Immunization Administration-b.#students	<input type="checkbox"/> Vision a. #screened
<input type="checkbox"/> Vision b. #RN re-check	<input type="checkbox"/> Hearing a. #screened	<input type="checkbox"/> Hearing b. #RN re-check
<input type="checkbox"/> Scoliosis a. #screened	<input type="checkbox"/> Scoliosis b. #RN re-check	<input type="checkbox"/> Height & Weight a. #screened
<input type="checkbox"/> Staff - Industrial Injury (referral required)	<input type="checkbox"/> Height & Weight b. #RN re-check	<input type="checkbox"/> Staff - Injury (referral not required)
<input type="checkbox"/> Staff - Illness/Counseling	<input type="checkbox"/> B/P a. #screened	<input type="checkbox"/> B/P b. #RN re-check
<input type="checkbox"/> Dental a. #screened	<input type="checkbox"/> Dental b. #RN re-check	<input type="checkbox"/> Pediculosis a. #screened
<input type="checkbox"/> Pediculosis b. #RN re-check	<input type="checkbox"/> TB Skin Test a. #administered	<input type="checkbox"/> TB Skin Test b. #Read by Rn
<input type="checkbox"/> Sickle Cell a. #screened	<input type="checkbox"/> Sickle Cell b. #RN Counseling	<input type="checkbox"/> Anemia a. #screened
<input type="checkbox"/> Physical Exams/Assessments	<input type="checkbox"/> Neurodevelopmental Assessments	<input type="checkbox"/> Fluoride Mouthrinse Program

Figure 5.44 – Health Incident List Report Interface

- Select the date range of the incidents to be included in the lists from the **Incident Dates**. Dates must be entered in MM/DD/YY format or they can be selected by clicking on the Calendar button.
- Select the **Health Codes** to be included in the report by checking the boxes. To check or uncheck all of the health codes, click on the Uncheck/Check All buttons. To exclude these codes instead of including them, check the **Exclude Selected Health Codes** box.



Hope High School
Health Incident List
08/30/2010 - 06/03/2011

Year: 2010-2011
Report: HLT406

Date	Time	School	Student Name	Perm ID	Health Code	Location	Activity
10/01/2010		Hope High School	Abbott, Billy C.	905483	Nursing Assessment/Treatment/Iness		
09/20/2010		Hope High School	Fort, Rachel J.	873725	Nursing Assessment/Treatment/Iness		
10/22/2010		Hope High School	Lathe, Carl J.	987319	Dental		

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Figure 5.45 – Health Incident List Report

HLT407 – Medication Task List

The Medication Task Lists shows all medications and procedures that must be completed for a specific date or range of dates.

This report can be customized using the following options:

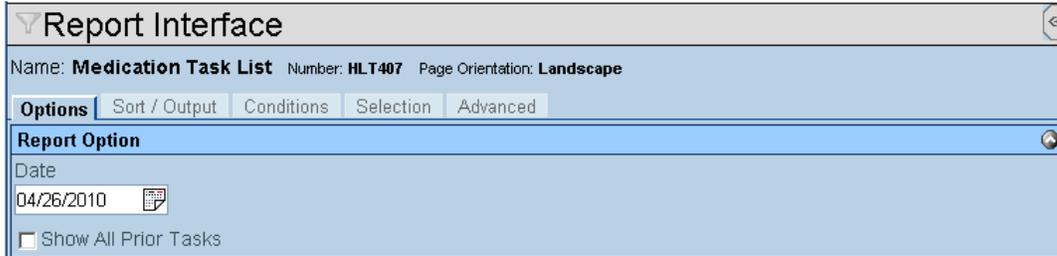


Figure 5.46 – Medication Task List Report Interface

- To show all tasks for a specific date, enter the **Date** in MM/DD/YY format or it can be selected by clicking on the Calendar  button.
- To show all tasks on or before that date, click on the **Show All Prior Tasks** box.

Student Name	SIS Number	Date	Time	Grade	Medications and Services	Units	Dosage	Note
Abbott, Billy C.	905483	04/22/2011	1:00 PM	12	Insulin Test	1.00		

Figure 5.47 – Medication Task List Report

HLT408 – Tuberculosis Section List Report

The Tuberculosis Section List report prints a page for each class listing all of the students in the class, with spaces to record their screening results. If the student has been screened, their results will display on the report.

This report can be customized using the following options:



Figure 5.48 – Tuberculosis Section List Report Interface

- To print the report for just one class, enter the **Section ID** for the class.
- To print only the records for students that have not been screened, check the box **Hide Students with Tuberculosis Records**.

Hope High School Tuberculosis Section List Report											
										Year: 2010-2011	Report: HLT408
Section ID 1119	Period 1	Course ID EN60	Course Title Eng (brit) Lit			Teacher Name Nunes, Kathy			Room Name 230		
Student Name	Perm ID	Gen	Grd	Type 1	Date Given 1	Date Read 1	mm Ind. 1	Imp. 1	Waiver	Waiver Date	
Abbott, Billy C.	905483	M	12	PPD-Mantoux	07/31/2008	08/03/2008	0	Negative			
Allison, Kenneth B.	992737	M	11								
Beckstead, Phyllis M.	871738	F	12								
Blasdel, Todd C.	873622	M	12								
Brooks, Amy M.	881172	F	12								
Cannon, Sean Q.	968281	M	12								
Carter, Timothy A.	995413	M	12								
Coleman, Jose L.	874305	M	12								
Crandall, William D.	887833	M	11								
Denton, Carlos L.	873368	M	12								
Derosso, William P.	133302	M	12								
Devinder, Stephen	126945	M	12								
Du, Edward	874006	M	12								
Howell, Ruth M.	879162	F	12								
Kaipalea, Susan	880519	F	12								
Landreaux, Terry X.	890837	M	12								
Lesueur, Gloria D.	874776	F	12								
Mechem, Rebecca M.	875009	F	12								
Miku, Martha A.	874467	F	12								
Miller, Kathy	893178	F	12								
Mitchell, Larry T.	913350	M	12								
Phelps, Gloria	874558	F	12								
Ramsey, Louis A.	935271	M	12								
Roberts, Jason S. JR	874561	M	12								
Schumacher, Bruce W.	881093	M	12								
Seymore, Martha L.	879226	F	12								
Swofford, Angela M.	874329	F	12								
Vielma, Lisa	117116	F	12								
Wandrey, Jerry B.	900381	M	12								
Waters, Victor R.	153227	M	12								
Wolfe, Richard L.	845465	M	12								

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Figure 5.49 – Tuberculosis Section List Report

HLT409 – Vision Section List Report

The Vision Section List report prints a page for each class listing all of the students in the class, with spaces to record their screening results. If the student has been screened, their results will display on the report.

This report can be customized using the following options:

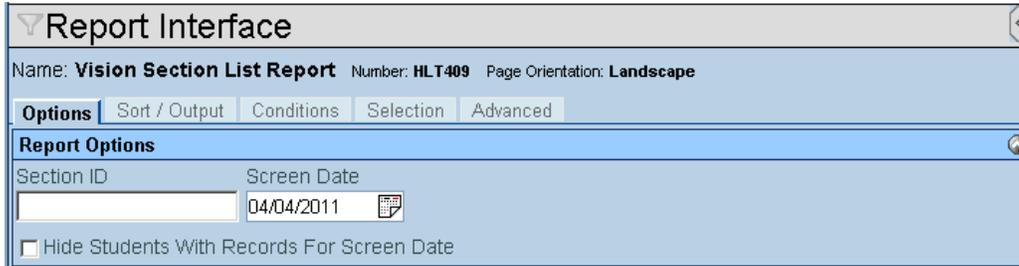


Figure 5.50 – Vision Section List Report Interface

- To print the report for just one class, enter the **Section ID** for the class.
- Enter the date on which the screening was (or will be) conducted in the **Screen Date** box. Dates must be entered in MM/DD/YY format or they can be selected by clicking on the Calendar button.

Section ID		Period	Course ID	Course Title	Teacher Name	Room Name	Screen Date
1119		1	EN60	Eng (brit) Lit	Nunes, Kathy	230	05/02/2011

Student Name	Perm ID	Gen	Grd	Without Glasses			With Glasses			Exam Grade
				Left Eye	Right Eye	Both Eyes	Left Eye	Right Eye	Both Eyes	
Abbott, Billy C.	905483	M	12	20/50+	20/50+	20/50+	20/20	20/20	20/20	12
Allison, Kenneth B.	992737	M	11							11
Beckstead, Phyllis M.	871738	F	12							12
Blasdell, Todd C.	873622	M	12							12
Brooks, Amy M.	881172	F	12							12
Cannon, Sean Q.	968281	M	12							12
Carter, Timothy A.	995413	M	12							12
Coleman, Jose L.	874305	M	12							12
Crandall, William D.	887833	M	11							11
Denton, Carlos L.	873368	M	12							12
Derosso, William P.	133302	M	12							12
Devinder, Stephen	126945	M	12							12
Du, Edward	874006	M	12							12
Howell, Ruth M.	879162	F	12							12
Kaipalea, Susan	880519	F	12							12
Landreaux, Terry X.	890837	M	12							12
Lesueur, Gloria D.	874776	F	12							12
Mechem, Rebecca M.	875009	F	12							12
Miku, Martha A.	874467	F	12							12
Miller, Kathy	893178	F	12							12
Mitchell, Larry T.	913350	M	12							12
Phelps, Gloria	874558	F	12							12
Ramsey, Louis A.	935271	M	12							12
Roberts, Jason S. JR	874561	M	12							12
Schumacher, Bruce W.	881093	M	12							12
Seymore, Martha L.	879226	F	12							12
Swofford, Angela M.	874329	F	12							12
Vielma, Lisa	117116	F	12							12
Wandrey, Jerry B.	900381	M	12							12
Waters, Victor R.	153227	M	12							12

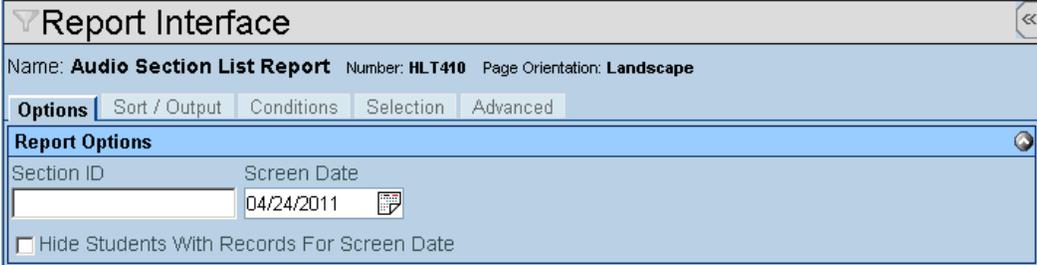
Printed by Admin User at 05/02/2011 1:23 PM Edupoint School District Page 1 of 2

Figure 5.51 – Vision Section List Report

HLT410 – Audio Section List Report

The Audio Section List report prints a page for each class listing all of the students in the class, with spaces to record their screening results. If the student has been screened, their results will display on the report.

This report can be customized using the following options:



The screenshot shows a web-based interface titled "Report Interface". Below the title, it displays "Name: Audio Section List Report", "Number: HLT410", and "Page Orientation: Landscape". There are five tabs: "Options" (selected), "Sort / Output", "Conditions", "Selection", and "Advanced". Under the "Options" tab, there is a section titled "Report Options" with two input fields: "Section ID" (empty) and "Screen Date" (containing "04/24/2011" with a calendar icon). Below these fields is a checkbox labeled "Hide Students With Records For Screen Date", which is currently unchecked.

Figure 5.52 – Audio Section List Report Interface

- To print the report for just one class, enter the **Section ID** for the class.
- Enter the date on which the screening was (or will be) conducted in the **Screen Date** box. Dates must be entered in MM/DD/YY format or they can be selected by clicking on the Calendar  button.
- To print only the records for students that were not screened on that date, check the box **Hide Students with Records For Screen Date**.

Section ID		Period	Course ID	Course Title	Teacher Name	Room Name	Screen Date
1119		1	EN60	Eng (brit) Lit	Nunes, Kathy	230	05/02/2011

Student Name	Perm ID	Gen	Grd	Reason	Left Result	Right Result	Referral	Clinic Date	Ref Date
Abbott, Billy C.	905483	M	12	Risk Audio	C2	Risk Audio	No change since previous test	01/04/2011	12/30/2010
Allison, Kenneth B.	992737	M	11						
Beckstead, Phyllis M.	871738	F	12						
Blasdel, Todd C.	873622	M	12						
Brooks, Amy M.	881172	F	12						
Cannon, Sean Q.	968281	M	12						
Carter, Timothy A.	995413	M	12						
Coleman, Jose L.	874305	M	12						
Crandall, William D.	887833	M	11						
Denton, Carlos L.	873368	M	12						
Derosso, William P.	133302	M	12						
Devinder, Stephen	126945	M	12						
Du, Edward	874006	M	12						
Howell, Ruth M.	879162	F	12						
Kaipelea, Susan	880519	F	12						
Landreaux, Terry X.	890837	M	12						
Lesueur, Gloria D.	874776	F	12						
Mechem, Rebecca M.	875009	F	12						
Miku, Martha A.	874467	F	12						
Miller, Kathy	893178	F	12						
Mitchell, Larry T.	913350	M	12						
Phelps, Gloria	874558	F	12						
Ramsey, Louis A.	935271	M	12						
Roberts, Jason S. JR	874561	M	12						
Schumacher, Bruce W.	881093	M	12						
Seymore, Martha L.	879226	F	12						
Swofford, Angela M.	874329	F	12						
Vielma, Lisa	117116	F	12						
Wandrey, Jerry B.	900381	M	12						
Waters, Victor R.	153227	M	12						
Wolfe, Richard L.	845485	M	12						

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Figure 5.53 – Audio Section List Report

HLT411 – Scoliosis Section List Report

The Scoliosis Section List report prints a page for each class listing all of the students in the class, with spaces to record their screening results. If the student has been screened, their results will display on the report.

This report can be customized using the following options:

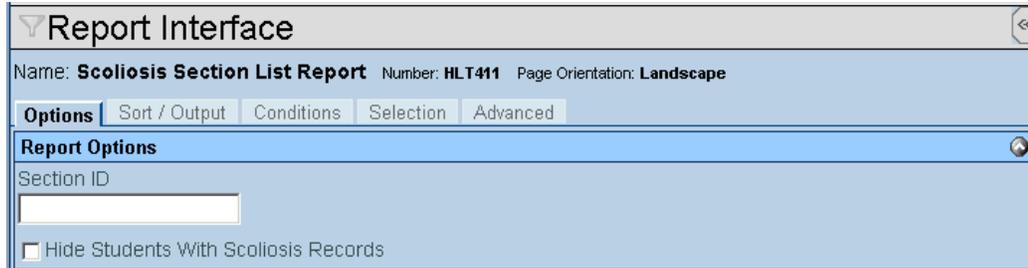


Figure 5.54 – Scoliosis Section List Report Interface

- To print the report for just one class, enter the **Section ID** for the class.
- To print only the records for students that have not been screened, check the box **Hide Students with Scoliosis Records**.



Hope High School
Scoliosis Section List Report

Year: 2010-2011
Report: HLT411

Section ID	Period	Counsel D	Course Title	Teacher Name	Room Name
1119	1	EN60	Eng (brit) Lit	Nunes, Kathy	230

Student Name	Perm ID	Gen	Grd	Exam Date	Result	Date Ref.	Exam Grd	Film Date 1	Imp. 1	Film Date 2	Imp. 2
Abbott, Billy C.	905483	M	12	05/02/2011	Fail	04/04/2011	12	05/05/2011	Normal		
Allison, Kenneth B.	992737	M	11								
Beckstead, Phyllis M.	871738	F	12								
Blasdell, Todd C.	873622	M	12								
Brooks, Amy M.	881172	F	12								
Cannon, Sean Q.	968281	M	12								
Carter, Timothy A.	995413	M	12								
Coleman, Jose L.	874305	M	12								
Crandall, William D.	887833	M	11								
Denton, Carlos L.	873368	M	12								
Derosso, William P.	133302	M	12								
Devinder, Stephen	126945	M	12								
Du, Edward	874006	M	12								
Howell, Ruth M.	879162	F	12								
Kaipelea, Susan	880519	F	12								
Landreaux, Terry X.	890837	M	12								
Lesueur, Gloria D.	874776	F	12								
Mechem, Rebecca M.	875009	F	12								
Miku, Martha A.	874467	F	12								
Miller, Kathy	893178	F	12								
Mitchell, Larry T.	913350	M	12								
Phelps, Gloria	874558	F	12								
Ramsey, Louis A.	935271	M	12								
Roberts, Jason S. JR	874561	M	12								
Schumacher, Bruce W.	881093	M	12								
Seymore, Martha L.	879226	F	12								
Swofford, Angela M.	874329	F	12								
Vielma, Lisa	117116	F	12								
Wandrey, Jerry B.	900381	M	12								
Waters, Victor R.	153227	M	12								
Wolfe, Richard L.	845465	M	12								

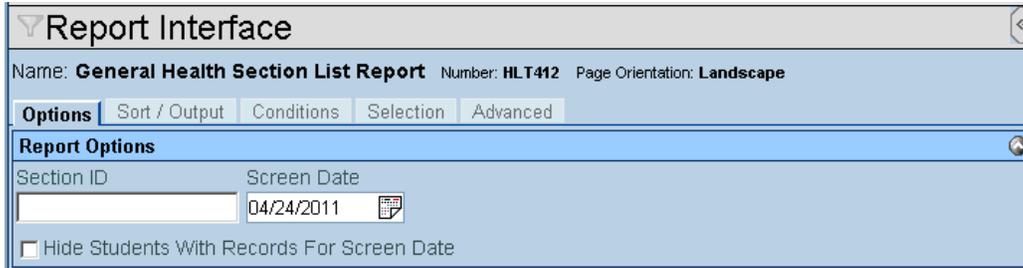
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Figure 5.55 – Scoliosis Section List Report

HLT412 – General Health Section List Report

The General Health Section List report prints a page for each class listing all of the students in the class, with spaces to record their screening results. If the student has been screened, their results will display on the report.

This report can be customized using the following options:



Report Interface

Name: **General Health Section List Report** Number: **HLT412** Page Orientation: **Landscape**

Options | Sort / Output | Conditions | Selection | Advanced

Report Options

Section ID: [] Screen Date: 04/24/2011 [Calendar Icon]

Hide Students With Records For Screen Date

Figure 5.56 – General Health Section List Report Interface

- To print the report for just one class, enter the **Section ID** for the class.
- Enter the date on which the screening was (or will be) conducted in the **Screen Date** box. Dates must be entered in MM/DD/YY format or they can be selected by clicking on the Calendar [Calendar Icon] button.
- To print only the records for students that were not screened on that date, check the box **Hide Students with Records For Screen Date**.

 Hope High School General Health Section List Report												
Section ID 1119	Period 1	Course ID EN60	Course Title Eng (brit) Lit				Teacher Name Nunes, Kathy		Room Name 230		Screen Date 05/02/2011	
Student Name	Perm ID	Gen	Grd	Height		Weight			Heart Rate	Blood Pressure	Ref. Date	Exam Grade
				Inches	Percentile	lbs	Percentile	BMI				
Abbott, Billy C.	905483	M	12	65	65	140	55	23.29	70	118		12
Allison, Kenneth B.	992737	M	11									11
Beckstead, Phyllis M.	871738	F	12									12
Blasdel, Todd C.	873622	M	12									12
Brooks, Amy M.	881172	F	12									12
Cannon, Sean Q.	968281	M	12									12
Carter, Timothy A.	995413	M	12									12
Coleman, Jose L.	874305	M	12									12
Crandall, William D.	887833	M	11									11
Denton, Carlos L.	873368	M	12									12
Derosso, William P.	133302	M	12									12
Devinder, Stephen	126945	M	12									12
Du, Edward	874006	M	12									12
Howell, Ruth M.	879162	F	12									12
Kaipelea, Susan	880519	F	12									12
Landreaux, Terry X.	890837	M	12									12
Lesueur, Gloria D.	874776	F	12									12
Mechem, Rebecca M.	875009	F	12									12
Miku, Martha A.	874467	F	12									12
Miller, Kathy	893178	F	12									12
Mitchell, Larry T.	913350	M	12									12
Phelps, Gloria	874558	F	12									12
Ramsey, Louis A.	935271	M	12									12
Roberts, Jason S. JR	874561	M	12									12
Schumacher, Bruce W.	881093	M	12									12
Seymore, Martha L.	879226	F	12									12
Swofford, Angela M.	874329	F	12									12
Vielma, Lisa	117116	F	12									12
Wandrey, Jerry B.	900381	M	12									12

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Figure 5.57 – General Health Section List Report

HLT413 – Dental Section List Report

The Dental Section List report prints a page for each class listing all of the students in the class, with spaces to record their screening results. If the student has been screened, their results will display on the report.

This report can be customized using the following options:

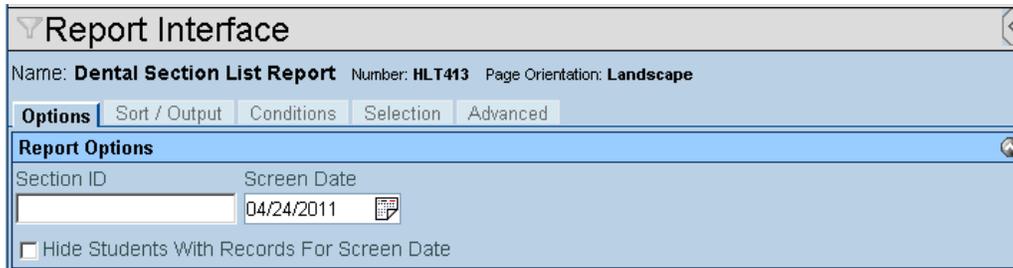


Figure 5.58 – Dental Section List Report Interface

- To print the report for just one class, enter the **Section ID** for the class.
- Enter the date on which the screening was (or will be) conducted in the **Screen Date** box. Dates must be entered in MM/DD/YY format or they can be selected by clicking on the Calendar  button.
- To print only the records for students that were not screened on that date, check the box **Hide Students with Records For Screen Date**.



Hope High School
Dental Section List Report

Year: 2010-2011
Report: HLT413

Section ID 1119	Period 1	Course ID EN60	Course Title Eng (brit) Lit	Teacher Name Nunes, Kathy	Room Name 230	Screen Date 05/02/2011
--------------------	-------------	-------------------	--------------------------------	------------------------------	------------------	---------------------------

Student Name	Perm ID	Gen	Grd	P/F	Vis. Fll.	Vis. Cav.	Treatment	Waiver	Fol. Up Date	Exam Grd
Abbott, Billy C.	905483	M	12	Pass	<input checked="" type="checkbox"/>	<input type="checkbox"/>	No obvious problem			12
Allison, Kenneth B.	992737	M	11		<input type="checkbox"/>	<input type="checkbox"/>				11
Beckstead, Phyllis M.	871738	F	12		<input type="checkbox"/>	<input type="checkbox"/>				12
Blasdeil, Todd C.	873622	M	12		<input type="checkbox"/>	<input type="checkbox"/>				12
Brooks, Amy M.	881172	F	12		<input type="checkbox"/>	<input type="checkbox"/>				12
Cannon, Sean Q.	968281	M	12		<input type="checkbox"/>	<input type="checkbox"/>				12
Carter, Timothy A.	995413	M	12		<input type="checkbox"/>	<input type="checkbox"/>				12
Coleman, Jose L.	874305	M	12		<input type="checkbox"/>	<input type="checkbox"/>				12
Crandall, William D.	887833	M	11		<input type="checkbox"/>	<input type="checkbox"/>				11
Denton, Carlos L.	873368	M	12		<input type="checkbox"/>	<input type="checkbox"/>				12
Derosso, William P.	133302	M	12		<input type="checkbox"/>	<input type="checkbox"/>				12
Devinder, Stephen	126945	M	12		<input type="checkbox"/>	<input type="checkbox"/>				12
Du, Edward	874006	M	12		<input type="checkbox"/>	<input type="checkbox"/>				12
Howell, Ruth M.	879162	F	12		<input type="checkbox"/>	<input type="checkbox"/>				12
Kalpelea, Susan	880519	F	12		<input type="checkbox"/>	<input type="checkbox"/>				12
Landreaux, Terry X.	890837	M	12		<input type="checkbox"/>	<input type="checkbox"/>				12
Lesueur, Gloria D.	874776	F	12		<input type="checkbox"/>	<input type="checkbox"/>				12
Mechem, Rebecca M.	875009	F	12		<input type="checkbox"/>	<input type="checkbox"/>				12
Miku, Martha A.	874467	F	12		<input type="checkbox"/>	<input type="checkbox"/>				12
Miller, Kathy	893178	F	12		<input type="checkbox"/>	<input type="checkbox"/>				12
Mitchell, Larry T.	913350	M	12		<input type="checkbox"/>	<input type="checkbox"/>				12
Phelps, Gloria	874558	F	12		<input type="checkbox"/>	<input type="checkbox"/>				12
Ramsey, Louis A.	935271	M	12		<input type="checkbox"/>	<input type="checkbox"/>				12
Roberts, Jason S. JR	874561	M	12		<input type="checkbox"/>	<input type="checkbox"/>				12
Schumacher, Bruce W.	881093	M	12		<input type="checkbox"/>	<input type="checkbox"/>				12
Seymore, Martha L.	879226	F	12		<input type="checkbox"/>	<input type="checkbox"/>				12
Swofford, Angela M.	874329	F	12		<input type="checkbox"/>	<input type="checkbox"/>				12
Vielma, Lisa	117116	F	12		<input type="checkbox"/>	<input type="checkbox"/>				12
Wandrey, Jerry B.	900381	M	12		<input type="checkbox"/>	<input type="checkbox"/>				12
Waters, Victor R.	153227	M	12		<input type="checkbox"/>	<input type="checkbox"/>				12
Wolfe, Richard L.	845465	M	12		<input type="checkbox"/>	<input type="checkbox"/>				12

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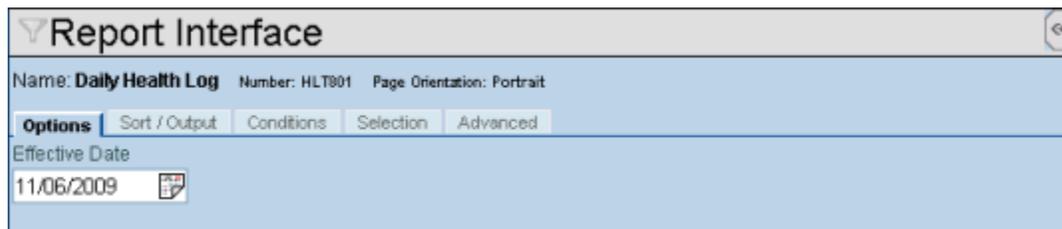
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Figure 5.59 – Dental Section List Report

HLT801 – Daily Health Log

The Daily Health Log report lists all health-related incidents for a given day.

This report can be further customized with the following options:



The screenshot shows a web-based report interface. At the top, it says "Report Interface" with a back arrow icon. Below that, it displays "Name: Daily Health Log", "Number: HLT801", and "Page Orientation: Portrait". There are five tabs: "Options" (selected), "Sort / Output", "Conditions", "Selection", and "Advanced". Under the "Options" tab, there is a label "Effective Date" and a text input field containing "11/06/2009" with a small calendar icon to its right.

Figure 5.60 – Daily Health Log Report Interface

- Select the date to be displayed in the report from the **Effective Date** field. The date must be entered in MM/DD/YY format or they can be selected by clicking on the Calendar  button. This date must be selected for this report to run.

		Hope High School			Year: 2010-2011	
		Daily Health Log			Report: HLT801	
		05/09/2011				
Time In/ Time Out	Name	Perm ID	Homeroom	Grade	Health Code	
4:00 PM	Acosta, John A.	150285		11	Allergy	
5:00 PM	Taken By:		Staff:	Hyde, Kathy		
	Time Taken:		Where Taken:		Clinical Code 310.11	
	Subjective Objective:					
	Assessment Plan:					
Nurse Signature			Health Assistant Signature			
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Figure 5.61 – Daily Health Log Report

HLT601 – Health Condition Totals

The Health Condition Totals summary report provides a list of health conditions and how many females or males have the condition as well as a total count.

This report can be customized using the following options:

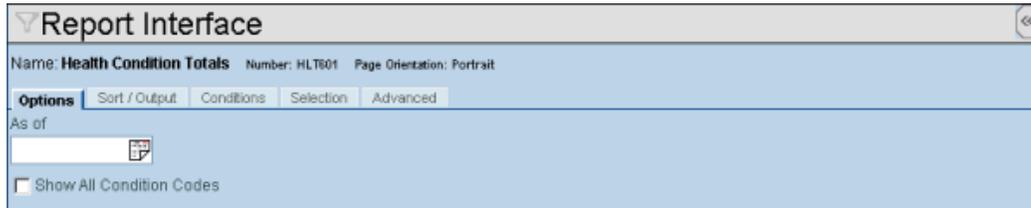


Figure 5.62 – Health Condition Totals Report Interface

- Select the date in the **As Of** box to show the conditions that were active as of that date. The date must be entered in MM/DD/YY format or they can be selected by clicking on the Calendar  button.
- To list the codes as well as the comments for the health conditions, check the **Show All Condition Codes** box.

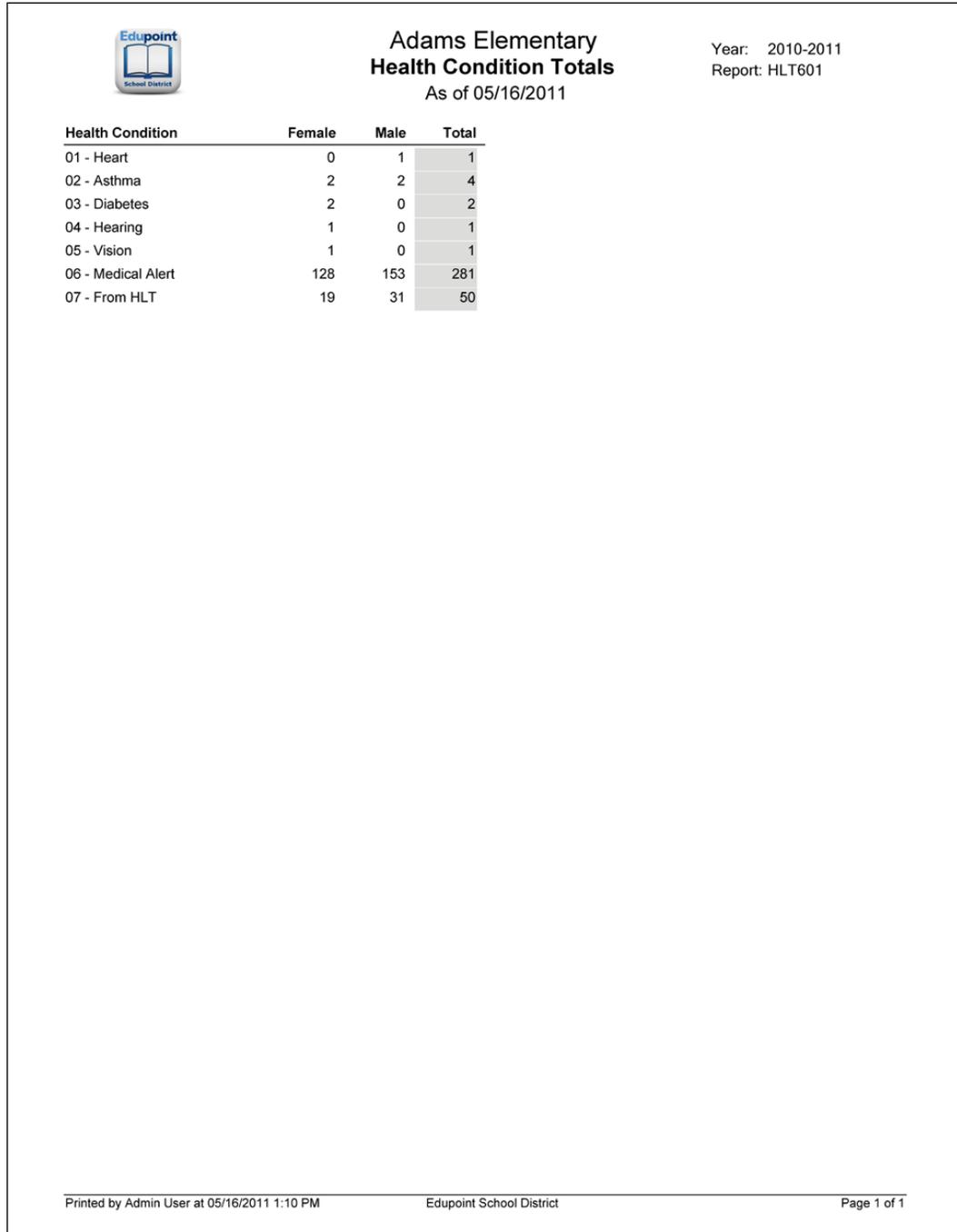


Figure 5.63 – Health Condition Totals Report

HLT602 – Class Incident Summary Report

The Class Incident Summary report provides a list of students by class and show the total number of health-related incidents in which the student has been involved.

This report can be customized using the following options:

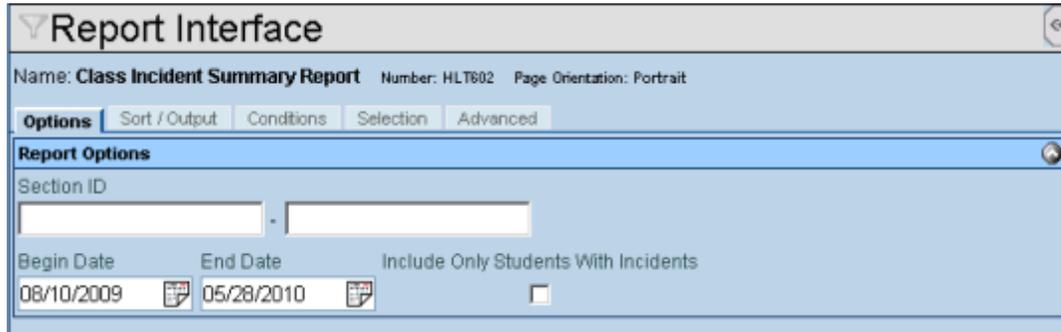


Figure 5.64 – Class Incident Summary Report Interface

- An individual section or range of sections can be included in the report by entering the **Section ID** in the boxes provided.
- Select the data range for the incidents to be summarized in the **Begin Date** and **End Date** boxes. The dates must be entered in MM/DD/YY format or they can be selected by clicking on the Calendar  button.
- To list only students that have been involved in a health-related incident, check the box **Include Only Students With Incidents**.

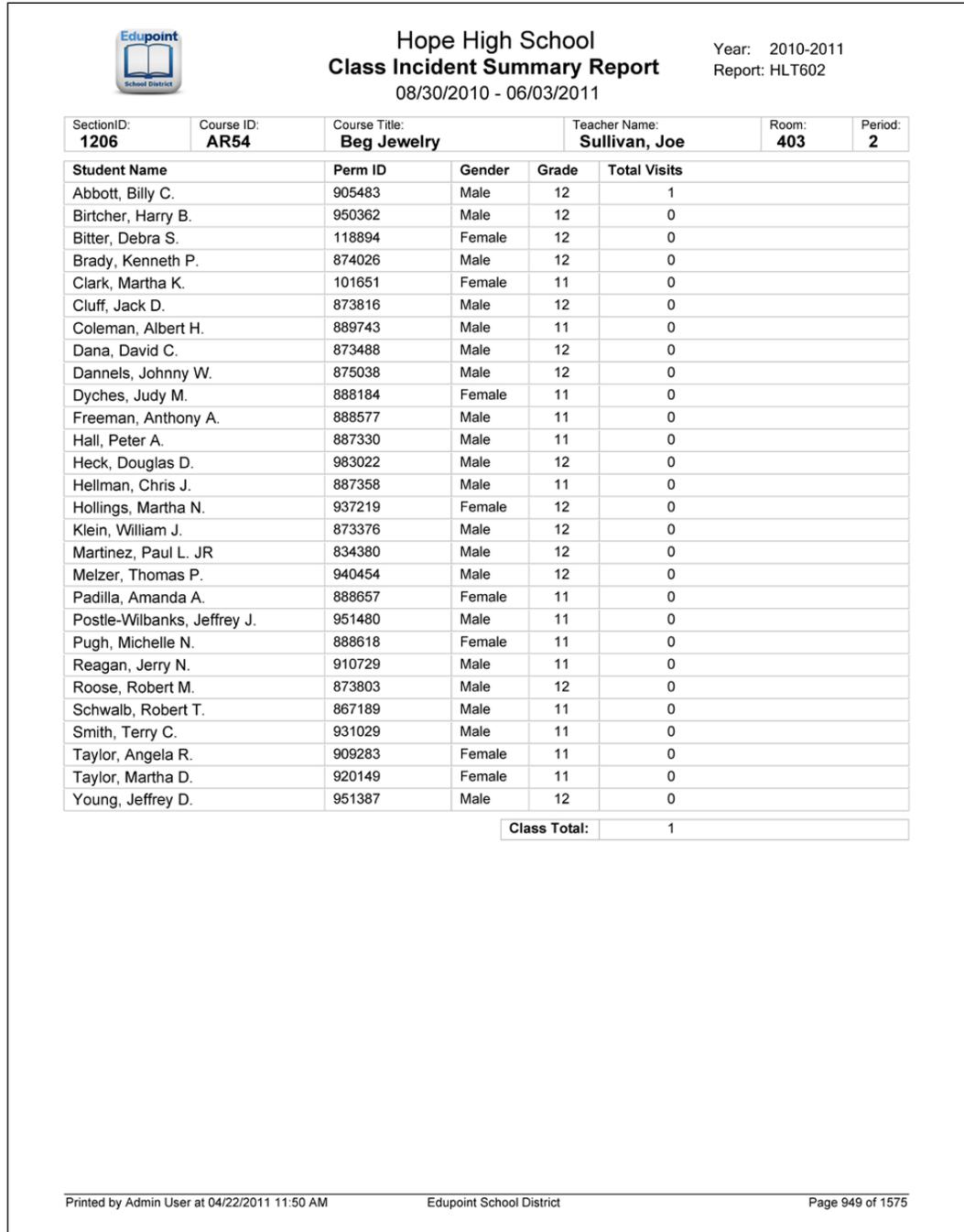


Figure 5.65 – Class Incident Summary Report

HLT603 – Clinical Code Totals

The Clinical Code Totals report lists the number of incidents by clinical code. The report can summarize both the incidents recorded in the Nurse's Log tab of the Health screen and the incidents recorded in the Health Log Other screen.

This report can be customized using the following options:

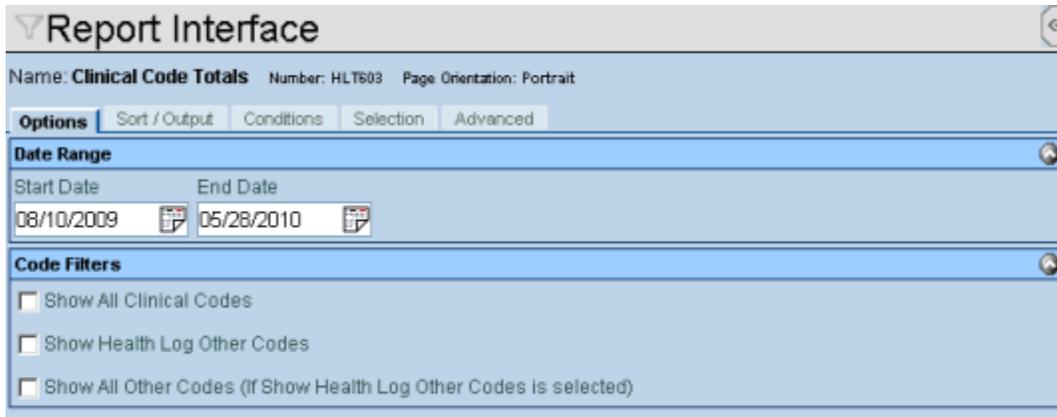


Figure 5.66 – Clinical Code Totals Interface

- Select the **Date Range** of the incidents to be included in the totals. The dates must be entered in MM/DD/YY format or they can be selected by clicking on the Calendar  button.
- To show all the Clinical Codes used on the Nurse's Log (for students) even if no incidents were reported, check the **Show All Clinical Codes** box.
- To show the codes used in the Health Log Other screen for non-students, check the box **Show Health Log Other Codes**.
- If the codes in the Health Log Other are selected, the **Show All Other Codes** box can be checked to show all of these codes even if they were not used.

		Adams Elementary Clinical Code Totals From 08/30/2010 to 06/03/2011		Year: 2010-2011 Report: HLT603	
Code	Description	Total	Code	Description	Total
001	Nursing Assessment/Treatment/Illness	0	1000.11	Industrial Injury (referral required) (Needing	0
001.00	Nursing Assessment/Treatment/Illness	17	1000.22	Industrial Injury (referral required) (Referre	0
005	Nursing Assessment/Treatment/Injury	0	1005	Staff - Injury (referral not required)	0
005.00	Nursing Assessment/Treatment/Injury	10	1005.11	Injury (referral not required) (Needing Nurs	0
010	Health Conference/ Counseling	0	1005.22	Injury (referral not required) (Referred)	1
010.00	Health Conference/ Counseling	0	1015	Staff - Illness/Counseling	0
010.50	IN H.O. FOR DISCI.	0	1015.11	Illness/Counseling (Needing Nursing Interv	0
015	Medication # Doses given	0	1015.22	Illness/Counseling (Referred)	0
015.00	Medication # Doses given	0	105	B/P a. #screened	0
017	Personal Feminine Needs	0	105.00	B/P a. #screened	0
017.00	Personal Feminine Needs	0	110	B/P b. #RN re-check	0
018	Medication : TYL.	0	110.00	B/P b. #RN re-check	0
018.00	Medication : TYL.	1	115	Dental a. #screened	0
020	Nursing Procedures	0	115.00	Dental a. #screened	0
020.00	Nursing Procedures	1	120	Dental b. #RN re-check	0
030	Parent Contact	0	120.00	Dental b. #RN re-check	0
030.00	Parent Contact	3	125	Pediculosis a. #screened	0
035	Home Visits	0	125.00	Pediculosis a. #screened	0
035.00	Home Visits	0	130	Pediculosis b. #RN re-check	0
040	Student Health Record [Enrollment]	0	130.00	Pediculosis b. #RN re-check	0
040.00	Student Health Record [Enrollment]	1	135	TB Skin Test a. #administered	0
045	Student Health Records[Withdrawal]	0	135.00	TB Skin Test a. #administered	0
045.00	Student Health Records[Withdrawal]	0	140	TB Skin Test b. #Read by Rn	0
050	Immunization Records	0	140.00	TB Skin Test b. #Read by Rn	0
050.00	Immunization Records	0	145	Sickle Cell a. #screened	0
055	Immunization Administration a. #adults	0	145.00	Sickle Cell a. #screened	0
055.00	Immunization Administration a. #adults	0	150	Sickle Cell b. #RN Counseling	0
060	Immunization Administration-b.#students	0	150.00	Sickle Cell b. #RN Counseling	0
060.00	Immunization Administration-b.#students	0	155	Anemia a. #screened	0
065	Vision a. #screened	0	155.00	Anemia a. #screened	0
065.00	Vision a. #screened	0	160	Physical Exams/Assessments	0
070	Vision b. #RN re-check	0	160.00	Physical Exams/Assessments	0
070.00	Vision b. #RN re-check	0	165	Neurodevelopmental Assessments	0
075	Hearing a. #screened	0	165.00	Neurodevelopmental Assessments	0
075.00	Hearing a. #screened	0	170	Fluoride Mouthrinse Program	0
080	Hearing b. #RN re-check	0	170.00	Fluoride Mouthrinse Program	0
080.00	Hearing b. #RN re-check	0	175	HealthEducation/Promotion/Resource	0
085	Scoliosis a. #screened	0	175.00	HealthEducation/Promotion/Resource	0
085.00	Scoliosis a. #screened	0	180	Classroom Presentation to Students	0
090	Scoliosis b. #RN re-check	0	180.00	Classroom Presentation to Students	0
090.00	Scoliosis b. #RN re-check	0	185	Special Education-Social/Dev Histories	0
095	Height & Weight a. #screened	0	185.00	Special Education-Social/Dev Histories	0
095.00	Height & Weight a. #screened	0	190	Re-evaluation Assessment	0
1	Staff - Industrial Injury (referral required)	0	190.00	Re-evaluation Assessment	0
100	Height & Weight b. #RN re-check	0	195	Child/Student Team Meetings	0
100.00	Height & Weight b. #RN re-check	0	195.00	Child/Student Team Meetings	0

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Figure 5.67 – Clinical Code Totals Report

HLT604 – Kindergarten Immunization Report

The Kindergarten Immunization Report summarizes the totals for the immunizations of the students in kindergarten at the school.

This report requires the Elementary Grade field to be filled in before the report will run. This report can be further customized with the following options:

The screenshot displays the 'Report Interface' for the 'Kindergarten Immunization Report'. At the top, it shows the report name, number (HLT604), and page orientation (Portrait). Below this is a navigation bar with tabs for 'Options', 'Sort / Output', 'Conditions', 'Selection', and 'Advanced'. The 'Options' tab is selected, revealing three main configuration areas: 'As of Date' with a text input showing '01/01/2009' and a calendar icon; 'Contact Person' with an empty text input field; and 'Elementary Grade' with a dropdown menu currently set to 'K'.

Figure 5.68 – Kindergarten Immunization Record Report Interface

- Select the date in the **As Of** box to show the state of the immunizations as of that date. The date must be entered in MM/DD/YY format or it can be selected by clicking on the Calendar  button.
- To display the person who should be contacted, enter their information in the **Contact Person** field. This information will display on the report.
- Select the grade of the students to summarize from the **Elementary Grade** drop-down list.

School Name Adams Elementary		School Type Public		Address 125 Robinson Av	
Contact Person		District Name Edupoint School District		District No. 123456000	
Principal Name		Phone 949-555-2425		City, State Zip Fountain Valley, AZ 85101	
		Fax		Included Grades K	
				County 19	
Kindergarten Only		#	Action Required		
1. How many students are enrolled?		72			
2. How many students have an immunization record or a valid exemption on file?		66	Require proof of immunization or an exemption for school entry.		
3. DTaP/DTP/DT					
How many students have received either 4-5 doses with one dose at 4 years of age or older, OR a total of 6 doses?		61	Meets the requirements.		
How many students have not received either 4-5 doses with one dose at 4 years of age or older, OR a total of 6 doses?		11	Does not meet the requirements.		
TOTAL (must equal number enrolled. see #1)		72			
4. Polio					
How many students have received either a total of 4 doses OR a total of 3 doses with the 3rd dose given at 4 years of age or older?		63	Meets the requirements.		
How many students have not received the doses described above?		9	Does not meet requirements. Polio #4 is required.		
TOTAL (must equal number enrolled. see #1)		72			
5. MMR					
How many students have received 2 doses, both given at 12 months of age or older?		63	Meets the requirements.		
How many students have not received 2 doses, both given at 12 months of age or older?		9	Does not meet requirements. 2 doses are required.		
TOTAL (must equal number enrolled. see #1)		72			
6. Hepatitis B					
How many students meet the requirement have 3 or more doses?		65	Meets the requirements.		
How many students do not meet the requirement have 3 or more doses?		7	Does not meet requirements. 3 doses are required.		
TOTAL (must equal number enrolled. see #1)		72			
7. Varicella (chicken pox)					
How many students have received 2 doses of Varicella vaccine? (Include those who have had chicken pox disease in addition to the immunizations.)		0	Meets the requirements.		
How many students have received one dose of Varicella vaccine, OR have history of chicken pox disease, OR have both the vaccine and history of disease?		0	Meets the requirements.		
How many students have no history of chicken pox and no Varicella vaccine doses?		72	Does not meet requirements. Varicella vaccination is required.		
TOTAL (must equal number enrolled. see #1)		72			
8. Exemptions		# of Permanent Exemptions	# of Temporary Exemptions		
How many have a personal beliefs exemption? (Indicate if exemption is limited to specific vaccines)		0	0		
How many have a medical exemption? (Indicate if exemption is limited to specific vaccines)		0	0		
How many have laboratory evidence of immunity? (Indicate specific vaccine(s) not needed)		0	0		

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Figure 5.69 – Kindergarten Immunization Record Report

HLT605 – School Grade Immunization Data Report

The School Grade Immunization Data Report provides a summary of the number of students at the school and the number of students with each immunization.

This report requires the Secondary Grade field and the High School Grade field be filled in before the report will run. This report can be further customized with the following options:

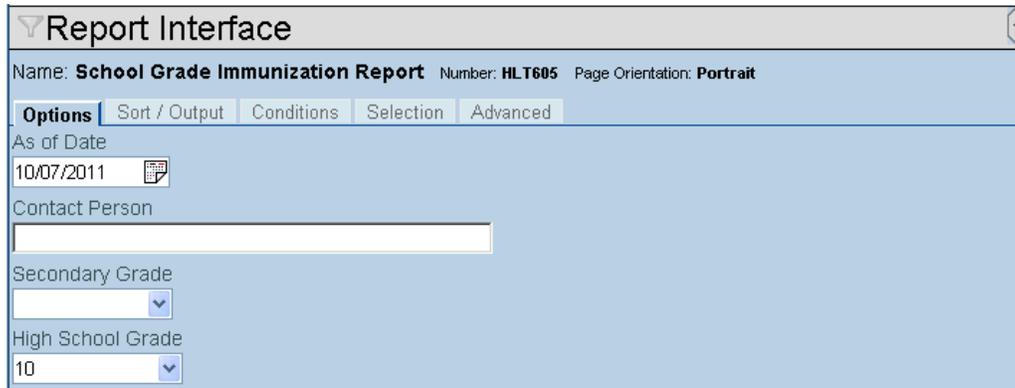


Figure 5.70 – School Grade Immunization Data Report Interface

- To display the person who should be contacted, enter their information in the **Contact Person** field. This information will display on the report.
- Select the **Secondary Grade** and **High School Grade** to be displayed. Each grade selected will be summarized in a separate column.

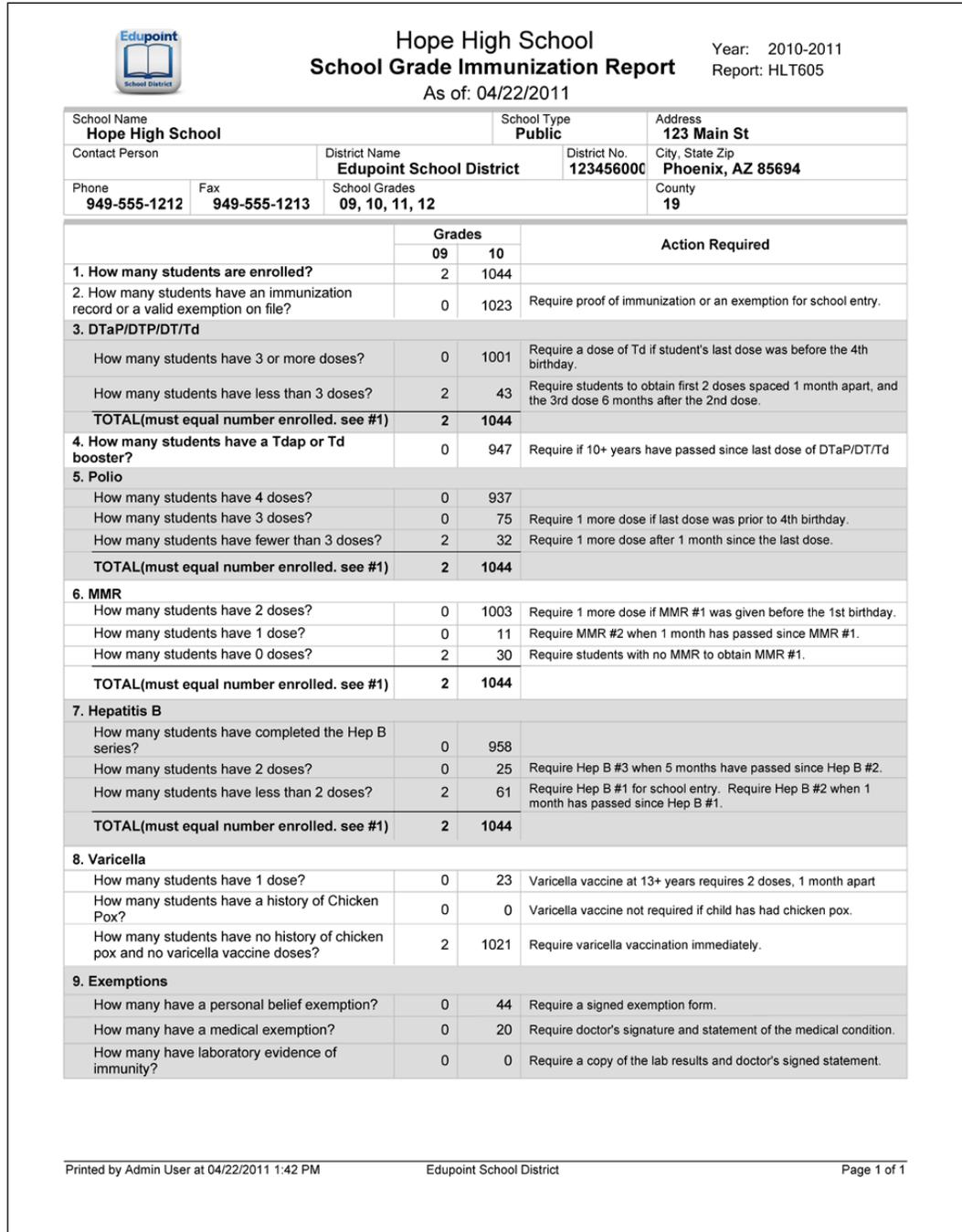


Figure 5.71 – School Grade Immunization Data Report

HLT606 – Health Incident Summary

The Health Incident Summary report summarizes the number of health-related incidents at a school overall and by gender, time of day, age, location, type of injury, activity, and type of equipment involved.

This report can be customized using the following options:

Figure 5.72 – Health Incident Summary Report Interface

- Select the range of dates for the incidents to be included from the **Report Dates From** and **To** boxes. The dates must be entered in MM/DD/YY format or they can be selected by clicking on the Calendar button.
- Select the schools to be included in the report by checking the boxes in the **School Selection** section. To check or uncheck all of the schools, click on the Uncheck/Check All buttons.

		Hope High School Health Incident Summary 08/30/2010 - 06/03/2011		Year: 2010-2011 Report: HLT606
Summary Totals				
	Description	Total	HOP	
	Total Accident Reports	3	3	
Accidents by Gender				
	Description	Total	HOP	
	Female	1	1	
	Male	2	2	
Accidents by Time				
	Description	Total	HOP	
	0:00 - 0:59	0	0	
	1:00 - 1:59	0	0	
	2:00 - 2:59	0	0	
	3:00 - 3:59	0	0	
	4:00 - 4:59	0	0	
	5:00 - 5:59	0	0	
	6:00 - 6:59	0	0	
	7:00 - 7:59	0	0	
	8:00 - 8:59	0	0	
	9:00 - 9:59	0	0	
	10:00 - 10:59	0	0	
	11:00 - 11:59	0	0	
	12:00 - 12:59	0	0	
	13:00 - 13:59	0	0	
	14:00 - 14:59	0	0	
	15:00 - 15:59	0	0	
	16:00 - 16:59	0	0	
	17:00 - 17:59	0	0	
	18:00 - 18:59	0	0	
	19:00 - 19:59	0	0	
	20:00 - 20:59	0	0	
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Figure 5.73 – Health Incident Summary Report

HLT607 – Health Incident Comparison Report

The Health Incident Comparison Report summary report provides a bar graph comparison of the number of incidents at the schools checked in the Options section.

This report can be customized using the following options:

Figure 5.74 – Health incident Comparison Report Interface

- Select the range of dates for the incidents to be included from the **Report Dates From** and **To** boxes. The dates must be entered in MM/DD/YY format or they can be selected by clicking on the Calendar  button.
- Select the schools to be included in the report by checking the boxes in the **Options** section. To check or uncheck all of the schools, click on the Uncheck/Check All  buttons.

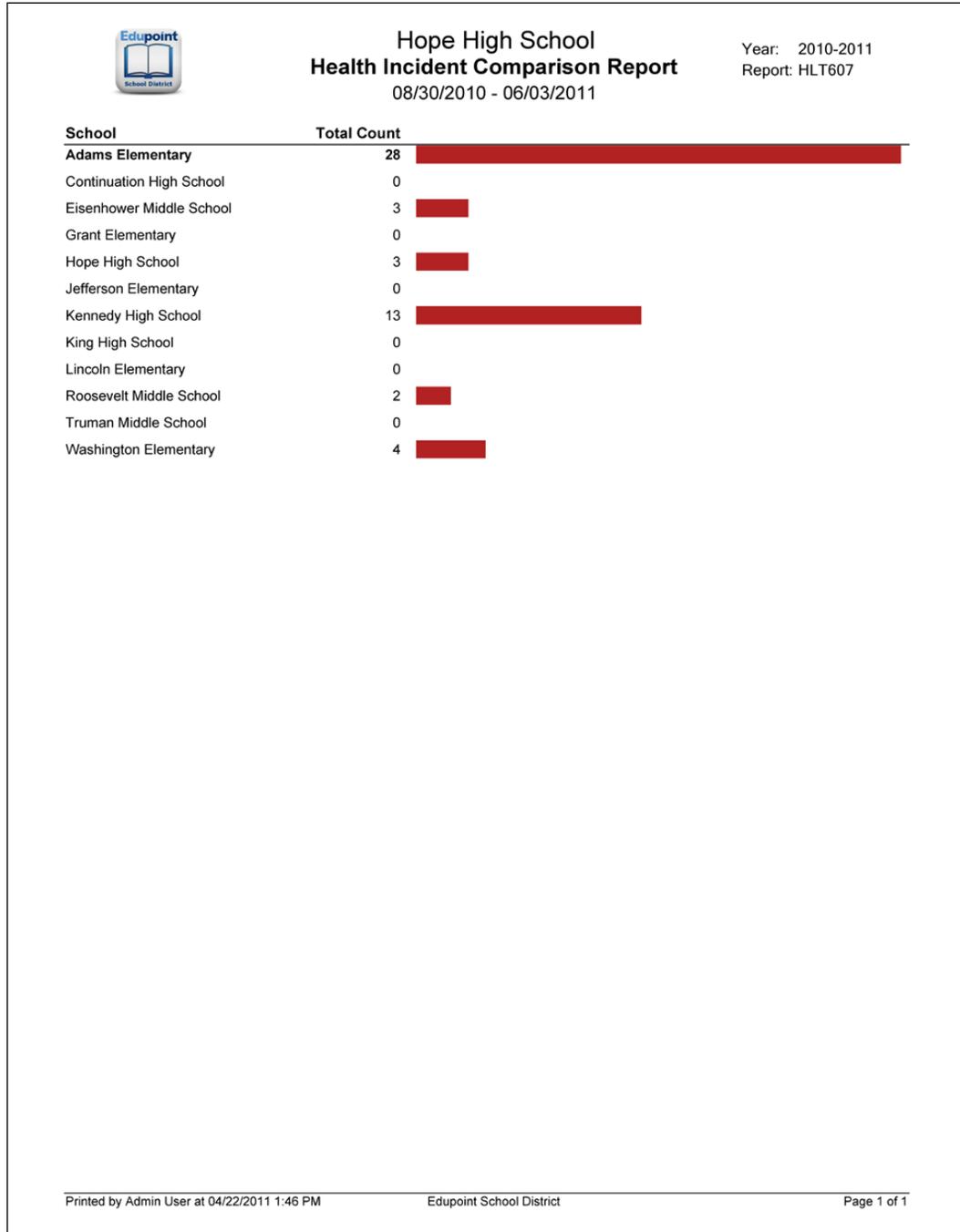


Figure 5.75 – Health incident Comparison Report

HLT609 – 6th Grade Immunization Report

The 6th Grade Immunization Report provides a summary of the immunization information for 6th graders at the school(s) selected.

This report requires the Grade field be filled in before the report will run. This report can be further customized with the following options:

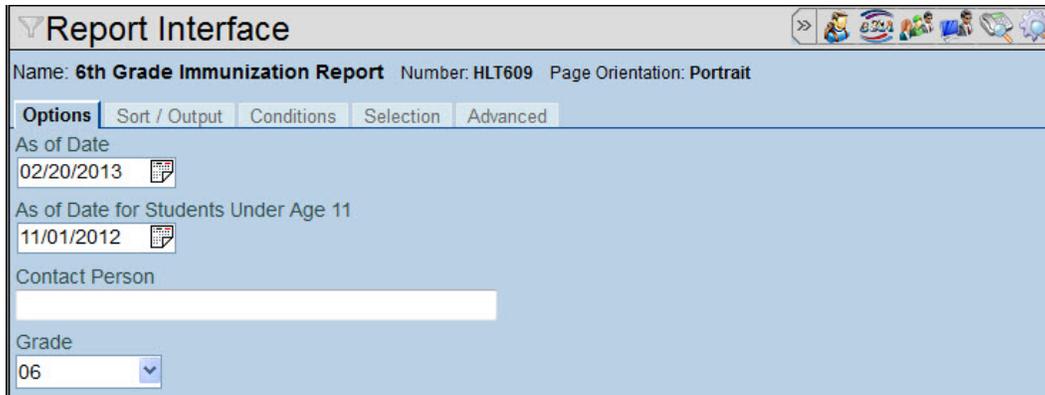


Figure 5.76 – 6th Grade Immunization Report Interface

- Select the date in the **As Of Date** field to show the status of the immunizations as of that date. The date must be entered in MM/DD/YY format or it can be selected by clicking on the Calendar  button.
- Select the date in the **As Of Date for Students Under Age 11** field to show the status of the immunizations for students who are younger than 11 as of that date. The date must be entered in MM/DD/YY format or it can be selected by clicking on the Calendar  button.
- To display the person who should be contacted, enter their information in the **Contact Person** field. This information will display on the report.
- Select the grade of the students to summarize from the **Grade** drop-down list.

School Name		School Type	Address	
Roosevelt Middle School		Public	1 Grape St	
Contact Person	District Name	District No.	City, State Zip	
	Edupoint School District	123456000	Fountain Valley, AZ 85101	
Principal Name	Phone	Fax	Included Grades	County
			06	19

Sixth Grade Only	#	Action Required	
1. How many students are enrolled?	0		
2. How many students have an immunization record or a valid exemption on file?	0	Require proof of immunization or an exemption for school entry.	
3. DTaP/DTP/DT/Td			
How many students have at least 4 doses, or 3 doses all given after 1 year of age?	0	Meets the requirements if student has a total of at least 4 doses, or only 3 doses with all given after 1 year of age.	
How many students have not received at least 4 doses or 3 doses given after 1 year of age?	0	Does not meet requirements. An additional tetanus/diphtheria dose is required.	
TOTAL (must equal number enrolled. see #1)	0		
4. Tdap			
How many students have received 1 dose of Tdap?	0	Meets the requirements.	
How many students have not received 1 dose of Tdap?	0		
TOTAL (must equal number enrolled. see #1)	0		
Tdap supplemental #1: How many students are under 11?	0		
#2: How many received a DTaP/DTP/Td in the last 5 years?	0		
5. Meningococcal (MV or MCV)			
How many students have 1 dose of MV or MCV?	0	Meets the requirements.	
How many students do not have 1 dose of MV or MCV?	0	MV/MCV is required for students 11 years or older.	
TOTAL (must equal number enrolled. see #1)	0		
6. Polio			
How many students have either 4 doses or at least 3 doses with dose #3 given at age 4 or older?	0	Meets the requirements.	
How many students have not received either 4 doses or at least 3 doses with dose #3 given at age 4 or older?	0	Does not meet the requirements.	
TOTAL (must equal number enrolled. see #1)	0		
7. MMR			
How many students have 2 doses?	0	Meets requirements if both doses were given after 12 months of age.	
How many students have less than 2 doses?	0	Requires MMR #2 when 4 weeks have passed since MMR #1.	
TOTAL (must equal number enrolled. see #1)	0		
8. Hepatitis B			
How many students have completed the Hepatitis B series with at least 3 doses?	0	Meets the requirements.	
How many students have documentation stating that they completed the special 2-dose adolescent Hepatitis B series, given to individuals 11-15 years of age?	0	Meets the requirements.	
How many have not completed the Hepatitis B series?	0		
TOTAL (must equal number enrolled. see #1)	0		
9. Varicella (chicken pox)			
How many have received 2 doses of Varicella vaccine?	0		
How many have received one dose of Varicella vaccine, OR have history of chicken pox disease, OR both?	0	Meets the requirements.	
How many have no Varicella history and no doses?	0	Does not meet requirements. Varicella vaccination is required.	
TOTAL (must equal number enrolled. see #1)	0		
10. Exemptions		# of Permanent Exemptions	# of Temporary Exemptions
How many have a personal beliefs exemption?		0	0
How many have a medical exemption?		0	0
How many have laboratory evidence of immunity?		0	0

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Figure 5.77 – 6th Grade Immunization Report

HLT610 – 10th Grade Immunization Report

The 10th Grade Immunization Report provides a summary of the immunization information for 10th graders at the school(s) selected.

This report can be customized using the following options:

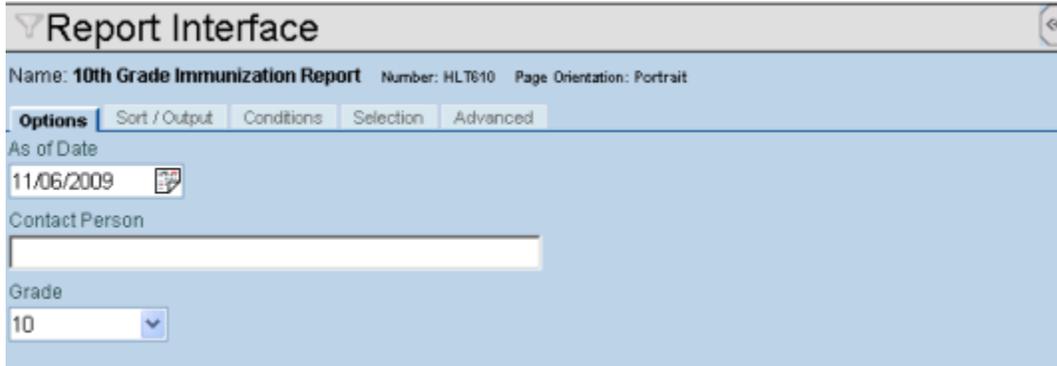


Figure 5.78 – 10th Grade Immunization Report Interface

- Select the date in the **As Of** box to show the state of the immunizations as of that date. The date must be entered in MM/DD/YY format or it can be selected by clicking on the Calendar  button.
- To display the person who should be contacted, enter their information in the **Contact Person** field. This information will display on the report.
- Select the grade of the students to summarize from the **Grade** drop-down list.

School Name		School Type		Address	
Hope High School		Public		123 Main St	
Contact Person Jason Dingle		District Name Edupoint School District		District No. 123456000	
Principal Name Tom McGrew		Phone 949-555-1212		City, State Zip Phoenix, AZ 85694	
		Fax 949-555-1213		Included Grades 10	
				County 19	
Tenth Grade Only		#	Action Required		
1. How many students are enrolled?		1046			
2. How many students have an immunization record or a valid exemption on file?		1025	Require proof of immunization or an exemption for school entry.		
3. Tdap					
How many students have received 1 dose of Tdap?		0	Meets the requirements. (Including DTaP boosters within 10 years)		
How many students have not received 1 dose of Tdap?		1046			
TOTAL (must equal number enrolled. see #1)		1046			
Tdap supplemental question: How many students received a DTaP, DTP, or Td dose within the last 10 years?		0	(Excluding students with at least 1 dose of Tdap)		
4. Meningococcal (MV or MCV)					
How many students have 1 dose of MV or MCV?		0	Recommended but not required for 10th grade students this year.		
How many students don't have 1 dose of MV or MCV?		1046			
TOTAL (must equal number enrolled. see #1)		1046			
5. MMR					
How many students have 2 doses?		1005	Meets requirements if both doses were given after 1 year of age.		
How many students have less than 2 doses?		41	Require MMR #2 when 4 weeks have passed since MMR #1.		
TOTAL (must equal number enrolled. see #1)		1046			
6. Hepatitis B					
How many students have completed the Hepatitis B series with at least 3 doses?		960	Meets the requirements.		
How many students have documentation stating that they completed the special 2-dose adolescent Hepatitis B series, given to individuals 11-15 years of age?		0	Meets the requirements.		
How many students have not completed the Hepatitis B series?		86			
TOTAL (must equal number enrolled. see #1)		1046			
7. Varicella (chicken pox)					
How many students have received 2 doses of Varicella vaccine? (Include those who have had chicken pox disease in addition to the immunizations.)		3	Meets the requirements.		
How many students have received one dose of Varicella vaccine, OR have history of chicken pox disease, OR have both the vaccine and history of disease?		20	Meets the requirements.		
How many students have no history of chicken pox and no Varicella vaccine doses?		1023	Does not meet requirements. Varicella vaccination is required.		
TOTAL (must equal number enrolled. see #1)		1046			
8. Exemptions					
		# of Permanent Exemptions		# of Temporary Exemptions	
How many have a personal beliefs exemption? (Indicate if exemption is limited to specific vaccines)		44		0	
How many have a medical exemption? (Indicate if exemption is limited to specific vaccines)		20		0	
How many have laboratory evidence of immunity? (Indicate specific vaccine(s) not needed)		0		0	

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Figure 5.79 – 10th Grade Immunization Report

HLT611 – Student Medication Refill

The Student Medication Refill lists the students that will need a refill of their medication shortly. The report includes the student's name, Perm ID and the date of last dosage.

This report can be customized using the following options:

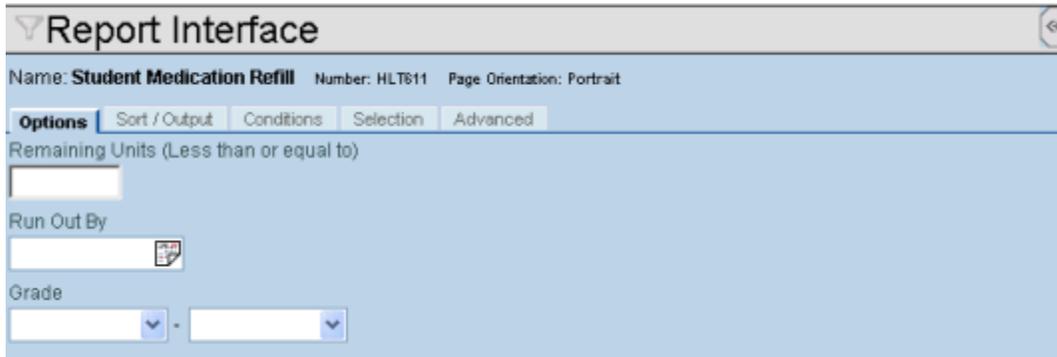


Figure 5.80 – Student Medication Refill Report Interface

- Enter the minimum number of **Remaining Units** to include on the report to filter by this number.
- To filter by the date on which the student will run out of their medication, enter the date in the **Run Out By** box. The date must be entered in MM/DD/YY format or it can be selected by clicking on the Calendar  button.
- The students to be included in the report can be selected by filtering on the **Grade**. For example, if grade 10-12 is selected the report prints an individual report for each student in grades 10-12.



Hope High School
Student Medication Refill
Remaining Dosages: All

Year: 2010-2011
Report: HLT611

Student Name	Perm ID	Grade	Date for Last Dosage
Abbott, Billy C.	905483	12	07/08/2011

Figure 5.81 – Student Medication Refill Report

HLT612 – Medication Disbursement Summary by Grade

The Medication Disbursement Summary by Grade report summarizes the number of medications given to students by type of medication, gender, grade and overall.

This report can be customized using the following options:

Report Interface

Name: **Medication Disbursement Summary By Grade** Number: HLT612 Page Orientation: Portrait

Options | Sort / Output | Conditions | Selection | Advanced

Please select at least one grade level.

Grade

09 10 11 12

Medication

Advair Insulin Other Ritalin Tylenol

Start Date End Date

08/10/2009 11/06/2009

Figure 5.82 – Medication Disbursement Summary by Grade Report Interface

- The students to be included in the report can be selected by filtering on the **Grade**. For example, if grade 10 & 12 is selected the report includes each student in grades 10 & 12.
- The types of medications included on the report can be selected by checking the boxes in the **Medication** section. To check or uncheck all of the medications, click on the Uncheck/Check All buttons.
- Select the date range for the summary by entering the **Start Date** and **End Date**. The dates must be entered in MM/DD/YY format or they can be selected by clicking on the Calendar button.



Hope High School
Medication Disbursement Summary By Grade
08/30/2010 - 04/22/2011

Year: 2010-2011
Report: HLT612

Medication	09			10			11			12			Other			Total
	Female	Male	Total													
Advair																
Insulin Test											1	1				1
Other																
Ritalin																
Tylenol																
Totals	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	1

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Figure 5.83 – Medication Disbursement Summary by Grade Report

HLT613 – Medication Disbursement Summary by Ethnic Code

The Medication Disbursement Summary by Ethnic Code report summarizes the number of medications given to students by type of medication, ethnic code, gender, and overall.

This report can be customized using the following options:

The screenshot shows a web-based report interface titled "Report Interface". The main title is "Medication Disbursement Summary By Ethnic Code" with a report number of "HLT613" and a page orientation of "Portrait". Below the title are tabs for "Options", "Sort / Output", "Conditions", "Selection", and "Advanced". The "Options" tab is active and contains two main sections: "Ethnic Code" and "Medication".

The "Ethnic Code" section includes a list of checkboxes for various ethnicities: American Indian, Asian - Chinese, Asian - Japanese, Asian - Korean, Asian - Vietnamese, Asian - Indian, Asian - Cambodian, Asian - Other, Black, Filipino, Hispanic, Pacific Islander - Native Hawaiian, Pacific Islander - Guamanian, Pacific Islander - Samoan, Pacific Islander - Tahitian, Pacific Islander - Other, White, and Declined to State. There are also "Uncheck/Check All" buttons for this section.

The "Medication" section includes checkboxes for Advair, Insulin Test, Other, Ritalin, and Tylenol, with a corresponding "Uncheck/Check All" button.

At the bottom, there are fields for "Start Date" (08/30/2010) and "End Date" (01/27/2011), each with a calendar icon for selection.

Figure 5.84 – Medication Disbursement Summary by Ethnic Code Report Interface

- Select the ethnic codes to be included in the report by checking the boxes in the **Ethnic Code** section. To check or uncheck all of the ethnicities, click on the Uncheck/Check All  buttons.
- The types of medications included on the report can be selected by checking the boxes in the **Medication** section. To check or uncheck all of the medications, click on the Uncheck/Check All  buttons.
- Select the date range for the summary by entering the **Start Date** and **End Date**. The dates must be entered in MM/DD/YY format or they can be selected by clicking on the Calendar  button.

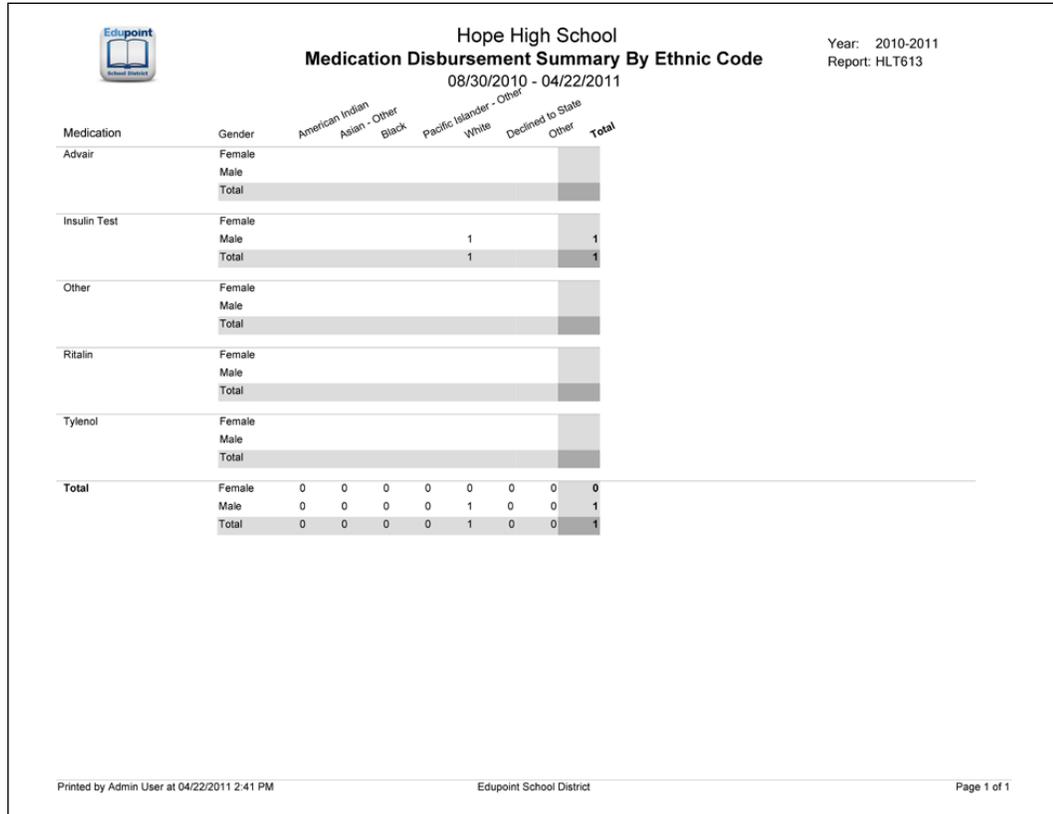


Figure 5.85 – Medication Disbursement Summary by Ethnic Code Report

HLT614 – Hearing Screening Program Report

The Hearing and Screening Program Report provides a summary count of the students by grade and the status of their screening.

This report can be customized using the following options:

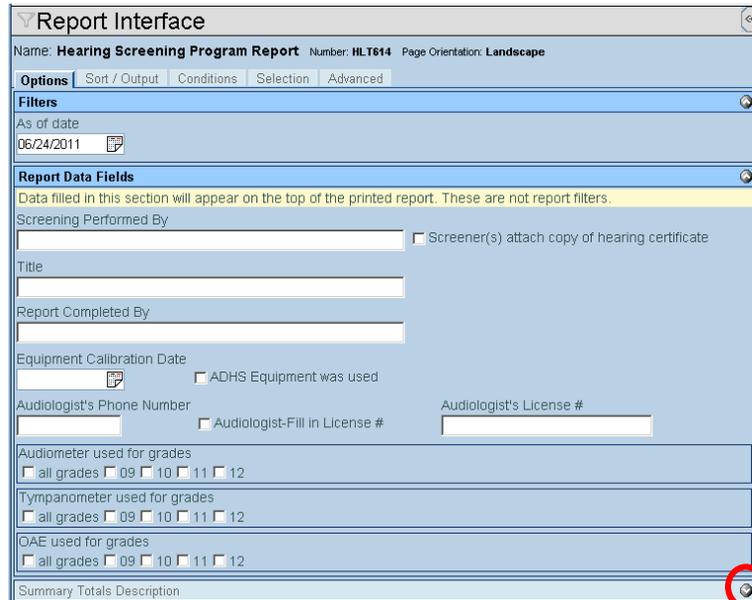
Figure 5.86 – Hearing Screening Program Report Interface

- Select the date in the **As Of** box to show the status of the screenings as of that date. The date must be entered in MM/DD/YY format or they can be selected by clicking on the Calendar button.
- Enter the **Screening Performed By**, **Report Completed By**, and **Title** to fill-in this information on the report.
- Check the **Screener(s) Attach Copy of Hearing Certificate** box if the screener(s) will be attaching a copy of the hearing certificate to the report.
- Enter the **Equipment Calibration Date** in MM/DD/YY format or it can be selected by clicking on the Calendar button. If **ADHS Equipment Was Used**, check the box.
- Enter the **Audiologist's Phone Number** to show on the report. Check the **Audiologist-Fill In License #** box if the license number is not available, or enter the number in the **Audiologist's License #** box.
- Select the grades where the **Audiometer**, **Tympanometer**, and **OAE** were used from the boxes provided.
- Choose the **Reason Codes** that do not count as **screened**. To check or uncheck all of the reason codes, click on the Uncheck/Check All buttons.

- Choose the **Reason Codes** that count as **failed**. To check or uncheck all of the reason codes, click on the Uncheck/Check All  buttons.

To view a description of the totals shown on the report:

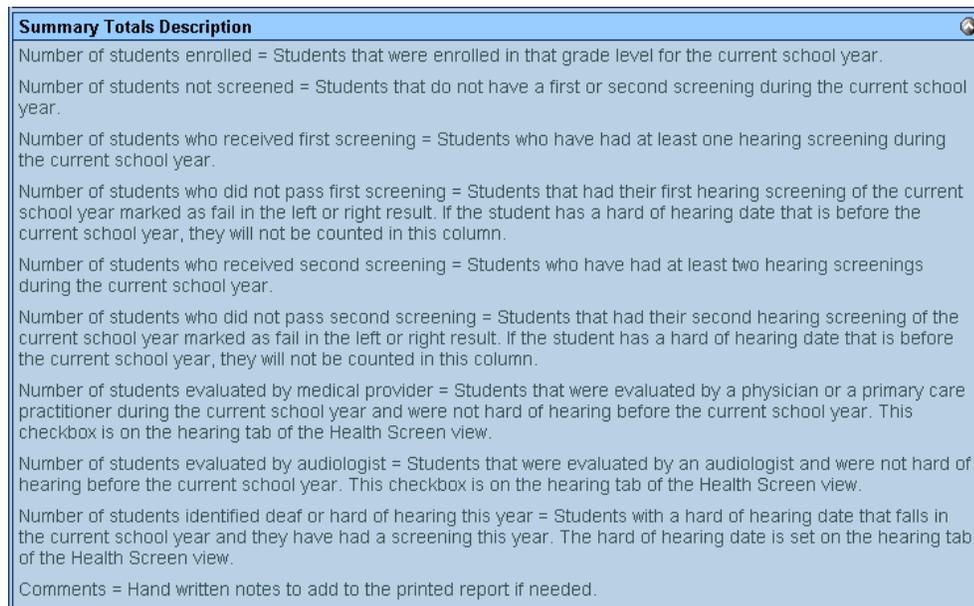
1. Click on the **Maximize** button in the Summary Totals Description section at the bottom of the report interface.



The screenshot shows a web-based report interface titled "Report Interface". At the top, it displays "Name: Hearing Screening Program Report", "Number: HLT614", and "Page Orientation: Landscape". Below this are tabs for "Options", "Sort / Output", "Conditions", "Selection", and "Advanced". A "Filters" section shows "As of date" set to "06/24/2011". The "Report Data Fields" section contains several input fields and checkboxes: "Screening Performed By", "Title", "Report Completed By", "Equipment Calibration Date", "Audiologist's Phone Number", "Audiologist's License #", and checkboxes for "ADHS Equipment was used", "Audiologist-Fill in License #", "Audiometer used for grades", "Tympanometer used for grades", and "OAE used for grades". Each of these last three sections has radio button options for "all grades", "09", "10", "11", and "12". At the bottom of the interface, the "Summary Totals Description" section is visible, with a red circle highlighting a maximize button in its top right corner.

Figure 5.87 – Showing the Summary Totals Description

2. A description of each total in the report is listed



The screenshot shows the "Summary Totals Description" section, which provides definitions for various report totals:

- Number of students enrolled = Students that were enrolled in that grade level for the current school year.
- Number of students not screened = Students that do not have a first or second screening during the current school year.
- Number of students who received first screening = Students who have had at least one hearing screening during the current school year.
- Number of students who did not pass first screening = Students that had their first hearing screening of the current school year marked as fail in the left or right result. If the student has a hard of hearing date that is before the current school year, they will not be counted in this column.
- Number of students who received second screening = Students who have had at least two hearing screenings during the current school year.
- Number of students who did not pass second screening = Students that had their second hearing screening of the current school year marked as fail in the left or right result. If the student has a hard of hearing date that is before the current school year, they will not be counted in this column.
- Number of students evaluated by medical provider = Students that were evaluated by a physician or a primary care practitioner during the current school year and were not hard of hearing before the current school year. This checkbox is on the hearing tab of the Health Screen view.
- Number of students evaluated by audiologist = Students that were evaluated by an audiologist and were not hard of hearing before the current school year. This checkbox is on the hearing tab of the Health Screen view.
- Number of students identified deaf or hard of hearing this year = Students with a hard of hearing date that falls in the current school year and they have had a screening this year. The hard of hearing date is set on the hearing tab of the Health Screen view.
- Comments = Hand written notes to add to the printed report if needed.

Figure 5.88 – Summary Totals Description

HEARING SCREENING PROGRAM REPORT
PLEASE PRINT ALL AREAS OF THIS REPORT

Name of School: Hope High School				District: Edupoint School District				Phone #: 949-555-1212		
School Address: 123 Main St				City: Phoenix		Zip Code: 85694		Fax #: 949-555-1213		
Screening Performed By:				<input type="checkbox"/> Screener(s)-Attach Copy of Hearing Screening Certificate*** <input type="checkbox"/> Audiologist-Fill in License #: _____ (if applicable)				School Year: 2012-2013		
Date Screening Performed:				TITLE:				DATE: 02/20/2013		
Equipment Calibration Date:				OR ADHS Equipment was used <input type="checkbox"/>				Type of School: <input type="checkbox"/> Public <input type="checkbox"/> Private <input type="checkbox"/> Charter <input type="checkbox"/> Preschool <input type="checkbox"/> Kindergarten <input type="checkbox"/> Other _____		
Type of Equipment (check all that apply; write in each grade screened using the equipment below or state 'all grades' for each equipment if applicable)										
<input type="checkbox"/> Audiometer used for grades: _____ <input type="checkbox"/> Tympanometer used for grades: _____ <input type="checkbox"/> OAE used for grades: _____										
SCHOOL GRADES	Number of students enrolled at initial screening	Number of students not screened	Number of students screened this year	Number of students that did not pass first screen	Number of students that received second screen	Number of students that did not pass second screen	Number of students evaluated by medical provider	Number of students evaluated by audiologist	Number identified deaf or hard of hearing this year	COMMENTS
Preschool										
Kindergarten										
First										
Second										
Sixth										
Ninth		1	1							
Special Ed. (do not be included in #s above)	3		2	2						
Other (students screened in grades other than those listed above)	2748		3143							

Report Completion Guidelines:

- ***Screeners attach copies of training certificate to this report
- Submit one report form for each school (Includes students enrolled throughout the school year)
- All Special Education students must be screened annually. (This includes students over 16)
- Ungraded student should be categorized by their age equivalent grade
- Use school address rather than district address

SUBMIT COMPLETED REPORT TO ADHS BETWEEN APRIL 1 AND JUNE 30 OF THE CURRENT SCHOOL YEAR

ADHS/BWCH SENSORY PROGRAM
150 North 18th Avenue, Suite 320
Phoenix, Arizona 85007-3242
602-364-1400 - www.azdhs.gov/dhs/bwch/sensory.htm

Checklist - Don't Forget to Include:

- Complete School Information
- Name(s) of Screener(s)
- Copy of Hearing Screening Certificate for each screener, include OAE & Tympanometer
- Equipment Calibration Date

Figure 5.89 – Hearing Screening Program Report

HLT615 – Vision Screening

The Vision Screening Program Report provides a count of the students who have either passed or failed all vision tests given and what is left to be completed in the comments section.

This report can be customized using the following options:

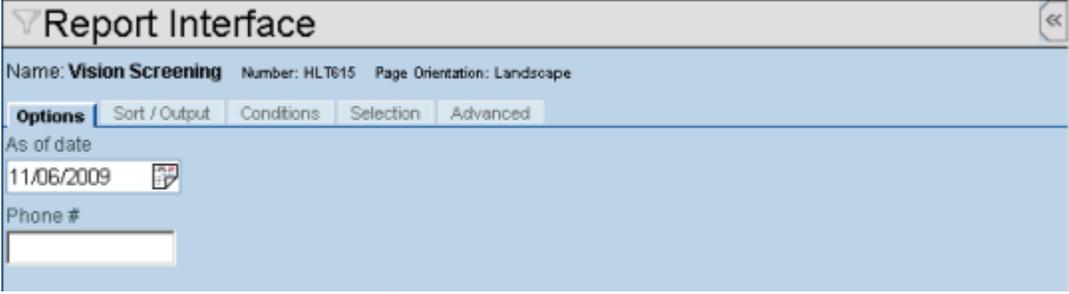


Figure 5.90 – Vision Screening Report Interface

- Select the date in the **As Of** box to show the status of the vision screenings as of that date. The date must be entered in MM/DD/YY format or they can be selected by clicking on the Calendar  button.
- Enter the **Phone #** to be contacted regarding the vision screening, as it should be printed on the report.

Vision Screening									
School	Hope High School		Phone #				School Year		2010-11
Grades	Distance Acuity		Near Acuity		Ocular Alignment		Color Deficiency		Outcomes
	Students Screened	Students referred for evaluation	Students that received care from eye care professional						
Pre K									
K									
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
Spec. Ed.									
Others									
Totals									
skb/vision screening.xls 3/2007									

Figure 5.91 – Vision Screening Report

HLT618 – Oral Health Assessment and Waiver Report

The Oral Health Assessment and Waiver Report provides a count of the students who have either passed or failed all dental tests given and what is left to be completed in the comments section. It produces both a PDF report with the totals, and a log that list each student and their status.

This report can be customized using the following options:



Figure 5.92 – Oral Health Assessment and Waiver Report Interface

- The **Kindergarten Grade** and the **First Grade** must be selected for the report to be printed.



Caution: For the HLT618 report to work correctly, the **Treatment Urgency** and **Dental Assessment** tables must be setup with the following values, as outlined in the *Synergy SIS – Health Administrator Guide* on page 48-49.

Treatment Urgency

Code	Description	Alt Code 3
0	No obvious problem	1
1	Early dental care recommended	2
2	Urgent care needed	3

Dental Assessment

Code	Description	Alt Code 3
0	Lack of access to insurance	2
1	Financial burden	1
2	Parental consent	3
3	Form not returned	4

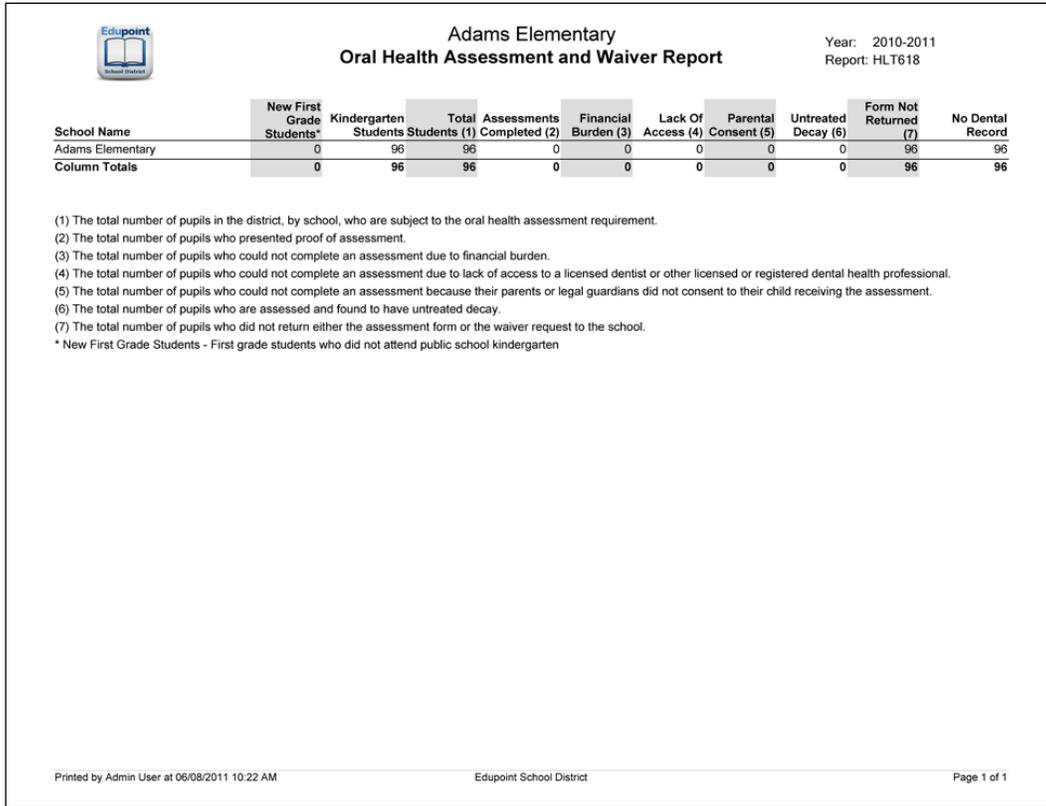


Figure 5.93 – Oral Health Assessment and Waiver Report

Student Name	SIS Number	Grade	FirstTimeInPublicSchool	NewFirstGradeStudent	AssessmentCompleted	FinancialBurden	LackOfAccess	ParentalConsent	UntreatedDecay	FormNotReturned
Adams Elementary (Adams, Lori P.)	147525	110								
Adams Elementary (Adams, Bruce)	141724	100								
Adams Elementary (Adams, Mary)	154481	100								
Adams Elementary (Arroyo Flores, Beverly)	142894	100								
Adams Elementary (Archer, Charles)	141707	100								
Adams Elementary (Arya, Rashly P.)	152094	110								
Adams Elementary (Bachman Robinson, Jason F.)	152901	100								
Adams Elementary (Bellevue, Mary S.)	157189	110								
Adams Elementary (Beltracchi, Paul D.)	144701	100								
Adams Elementary (Bittencourt, Tanny S.)	134021	110								
Adams Elementary (Bishopweber, Cheryl R.)	151191	110								
Adams Elementary (Boggs Walker, Steve L.)	151715	100								
Adams Elementary (Boggs, Clarence)	159756	110								
Adams Elementary (Bococque, Heather M.)	150725	110								
Adams Elementary (Brinkerhoff, Gloria)	150772	100								

Figure 5.94 – Oral Health Assessment and Waiver Log

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