Custom Computer Specialists
Right People. Right Results.®

Health Manual

Infinite Campus

Prepared by:
Custom Computer Specialists, Inc.
Professional Development Team

Version 1845
This manual created by
Custom Computer Specialists, Inc.
70 Suffolk Court
Hauppauge, NY 11788
www.customonline.com

Infinite Campus and Custom Computer Specialists, Inc.

About Infinite Campus

Infinite Campus is a comprehensive, Web-based K-12 student information system (SIS) with real-time access to administration, instruction, communication, curriculum, reporting and analysis, data warehousing functionality and more. For 25 years, Infinite Campus has successfully implemented its solutions for customers of all sizes. Managing 7.8 million students in 45 states, Infinite Campus is the most trusted name in student information. Infinite Campus customers range from school districts with fewer than 100 students to those with more than 600,000, as well as regional consortia, state departments of education and the federal government.

About Custom Computer Specialists, Inc.

Headquartered in Hauppauge, NY, Custom Computer Specialists, Inc., is a leading privately held Long Island based technology solution provider. Custom delivers a wide array of technology services including: project management, on-site staffing, managed services, networking and wireless solutions, desktop installation, and service and support.

Table of Contents

HEALTH

Description

The Health module allows health professionals the ability to manage and maintain student health data in Infinite Campus. The information for individual students is broken into tabs pertaining to specific parts of a student's health information. The module houses medication names and types, conditions, treatments, immunizations, screenings, and any appropriate documents such as a health action plan for a student. The module allows school health personnel to keep track of health office visits, schedule appointments, and log contact made with parents and other health professionals associated with each student.

The sample Health screens printed in this manual display the default fields. In some states there may be additional fields available for tracking state reportable information. More information is available on the Infinite Campus Community under the localization section.

Target Audience

This manual is intended for school health administrators and nurses who enter health information on students.

Objective

The purpose of this manual to assist health administration staff in understanding the different components of the Health Module.

VOCABULARY

Complaints – the reasons a student visited the health office. These are created by the health administrator at the district level and can be linked to observations and interventions.

Conditions/Flagable Conditions – medical conditions that have been reported for a student at the school. These can be temporary conditions, such as a broken arm, to more permanent conditions like allergies. Flagable Conditions are ones deemed important for all staff members, with read access to the student, to know such as an allergy.

Interventions – actions taken or allowed by the nurse when a student visits the health office but was not scheduled to do so. These are entered at the district level and can be linked to complaints and observations.

Observations – these are what the nurse visibly sees when a student visits the health office during an unscheduled visit. These are entered at the district level and can be linked to complaints and interventions.

Treatments – these are remedies used by the nurse when a student visits the health office during a visit for a pre-existing condition. These are defined at the district and/or state level.

Screenings – these are a student's check-ups, such as a physical.

Special Note:

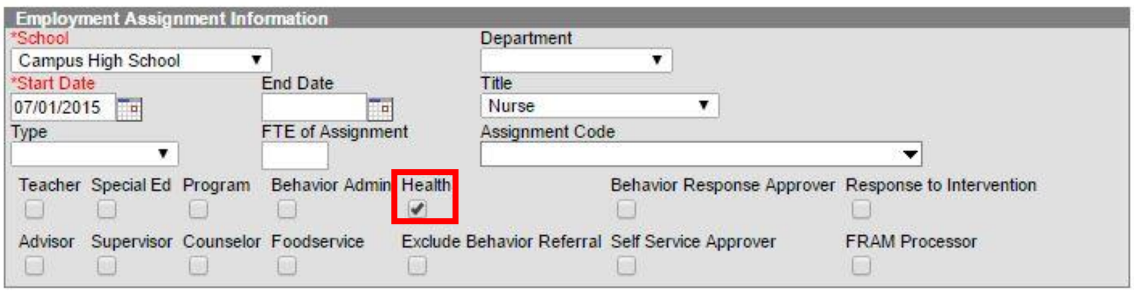
The students' health information should only be viewed and/or modified by users who have a health designation on their district assignment or are a system administrator.

ADMINISTRATIVE HEALTH SETUP

Description

This section is intended for health personnel and/or administrators tasked with determining the information to be available to the health professionals and staff. It is in this section conditions are created and flagged, medication names and forms are entered, observations, interventions, complaints, and discharge types are created. Once this is set up, it does not need to be done again but can be modified if needed.

Set up should be completed by someone who has the proper tool rights to create the elements needed and/or school health professionals who have Health checked on their District Assignments tab in *Census > People > District Assignments tab.*



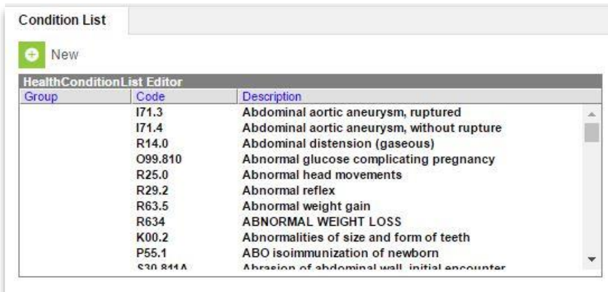
Creating Conditions

Conditions or diseases students may have, need to be created in order to be listed on the student's health tab. The Conditions may or may not require action by the health staff. Conditions that the health staff determines important for other staff to know about the student may be flagged which will put an indicator on the student  .

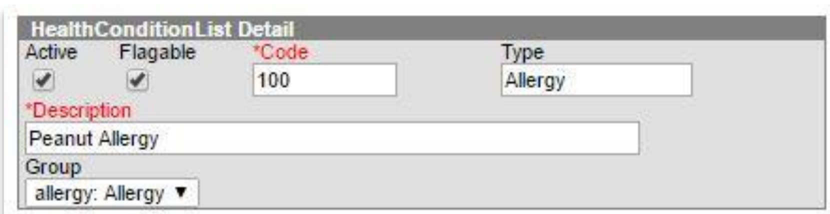
1. Navigate to *System Administration > Preferences > System Preferences* and select "Yes" in the "Flag Health Conditions" box.

2. Select whether to use ICD-9 codes, ICD-10 codes, or to create a custom list (by selecting 'No').

3. Navigate to *System Administration > Health > Condition List*. A list of ICD-9 or ICD 10 codes pre-populate in the Health Condition List Editor. If 'No' default is selected in the previous step, no codes will display. A code is considered an active code if it is displayed in bold. The list displays in alphabetical order of the Description. If a district does not use these codes and would like to make them inactive see the section on making conditions inactive on p. 7.



4. Click <New> to create a new Condition.



5. In the Health Condition List Detail there are two required fields and four others that are not necessary unless district or state law requires them to be completed.

    a. *Active*- when checked, the code becomes available to be assigned to a student.

    b. *Flagable*- when checked, this allows any user with read rights to a student to view a warning of this condition. The flag can be turned off for individual students if deemed appropriate.

    c. *Code*- can be either a district, state, or ICD code. It is a required field.

    d. *Type*- this also can be either a district, state, or ICD type. It is not a required field.

    e. *Description*- is description of the condition. Field is up to 60 characters in length. It is a required field.

   f. *Group*- If a district/state requires grouping of like conditions these will appear in the drop down. These are created in the Attribute Dictionary. It is not a required field.

6. When finished filling out the Health Condition List Detail click <Save>. The new code will populate in the list of codes in alphabetical order.

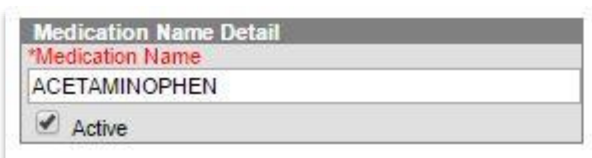
Deactivating Conditions

1. To deactivate a Condition, click on the name.
2. Uncheck <Active>.
3. Click <Save>. This will remove the condition from the options of available conditions but will not remove it from historical records or existing students.

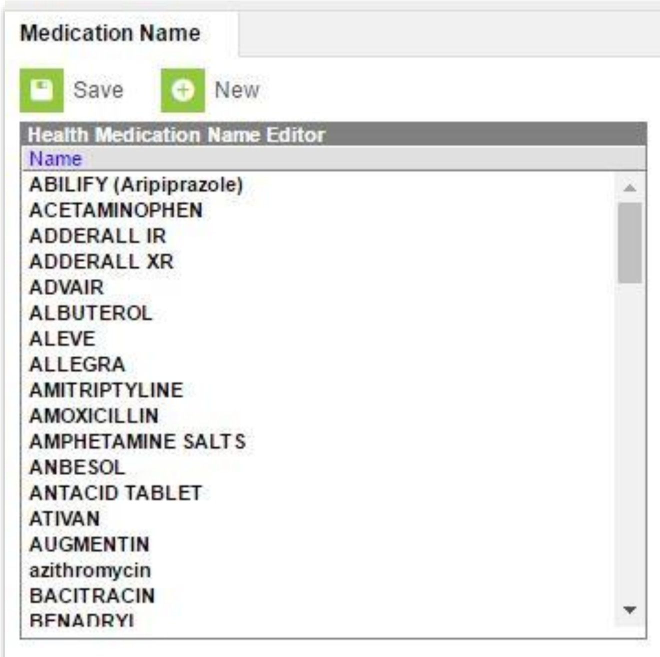
Adding and Editing Medication Names

Districts administrators create Medication Names for health staff to select when recording student health information. A medication name is recorded by health staff when a medication is given to the school's health office for disbursement during school hours. Any medication prescribed to students should be entered here for the health office to manage the medications. This information once assigned to a student can be viewed on the student's Medication tab.

1. Navigate to *System Administration > Health > Medication Name*.
2. The Health Medication Name Editor will appear. Click <New> to create a new Medication Name.
3. Type the name of the Medication as it should appear in the drop down list. This is a required field.



4. Check <Active> to make it available.
5. Click <Save>. The list will alphabetize the Medications. Active Medications will display in **bold**. Inactive Forms will display at the bottom of the list in plain text.



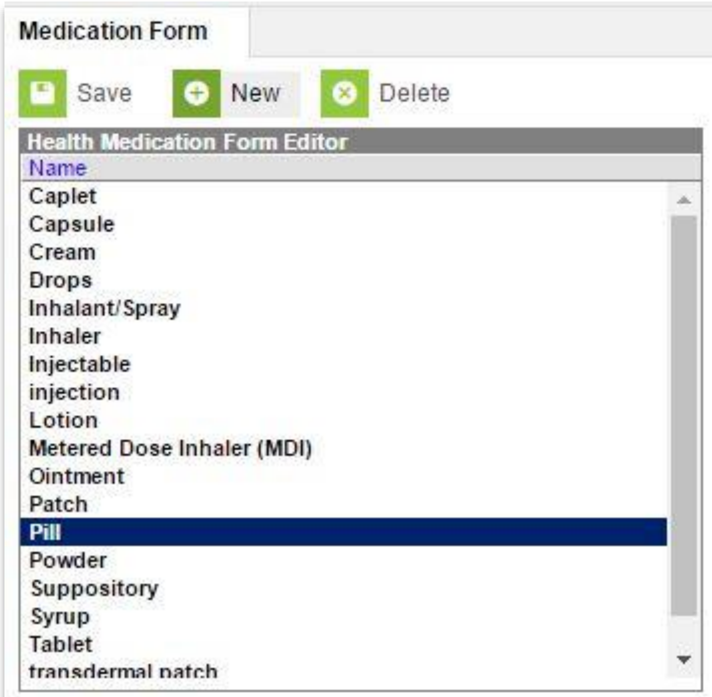
Note: To edit an existing Medication Name click on it, make the appropriate edits, and click <Save>.

Adding and Editing Medication Forms

Medication Forms refers to the different physical types of medications given to students. This information once assigned to a student can be viewed on the student's Medication tab.

1. Navigate to *System Administration > Health > Medication Form*.
2. Click <New> to create a new Form.
3. Type the name of the Medication as it should appear in the drop down list. This is a required field.

4. Check <Active> to make it available.
5. Click <Save>. The list will alphabetize the Medication Forms. Active Forms will display in **bold**. Inactive Forms will display at the bottom of the list in plain text.

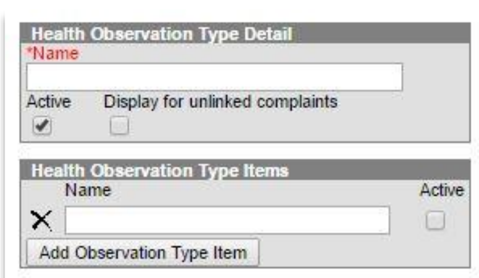


Note: To edit an existing Medication Form click on it, make the appropriate edits, and click <Save>.

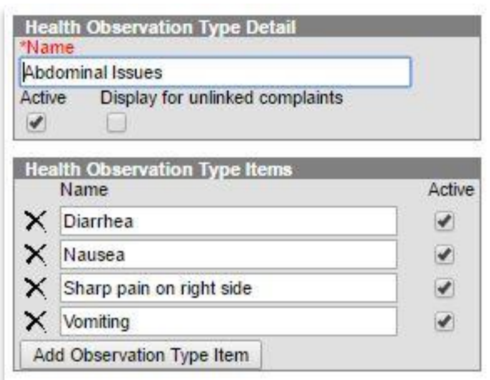
Adding and Editing Health Observation Types

Observations are assigned to a student based on a complaint when they make a health office visit.

1. Navigate to *System Administration* > *Health* > *Observation Types*.
2. The Health Observation Types list will appear. Click <New Observation Type>. Two editors will appear. The first, Health Observation Type Detail acts as a group to which the Observation Type Items belong. The second, Health Observation Type Items help the nurse determine the reason for the symptom.
3. In the Health Observation Type Detail type in the Observation Type Name as it should appear in the drop down list. This is a required field.



4. Check <Active> to make it available.
5. Check <Display for unlinked complaints> if the Observation should be an option for Complaints that are not linked.
6. In Health Observation Type Items add any of the specific Observations that apply to the Observation Type.
7. Check <Active> to make it available.
8. Click <Add Observation Type Item> to add more to the list (if necessary).
9. When finished, click <Save>.

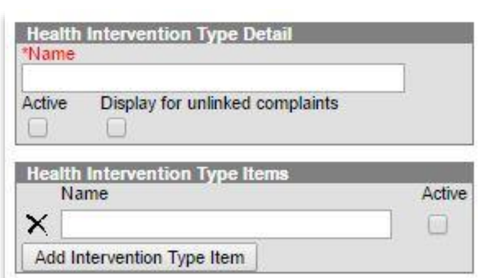


Note: To edit an existing Observation Type click on it, make the appropriate edits, and click <Save>.

Adding and Editing Health Intervention Types

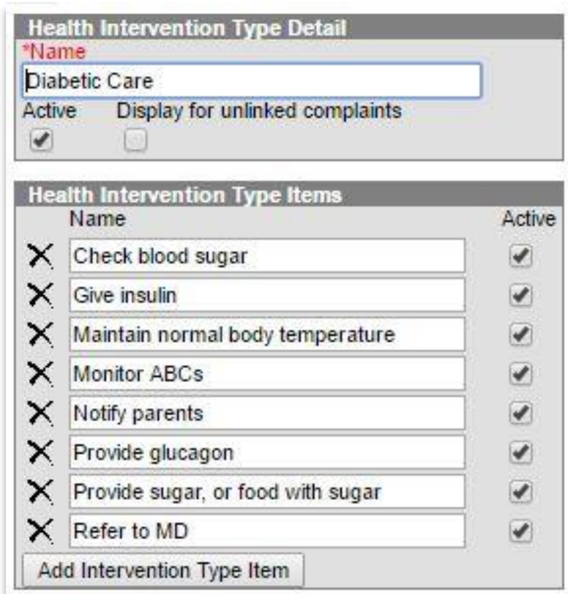
Interventions are actions taken by the health staff when a student visits the health office with a health condition.

1. Navigate to *System Administration > Health > Intervention Type.*
2. The Health Intervention Types list will appear. Click <New Intervention Type>. Two editors appear.



3. Type the Name in the Health Intervention Type Detail. This is a required field.

4. Check <Active> to make it available.
5. Check <Display for unlinked complaints> if the Intervention should be an option for Complaints that are not linked.
6. In Health Intervention Type Items add any of the specific Interventions that apply to the Intervention Type.
7. Check <Active> to make it available.
8. Click <Add Intervention Type Item> to add more to the list (if necessary).
9. When finished, click <Save>.

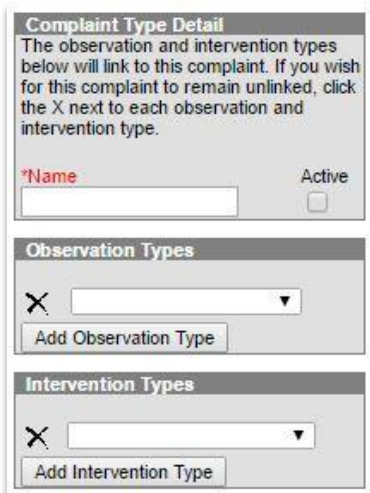


Note: To edit an existing Intervention Type click on it, make the appropriate edits, and click <Save>.

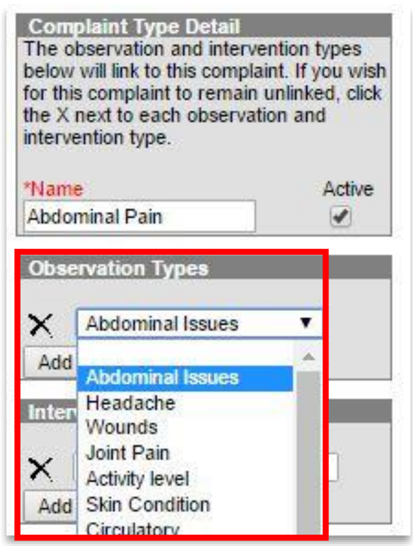
Adding, Editing, and Linking Health Complaint Types

The tool allows administrators to enter complaints a student might have when coming to the health office. These complaints can be linked to health observations and interventions.

1. Navigate to *System Administration > Health > Health Complaint Type*.
2. The Health Complaint Type Editor will appear. Click <New>.
3. Type the name of the Complaint in the Name field. This is a required field.



4. Check <Active> to make the Complaint available.
5. Select the appropriate Observation Type from the drop down list. This will link the Complaint to the Observation Type(s) selected.



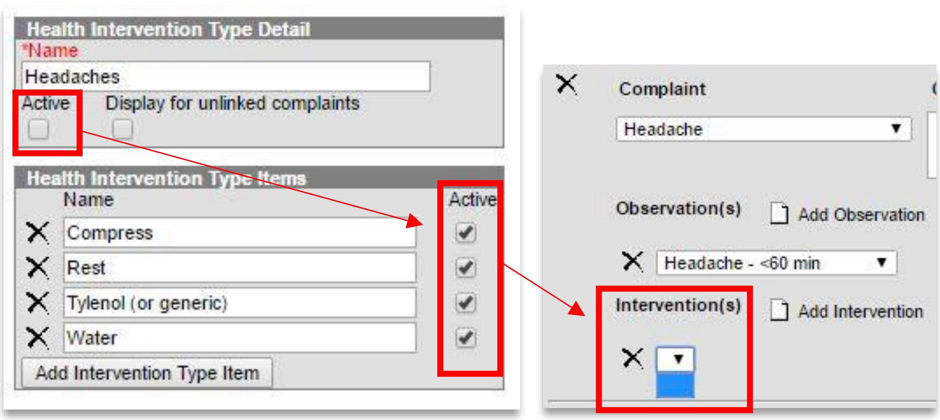
6. Click <Add Observation Type> if more are needed. Click the ✕ to delete ones that are not needed.
7. To add Intervention Types, select the appropriate Intervention Type from the drop down list. This will link the Complaint to the Intervention Type(s) selected.
8. Click <Add Intervention Type> if more are needed. Click the ✕ to delete ones that are not needed.

9. Click <Save>. The Complaints will appear in the Health Complaint Type Editor in alphabetical order. Active Complaints will appear in **bold**. Inactive ones will appear as plain text.

Note: To edit an existing Intervention Type click on it, make the appropriate edits, and click <Save>.

Special Note:

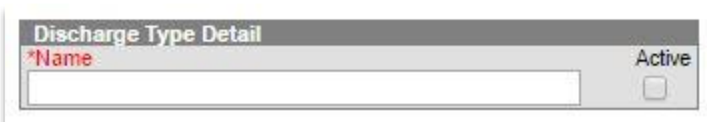
When unchecking <Active> on the Health Observation and/or Intervention Type Detail it will no longer be an option even if the Active button is checked for the Observation and/or Intervention Types.



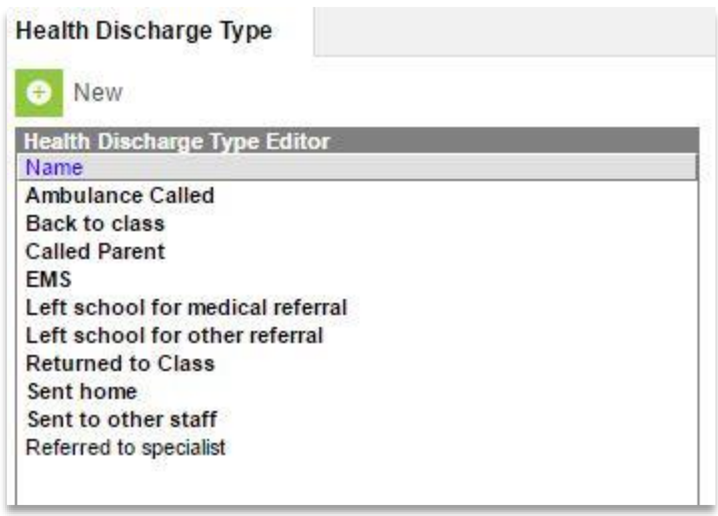
Adding and Editing Discharge Types

This tool allows administrators to enter reasons why a student was released from the health office. These will populate in a drop down list for health staff to assign to students.

1. Navigate to *System Administration > Health > Health Discharge Type*.
2. The Health Discharge Type Editor will appear. Click <New>.
3. Type the name of the Discharge Type in the Name field. This is a required field.



4. Check <Active> to make the Discharge Type available.
5. Click <Save>. The Discharge Type will appear in alphabetical order on the Health Discharge Type Editor in bold. Any inactive Discharge Types will appear at the bottom of the list in plain text.



Special Note:

If any of the health data has been assigned to a student it cannot be deleted unless the link to the student has also been deleted. Best practice is to mark the data inactive rather than delete it.

STUDENT HEALTH TABS

Student health information tabs act as a filing cabinet for all of a student's health data. Health staff can easily access a student's health information by selecting the associated tab. The information should only be viewed or modified by users who have a health designation on their district assignment or are a system administrator.

Summary Tab

The Summary tab displays the same information as the *Student Information* > *General* tab. It is like an emergency contact card for the student. It displays the demographics, address(es), phone number(s), and emergency contact(s) for the student as it has been entered in Census.

1. To view the student Summary tab, navigate to *Student Information* > *Health* > *General* > Search for a student. The Summary tab will display unless another Health tab has been previously viewed in which case the previous tab being viewed will display.

2. The Summary tab gives the health staff three printing options:
   a. *Person Summary Report*- this report generates a PDF copy of the information on the Summary Tab.
   b. *Print Mailing Label*- this generates mailing labels for the student. They are compatible with 1" x 2-5/8' labels (Avery 5160).
   c. *Print Envelope*- generates the address(es) as entered into Census for printing on a #10 envelope (4 1/8 x 9 1/2).

Example Person Summary Report

Person Summary Report

Abbate, James (Nickname: Jimmy) — **Person ID: 30878**

Gender:	M	**Student Number:**	600927208
Birth Date:	05/30/2002		
Staff Number:			

Contact Information:

Other Phone:		**Pager:**	
Work Phone:		**Email:**	
Cell Phone:		**Secondary Email:**	
Preferred Language:			

Primary Household: Abbate

Household Phone:	(555)123-1234	
Address(es):	102 CINDERELLA LN , Stonefield, NY 11790-3109	
Abbate, Teresa	Brother/Sister	
Abbate, Alice	Brother/Sister	
Abbate, Sharon	Mother/Son	Cell: (555)123-1234 Other: (555)123-1234 Work: (555)123-1234 Email: abbate@parent.com
Abbate, Peter	Brother/Brother	
Abbate, Adam	Brother/Brother	

Non-Household Relationships

Wilson, Elizabeth	Emergency Contact 1 92 QUAKER PATH East Springfield, NY 11733-1723	Home: (555)123-1234 Other: (555)123-1234 Work: (555)123-1234
Scholl, Dr. James	Doctor/Patient	Work: (555)123-1234
Abbate, William	Father/Son 401 Main Street Islip, NY 11751	Home: (516)555-2432

Race/Ethnicity Information

State Race/Ethnicity:	W:White
Federal Race/Ethnicity Designation:	6:White
Race(s):	White
Hispanic/Latino:	N:No
Race/Ethnicity Determination:	
Date Entered US:	
Date Entered US School:	

Person Comments:

Contact Information Comments:

Example Mailing Labels

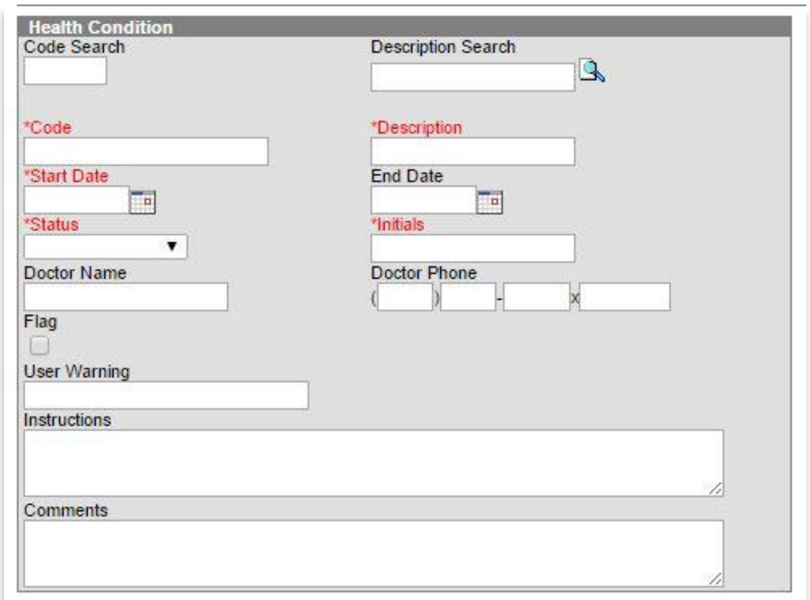
TO PARENT/GUARDIAN OF:
JAMES ABBATE
401 MAIN STREET
ISLIP NY 11751

TO PARENT/GUARDIAN OF:
JAMES ABBATE
102 CINDERELLA LN
STONEFIELD NY 11790-3109

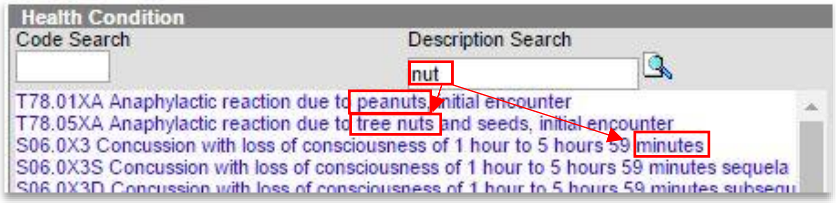
Conditions Tab

All of a student's medical Conditions reported to the health office are entered on this tab. From this tab, health staff can view, add, and/or delete conditions on a student. Treatment for the Condition and a schedule of appointments for the treatment may also be entered on this tab.

1. Navigate to *Student Information* > *Health* > *General* > *Conditions* tab.
2. The Health Conditions list will appear. To create a new Condition for a student click <New Condition>.



3. The following fields appear:
   a. *Code Search*- If the user knows the code or partial code for the Condition it can be used to search. Type it into the Code Search field and click on the magnifying glass next to Description Search. Click on the Condition to add it to the student. The Code and Description fields will auto-populate. They will be in gray text which means they cannot be edited by typing. In order to change the Condition, the user must search and select the appropriate Condition.
   b. *Description Search*- In order to fill in the Code and Description fields the user must use one of the Search fields. Partial Codes or Descriptions will yield results. For example, if a user wants to add a peanut allergy to a student the user can type "nut" in the Description Search field, click the magnifying glass icon then all Health Conditions with "nut" in the description will appear.



c. *Code*- This field will automatically populate with the district assigned or ICD code once a Condition is selected from a search. This is a required field.

d. *Description*- This field will automatically populate with the district assigned or ICD description once a Condition is selected from a search. This is a required field.

e. *Start Date*- This is the date the health office was made aware of the student's Condition. It is also used to determine whether the Condition appears in the Health Office Visits tab. This is a required field.

f. *End Date*- This is the date the health office was made aware that the Condition no longer exists/applies to the student.

g. *Status*- Choose whether or not the health condition is R: Resolved, N: Not Resolved, or U: Unknown. This is a required field.

h. *Initials*- The initials of the health office staff person entering the Condition on the student. This is a required field.

i. *Doctor Name*- Name of the student's doctor. This information is used in conjunction with Medicaid billing services.

j. *Doctor Phone*- Phone number for the student's doctor.

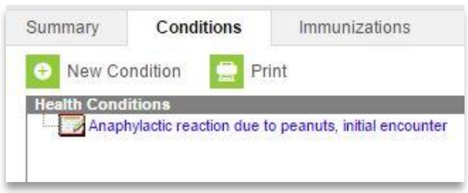
k. *Flag*- If the Condition should be marked next to the student's name this should be checked on. Flagable Conditions are determined at the district level. If this box is checked, the User Warning field becomes a required field. The indicator to the user viewing the student will see next to the student's name above the tabsets.

l. *User Warning*- When a user hovers over the Health Condition indicator on a student this warning will appear. It is not required unless it is a Flagged Condition.

m. *Instructions*- How to handle the situation if the Condition affects the student during the school day. For other staff members to see these they will have to click on the Health Condition indicator on the student.

n. *Comments*- Additional comments related to the Condition. These do not display to any other users but can be pulled out in reports.

4. Click <Save Condition>. The Condition will appear in the Health Conditions List.



5. To edit the Condition, click on the name of the Condition, make the necessary changes and click <Save>.

Special Note:

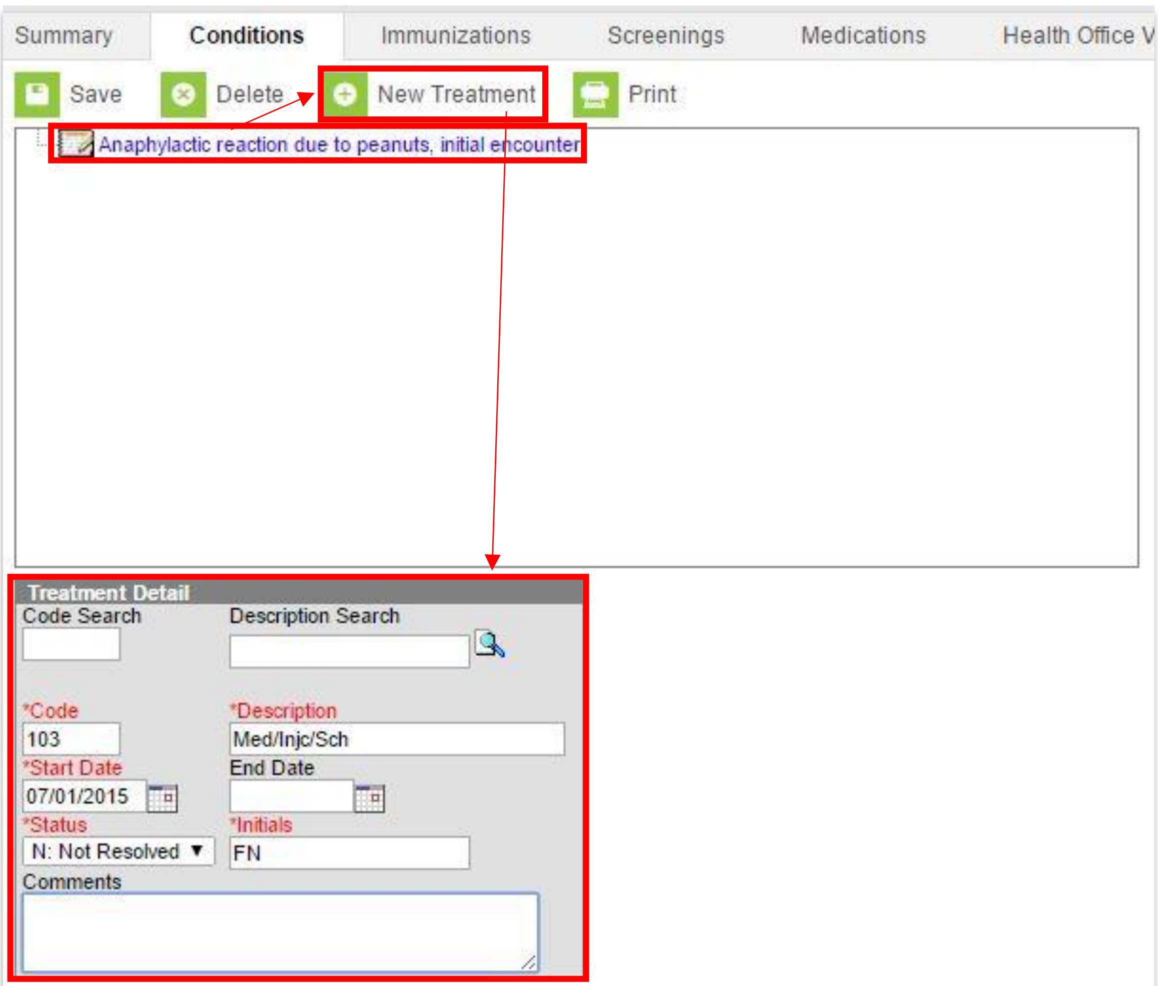
If a student has more than one flagged Health Condition, only one EMT symbol will display. All User Warnings will be listed when hovered over.

Adding and Editing Treatments on the Conditions Tab

Treatments are considered any reason a student may need to visit the health office for an intervention due to a Condition. Treatments may be assigned for Conditions on the Conditions tab. The Treatment should describe what needs to happen each time the student receives the Treatment. Each time the Treatment is administered to the student, it should be entered on the Health Office Visit tab.

1. To add a Treatment to the Condition, click on the name of the Condition and click <New Treatment>.
2. A Treatment Detail box will display with Code Search and Description Search. These function the same as the Search fields for Conditions. Type in either the Code or Description in whole or in part and click the magnifying glass to search. Note: This is <u>not</u> a search for Medications.
3. Select the appropriate Treatment from the list. This will auto-populate the Code and Description fields in the Treatment Detail. Code and Description are required fields.
4. Enter the Start Date, the date the school was notified of the treatment. This is a required field.
5. Enter an End Date only if the treatment is temporary or no longer applies to the Condition.
6. Type the Initials of the person who is entering the information on the student. This is a required field.
7. Comments can be additional information related to the Treatment.

8. Click <Save>. The Treatment will display under the Condition. Repeat for additional Treatments.
9. To edit a Treatment, click on the Treatment name, make the appropriate edits, and click <Save>.



Scheduling Treatment Appointments on the Conditions Tab

The Treatment must be linked to a Condition in order for an appointment to be scheduled. This would be done for single and recurring appointments.

1. While on the Conditions Tab, click on the name of the Treatment.
2. Click <Schedule Appointments>.
3. Date and Appointment Time are required fields. The default data populates with the current the Date and Time but can be modified for future dates and times.
4. Select how often the appointment should occur.

a. *Single Appointment*- the student only has to come in the one time for the Treatment. This is the default option.

b. *Daily*- the student has to come in every day or only certain days for the Treatment. For example, the student only has to take the medication every other day.

c. *Weekly*- the student has to come in once weekly, bi-weekly, etc. for the Treatment.

d. *Monthly*- the student has to come in on the same date once per month for the Treatment.

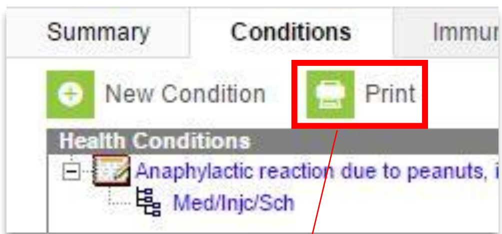
e. *Recurrence*- The default is to repeat until the end of the school year. The user may also choose the option to repeat the student visit a certain number of times for the Treatment.

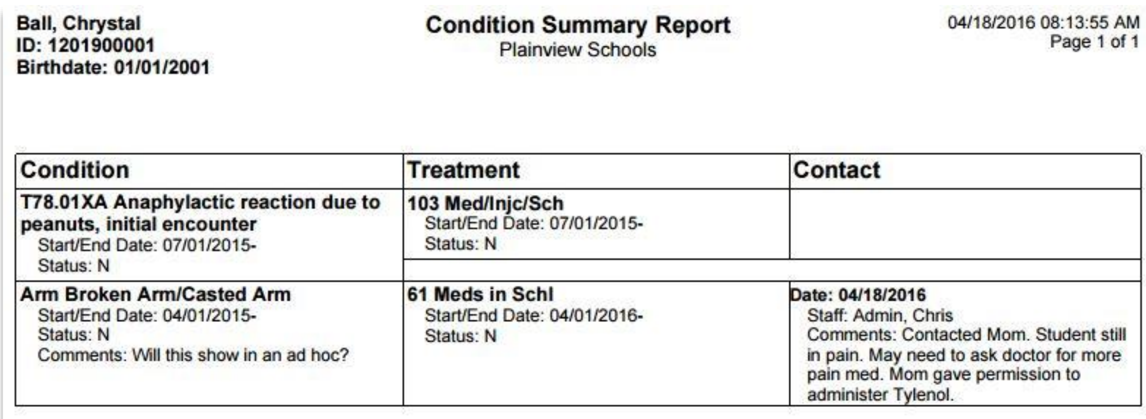
5. Comments can be added and applied to all appointments. These will print on reports. An example where this might be useful would be if a student needs to take a medication with food, the health staff could enter it in this text box.
6. The “Cancel previously scheduled appointments” box, if checked, will cancel any appointments linked to this Treatment after the current date and time. Previously scheduled appointments may also be canceled by selecting the checkbox at the bottom of the Schedule Appointments editor.
7. Select <Save>. The newly scheduled appointment will then display on the Health Office Calendar.

Note: If a student is scheduled to come in for a visit on a non-instructional and/or non-attendance days, the system will display a warning message that allows users to view the date(s) of the appointment(s) that could not be scheduled.

Printing from the Conditions Tab

Health staff may print an individual student's Condition and Treatment Summary. The information shown on the report includes Conditions, Treatments, and Contact that has been made in association with the Condition.





Ball, Chrystal
ID: 1201900001
Birthdate: 01/01/2001

Condition Summary Report
Plainview Schools

04/18/2016 08:13:55 AM
Page 1 of 1

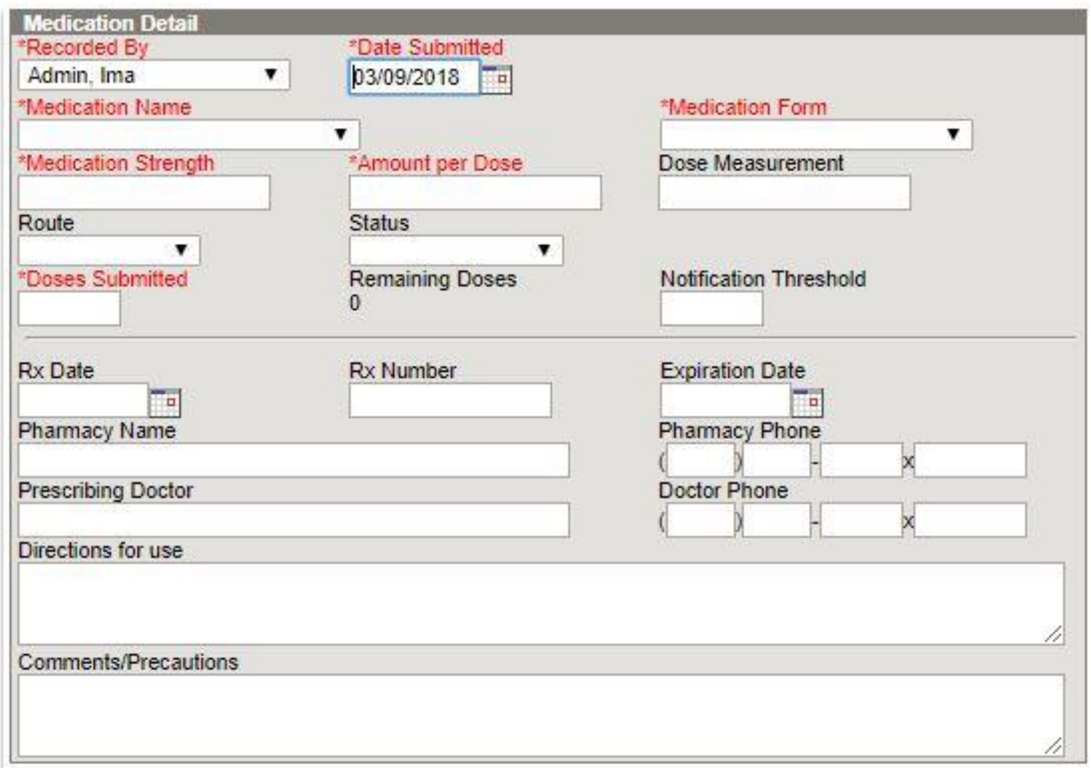
Condition	Treatment	Contact
T78.01XA Anaphylactic reaction due to peanuts, initial encounter Start/End Date: 07/01/2015- Status: N	**103 Med/Injc/Sch** Start/End Date: 07/01/2015- Status: N	
Arm Broken Arm/Casted Arm Start/End Date: 04/01/2015- Status: N Comments: Will this show in an ad hoc?	**61 Meds in Schl** Start/End Date: 04/01/2016- Status: N	**Date: 04/18/2016** Staff: Admin, Chris Comments: Contacted Mom. Student still in pain. May need to ask doctor for more pain med. Mom gave permission to administer Tylenol.

Medications Tab

Any medications a student has been prescribed to take while in school will be entered and stored on the Medications tab. The tab allows the health office staff to keep track of the number of doses a student has available and to schedule appointments for taking the medication. The Medication Names and Forms of Medication must be set up in *System Admin > Health* before they can be added on this tab.

Viewing and/or Creating Medications on the Medications Tab

1. To create a new Medication on a student, navigate to *Student Information > Health > General > Medications* tab.



2. Click <New>. The Medication Detail will display with various fields to fill in.
   a. *Recorded By*- this is the person entering the Medication on the student. Default is the current user but any user with an active Health District Assignment may be selected. It is a required field. If a user is no longer employed by the district the name will be displayed in red text with their active employment dates.
   b. *Date Submitted*- when the medication was brought to the health office. The default is the current date but it may be edited. It is a required field.

c. *Medication Name*- drop-down list of Medications created by the district. Choose the name of the Medication to be administered to the student. It is a required field.

d. *Medication Form*- drop-down list of Medication Forms created by the district. Choose the form of the Medication that will be given to the student. It is a required field.

e. *Medication Strength*- this is the amount per dose. For example, if one ibuprofen tablet is 100 mg, the strength is 100, even if what is prescribed is 400mg. This field cannot be edited once the record is saved. It is a required field.

f. *Amount per Dose*- total number of the medication given to the student per dose. For example, if the strength is 100mg but the prescription is for 400mg, the amount per dose would be 4. If dosage amount varies, put the smallest dose amount. This field allows up to five numbers before a decimal and three numbers after. This is a required field.

g. *Dose Measurement*- this is the unit of measurement for the medication. For example, milligrams (mg), milliliters (mL), etc. This is not a required field. This may also be entered in the Medication Strength field.

h. *Doses Submitted*- this is how many doses were given to the health office. It is a required field.

i. *Route*- this is how the medication is to be administered. The options on the list are customizable at the admin level. This field remains editable until there is a value entered. Once a value is entered and saved, this field becomes read-only.

j. *Status*- this field indicates the administration status or frequency of the medication. The options on the list are customizable at the admin level.

k. *Remaining Doses*- this field will auto-populate with the amount of doses available when a change is made to the dosage. For example, a student comes in to take the medication, the nurse marks the visit on the Health Office Calendar, the dosage count will decrease.

l. *Notification Threshold*- if the medication is for an ongoing treatment and will need to be replenished as the quantity runs out, enter a value in this field. Be sure to provide a sufficient cushion as to allow the parent/guardian to bring in additional doses. This does not notify the parent/guardian. It is only a notification for health office staff that the dosage available is running low. The medication will display in red in the list editor. The health office staff will need to notify the parent/guardian to bring in more.

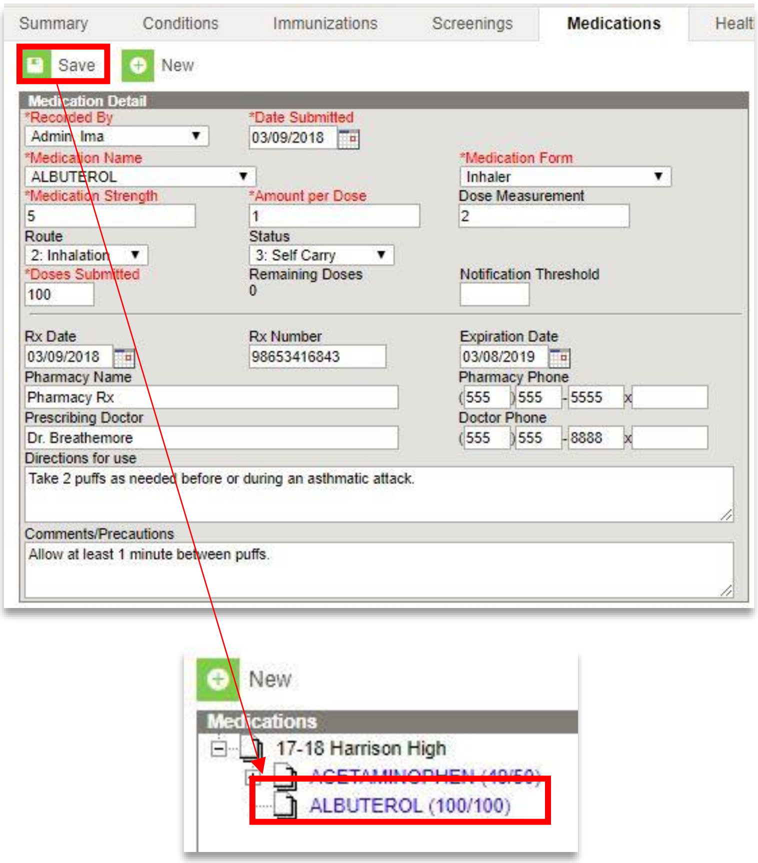
The following fields are details about the Prescription. These fields are not required by Infinite Campus.

m. *Rx Date*- this is the date the prescription was assigned.
n. *Rx Number*- this is the prescription number assigned typically assigned by the filling pharmacy.
o. *Expiration Date*- this is the date the prescription expires.
p. *Pharmacy Name*- this is the name of the pharmacy that filled the prescription or the name of the pharmacist.
q. *Pharmacy Phone*- this is the phone number of the pharmacy.
r. *Prescribing Doctor*- the name of the doctor who prescribed the medication.
s. *Doctor Phone*- the phone number of the doctor who prescribed the medication.
t. *Directions for Use*- instructions for giving the medication.
u. *Comments/Precautions*- additional comments for the medication.

3. Once the detail has been filled in click <Save>. The medication will appear in the Medications list under the current school year and also be an option for the nurse to select when entering Health Office Visits in the Health Office Calendar.

Special Note:

If the dosage of a medication has changed or if the medication strength has changed, a new medication record will need to be created. The existing one cannot be modified. Any scheduled Health Office Visits will also need to be cancelled and new ones scheduled.

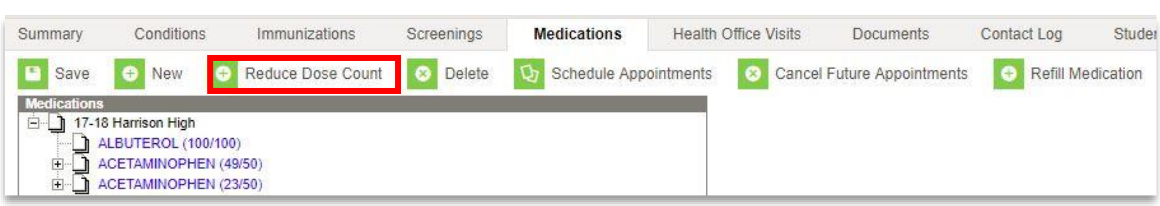


Managing Medications

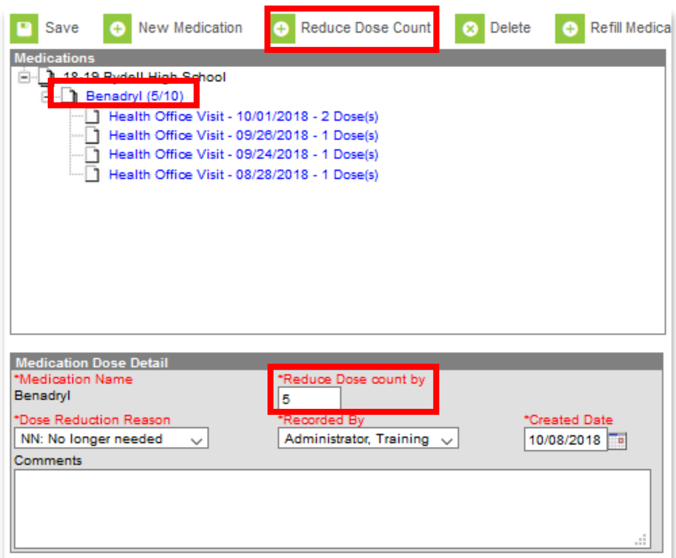
Refills, spillage, or the expiration of medications may be tracked on the Medications tab. This option allows health staff to utilize the same medication information without the need to set up a new medication. Health staff may also adjust the available amount of dosages on the Medications tab.

Scenario 1: Parent comes in to retrieve remaining Doses after no longer needed.

1. While on the Medications tab, click on the name of the medication that needs to be modified. The medication detail will appear. Information that had previously been saved will display.

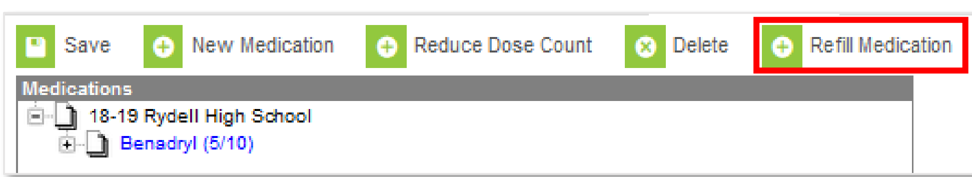


2. Click on <Reduce Dose Count>. The Medication Dose Detail will display. The name of the Medication will be auto-populated as will the name of the person recoding the information.
3. Fill in the Reduce Dose count by field with however many doses returned.
4. Select the Dose Reduction Reason from the drop-down.
5. Fill in any Comments if necessary.
6. Click <Save>. The amount of available dosages will automatically be adjusted to reflect the change.

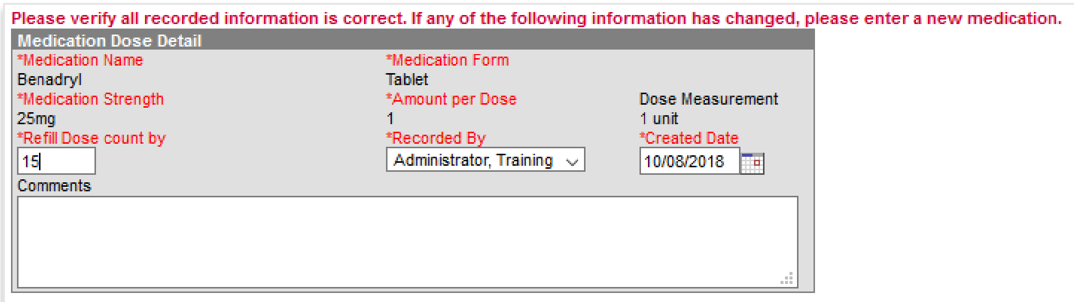


Scenario 2: A parent brings in more Medication to replenish the supply.

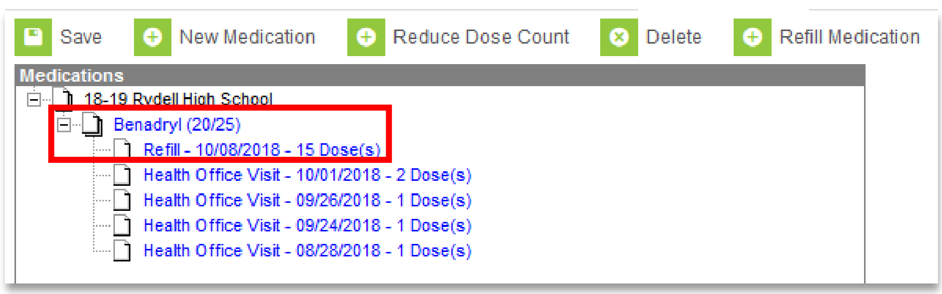
1. While on the Medications tab, click on the name of the medication that needs to be modified. The medication detail will appear. Information that had previously been saved will display.



2. Click on <Refill Medication>. A warning message will display asking the user to verify all recorded information is correct. If it is, proceed to the next step. If it has changed (e.g. strength, amount per dose, etc.) create a new Medication.



3. Fill in the amount of doses brought to the health office in the Refill Dose count by field.
4. Adjust the Recorded By, if different than the current user.
5. Type any comments pertaining to the Medication refill if needed.
6. Click <Save>. A warning to check the expiration date on the Medication will appear if one was entered on the original record. The dose amount will automatically be adjusted.



Scheduling Appointments for Medications on the Medications Tab

Similar to the Conditions tab, if a student has to take Medication at a certain time of the school day it can be scheduled on the Medications tab.

1. While on the Medications tab, click on the name of the medication that needs to be scheduled.
2. Click <Schedule Appointments>. The Schedule Appointments editor will appear.
3. Date and Appointment Time are required fields. The default data populates with the current the Date and Time but can be modified for future dates and times. Multiple times can be created by selecting the <Add> button.
4. Select how often the appointment should occur.
    a. *Single Appointment*- the student only has to come in the one time for the Medication. This is the default option.

   b. *Daily*- the student has to come in every day or only certain days for the Medication. For example, the student only has to take the medication every other day.

   c. *Weekly*- the student has to come in once weekly, bi-weekly, etc. for the Medication.

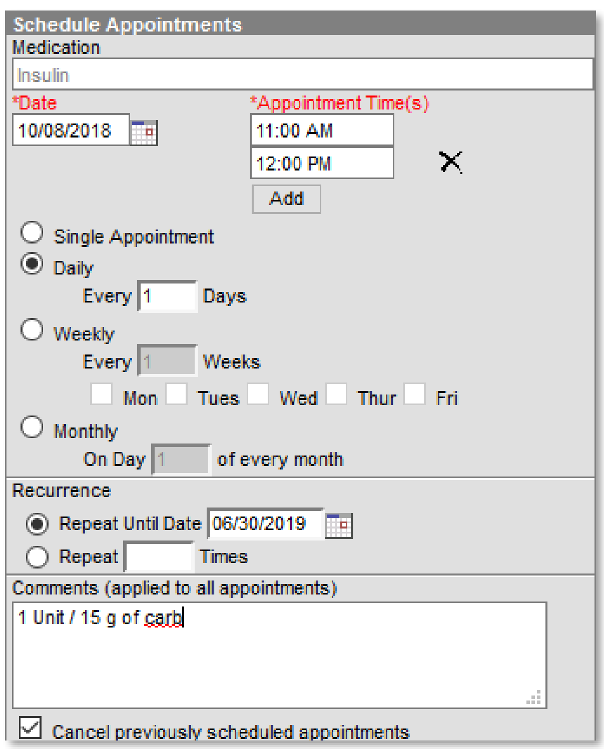
   d. *Monthly*- the student has to come in on the same date once per month for the Medication.

   e. *Recurrence*- The default is to repeat until the end of the school year. The user may also choose the option to repeat the student visit a certain number of times for the Medication.

5. Comments can be added and applied to all appointments. These will print on reports. An example where this might be useful would be if a student needs to take a medication with food, the health staff could enter it in this text box.

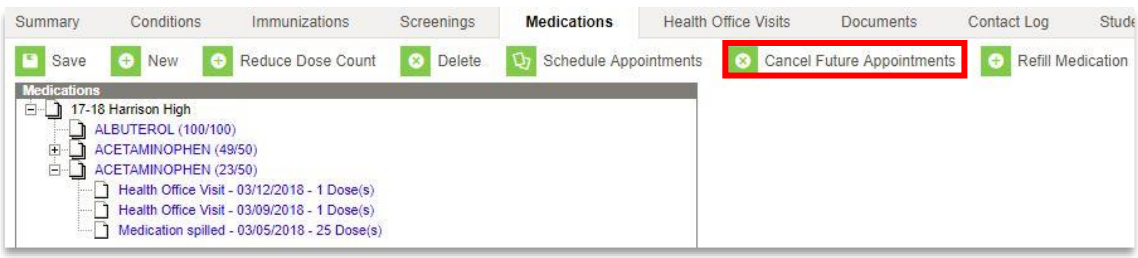
6. The “Cancel previously scheduled appointments” box, if checked, will cancel any appointments linked to this Medication after the current date and time. Previously scheduled appointments may also be canceled by selecting the checkbox at the bottom of the Schedule Appointments editor.

7. Select <Save>. The newly scheduled appointment will then display on the Health Office Calendar.



Canceling Scheduled Appointments on the Medications Tab

1. To cancel appointments, click on the name of the Medication.
2. Click <Cancel Future Appointments>. The Cancel Scheduled Appointments editor will appear.
3. Select on or after which date appointments should be cancelled.
4. Click <Save>. This will cancel all appointments linked to this medication.



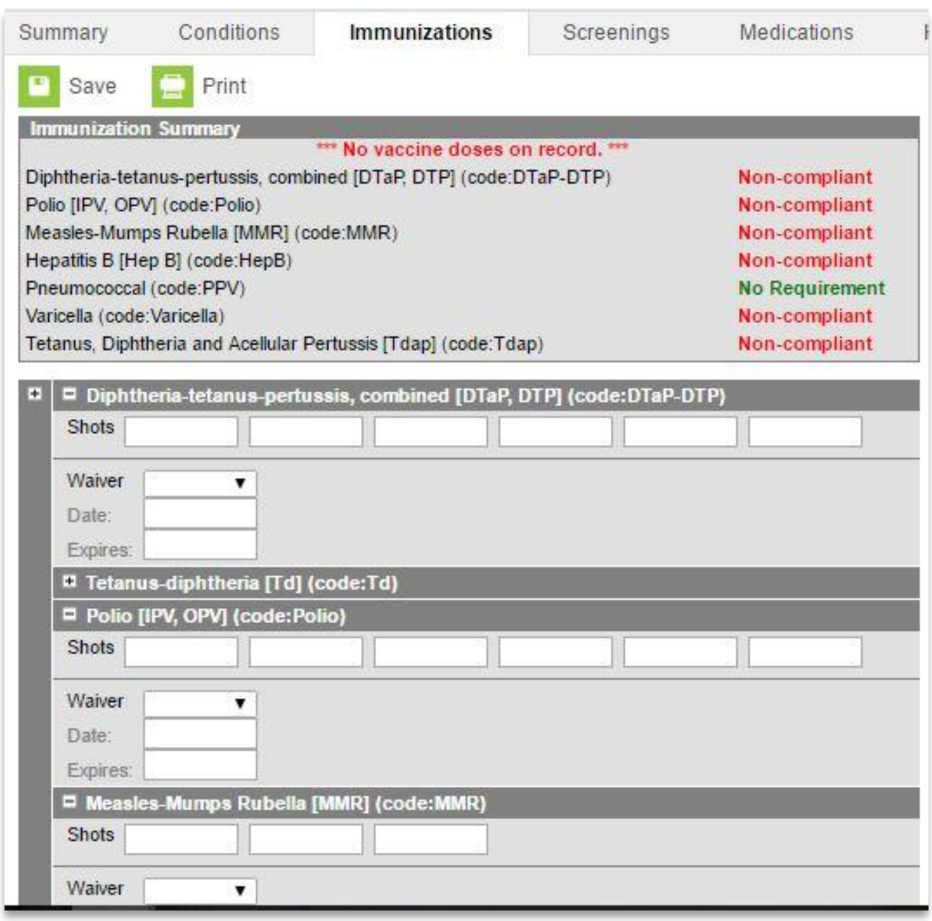
Note: If a student is scheduled to come in for a visit on a non-instructional and/or non-attendance days, the system will display a warning message that allows users to view the date(s) of the appointment(s) that could not be scheduled.

Immunizations Tab

The Immunizations tab displays the student's current level of immunization compliance based on state requirements at the time the student enrolled in school, his/her age, and the student's documented doses of a vaccine. Health staff entering students who are exempt from certain vaccines will have the option to choose the exempt and the reason for exemption. Vaccines considered non-compliant are automatically expanded, allowing users to add these dates of vaccinations. Infinite Campus will make any needed State and/or Federal compliance updates. Immunizations may be entered by hand or by using the Immunization Import tool.

Entering Immunizations and/or Waivers on the Immunizations Tab

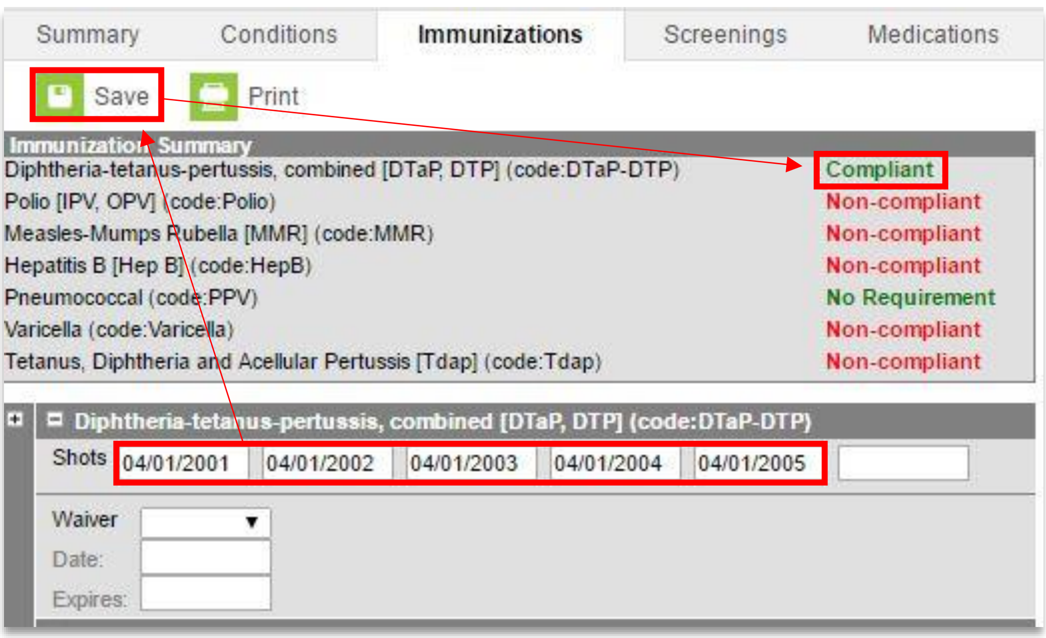
1. Navigate to *Student Information* > *Health* > *General* > *Immunizations* tab.
2. At the top of the tab an Immunization Summary will display showing the student's compliancy with certain vaccines. Underneath will be Immunization details. It is in the details where health staff enters information regarding the Immunizations.

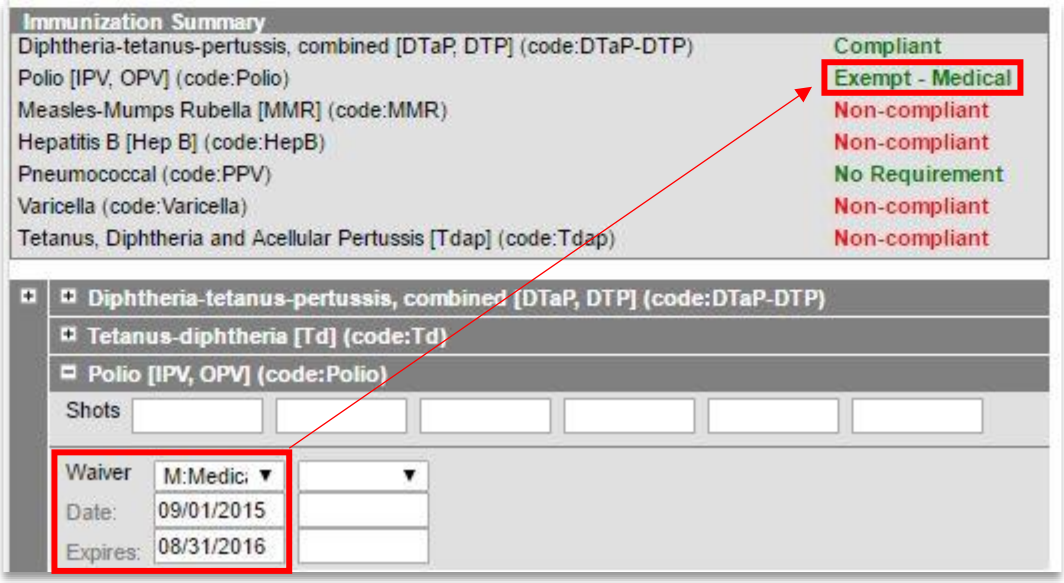


NOTE: To determine immunization compliancy, Infinite Campus uses the rules that apply at the time a student first enrolls in school.

3. Health office staff may enter the data on the appropriate vaccine. In the date fields and those labeled "Shots" dates may be entered in mmddyy format without slashes. The system will convert them to mm/dd/yyyy.

4. Click <Save>. When a student has achieved compliancy, the system will change the display from "Non-Compliant" in red text to "Compliant" in green text or "Exempt- *Status*" in green text if a waiver has been assigned. Note: Vaccine exemption codes vary state by state. These can be created in *System Administration > Health > Vaccine Exemptions.*



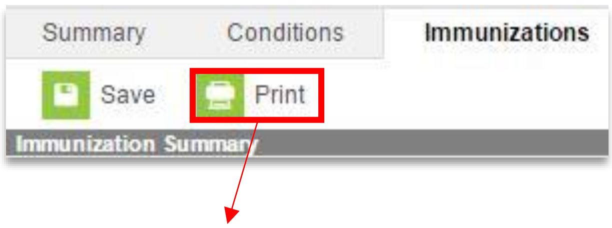


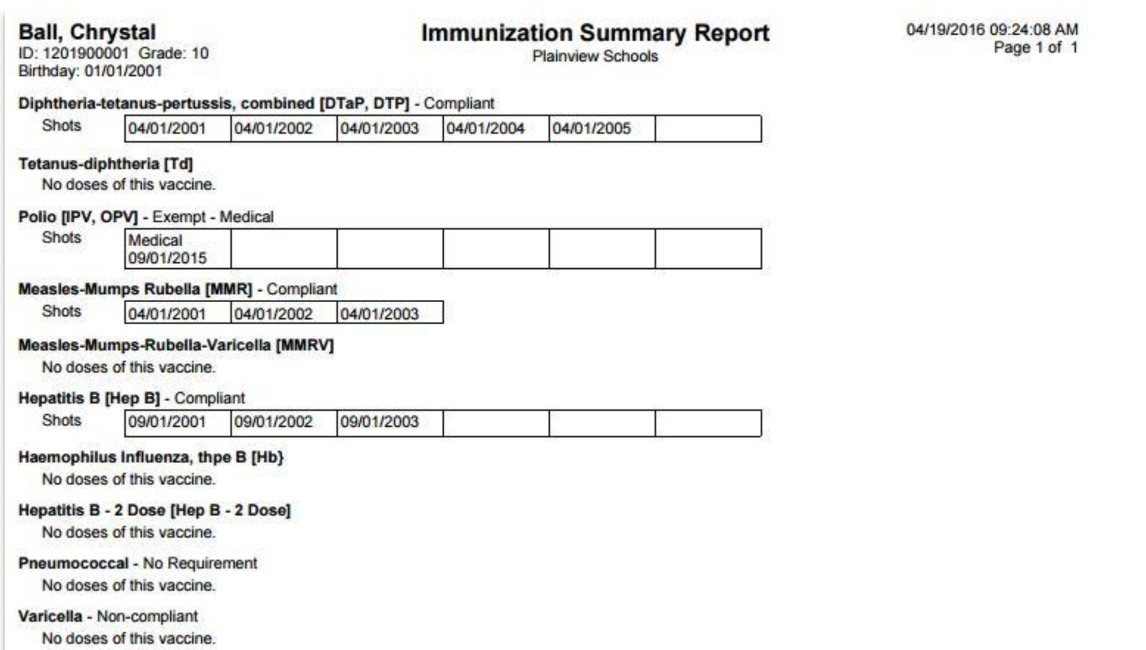
Special Note:

If a student is exempt from a vaccine and a waiver has been selected, the health staff must enter a date they were informed of the exemption. Some states may require an expiration date for the exemption.

Printing Individual Student Immunizations from the Immunizations Tab

1. Navigate to *Student Information* > *Health* > *General* > *Immunizations* tab.
2. Select the <Print>. This will generate a PDF summary report of the student's Immunization records including the date and type of vaccine the student received.





Ball, Chrystal
ID: 1201900001 Grade: 10
Birthday: 01/01/2001

Immunization Summary Report
Plainview Schools

04/19/2016 09:24:08 AM
Page 1 of 1

Diphtheria-tetanus-pertussis, combined [DTaP, DTP] - Compliant

Shots	04/01/2001	04/01/2002	04/01/2003	04/01/2004	04/01/2005	

Tetanus-diphtheria [Td]
No doses of this vaccine.

Polio [IPV, OPV] - Exempt - Medical

Shots	Medical 09/01/2015					

Measles-Mumps Rubella [MMR] - Compliant

Shots	04/01/2001	04/01/2002	04/01/2003

Measles-Mumps-Rubella-Varicella [MMRV]
No doses of this vaccine.

Hepatitis B [Hep B] - Compliant

Shots	09/01/2001	09/01/2002	09/01/2003			

Haemophilus Influenza, thpe B [Hb}
No doses of this vaccine.

Hepatitis B - 2 Dose [Hep B - 2 Dose]
No doses of this vaccine.

Pneumococcal - No Requirement
No doses of this vaccine.

Varicella - Non-compliant
No doses of this vaccine.

✍ Special Note:

A nightly script now runs automatically in the active database to calculate a student's compliancy in each tracked vaccine. The results of this script can be viewed using an Ad hoc Filter.

Health Screenings Tab

The Screenings tab stores health screening information for a student. If a screening has been completed in the past, it will be shown within the Screening History window. When a certain type of screening is selected from the dropdown list, only the areas requiring data entry will open.

Entering Health Screening Results on the Screenings Tab

Screenings are broken down by type. For example, Sports Physical, Vision, Hearing, etc.

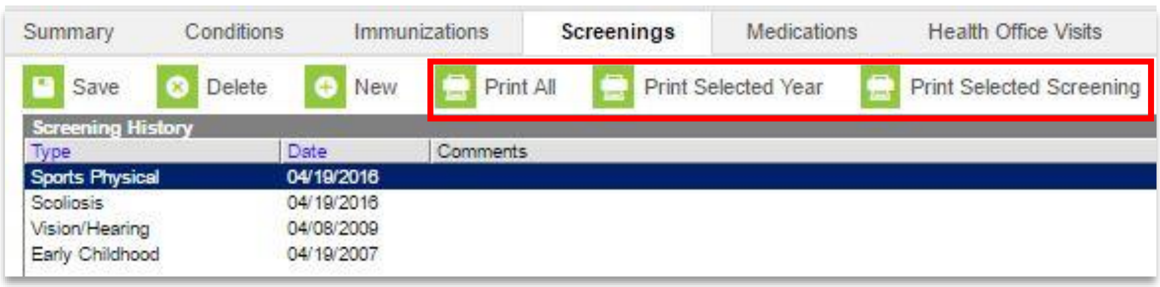
1. Navigate to *Student Information* > *Health* > *General* > *Screenings* tab.
2. Click <New>. A Screening Detail will appear below the Screening History window.
3. Enter the date of the Screening. The current date is the default.
4. Select the Type of Screening from the drop down. Once a Screening has been selected. The appropriate area(s) will expand below.
5. If needed, type any comments in the Comments box. These will display on the Screenings History window and print out in reports.
6. Fill in the necessary information. No information is required so health staff can enter as much or as little as is needed.
7. Click <Save>. The Screening will appear in the Screening History window.

Special Note:

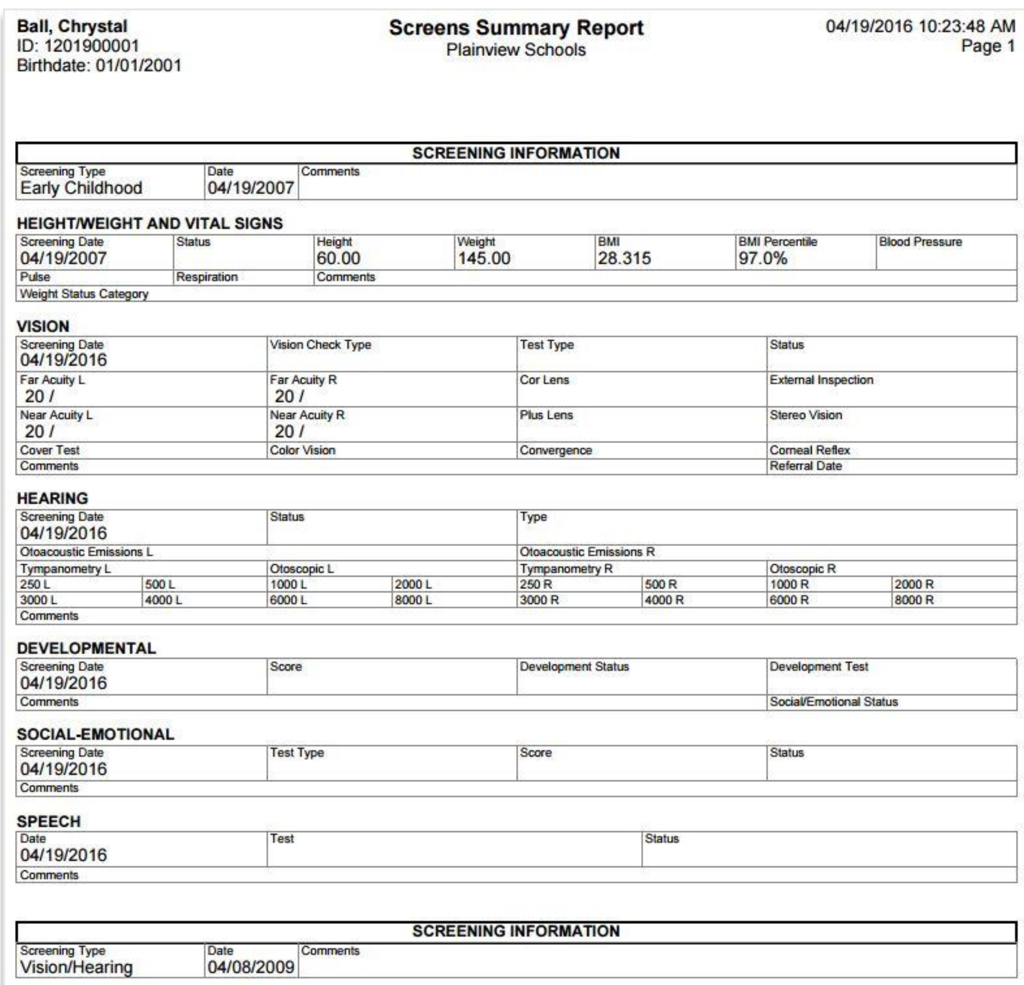
When filling in the Height/Weight and Vital Signs section, BMI will auto-calculate when Height and Weight fields are filled in. The BMI percentile cannot be calculated for non-binary gendered students. When creating or updating a Health Screening that includes the sub-screening for Height/Weight and Vital Signs for a student with gender that is not Male or Female, the user receives a message, "BMI percentile can only be displayed for students with gender of M or F." The user can Save the record without the BMI percentile calculation populated.

Printing Health Screening Results from the Screenings Tab

There are three options for printing from the Screenings tab: Print All, Print Selected Year, and Print Selected Screening. Each will generate its own PDF report.



1. The <Print All> option prints every record of saved screenings for the student. Screenings print in chronological order.



Ball, Chrystal
ID: 1201900001
Birthdate: 01/01/2001

Screens Summary Report
Plainview Schools

04/19/2016 10:23:48 AM
Page 1

SCREENING INFORMATION

Screening Type	Date	Comments
Early Childhood	04/19/2007	

HEIGHT/WEIGHT AND VITAL SIGNS

Screening Date	Status	Height	Weight	BMI	BMI Percentile	Blood Pressure
04/19/2007		60.00	145.00	28.315	97.0%	
Pulse	Respiration	Comments				
Weight Status Category						

VISION

Screening Date	Vision Check Type	Test Type	Status
04/19/2016			
Far Acuity L 20 /	Far Acuity R 20 /	Cor Lens	External Inspection
Near Acuity L 20 /	Near Acuity R 20 /	Plus Lens	Stereo Vision
Cover Test	Color Vision	Convergence	Corneal Reflex
Comments			Referral Date

HEARING

Screening Date		Status		Type			
04/19/2016							
Otoacoustic Emissions L				Otoacoustic Emissions R			
Tympanometry L		Otoscopic L		Tympanometry R		Otoscopic R	
250 L	500 L	1000 L	2000 L	250 R	500 R	1000 R	2000 R
3000 L	4000 L	6000 L	8000 L	3000 R	4000 R	6000 R	8000 R
Comments							

DEVELOPMENTAL

Screening Date	Score	Development Status	Development Test
04/19/2016			
Comments			Social/Emotional Status

SOCIAL-EMOTIONAL

Screening Date	Test Type	Score	Status
04/19/2016			
Comments			

SPEECH

Date	Test	Status
04/19/2016		
Comments		

SCREENING INFORMATION

Screening Type	Date	Comments
Vision/Hearing	04/08/2009	

2. The <Print Selected Year> option prints all records of saved screenings for the school year selected in the Campus toolbar.

Ball, Chrystal
ID: 1201900001
Birthdate: 01/01/2001

Screens Summary Report
Plainview Schools

04/19/2016 11:03:01 AM
Page 1

SCREENING INFORMATION

Screening Type	Date	Comments
Sports Physical	04/19/2016	

SPORTS PHYSICAL

Status	Comments
Full Participation	

SCREENING INFORMATION

Screening Type	Date	Comments
Scoliosis	04/19/2016	

SCOLIOSIS

Screening Date	Character	Type	Degree of Curve
04/19/2016	Normal	Original	
Curvature Location	Comments		

3. The <Print Selected Screening> option appears when a Screening is selected in the Screenings History window. It will print the information of the selected Screening only.

Ball, Chrystal
ID: 1201900001
Birthdate: 01/01/2001

Screens Summary Report
Plainview Schools

04/19/2016 11:04:07 AM
Page 1

SCREENING INFORMATION

Screening Type	Date	Comments
Sports Physical	04/19/2016	

SPORTS PHYSICAL

Status	Comments
Full Participation	

Health Office Visits Tab

The Health Office Visits tab allows a school to track the time and date of when a student came into the health office, when the student left, and why the student was there. From this tab, a district is able to establish a care pathway by documenting any complaints, observations, interventions or discharges related to a student's health office visit.

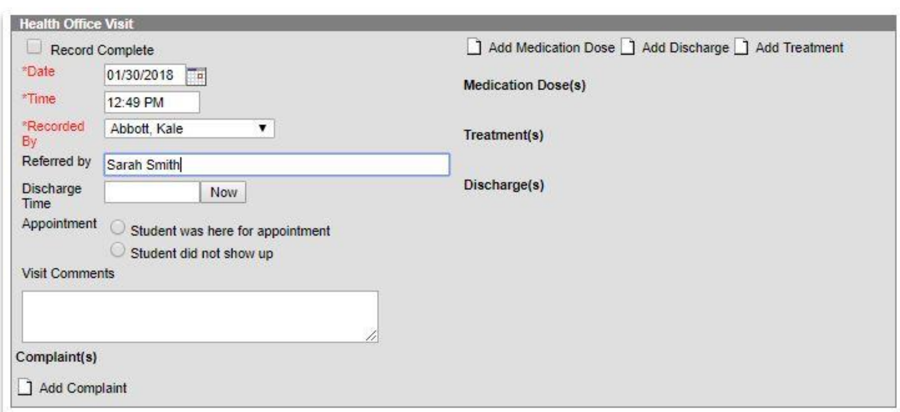
All observations and interventions are predefined by the district to assure that consistent and predictable care is offered for all students.

Entering an Unscheduled Health Office Visit

1. Navigate to *Student Information* > *Health* > *General* > *Health Office Visits* tab.

2. The Health Office Visits Editor will appear. If a student has scheduled visits those will appear at the top of the list. Completed visits will appear at the bottom of the list with a padlock icon.

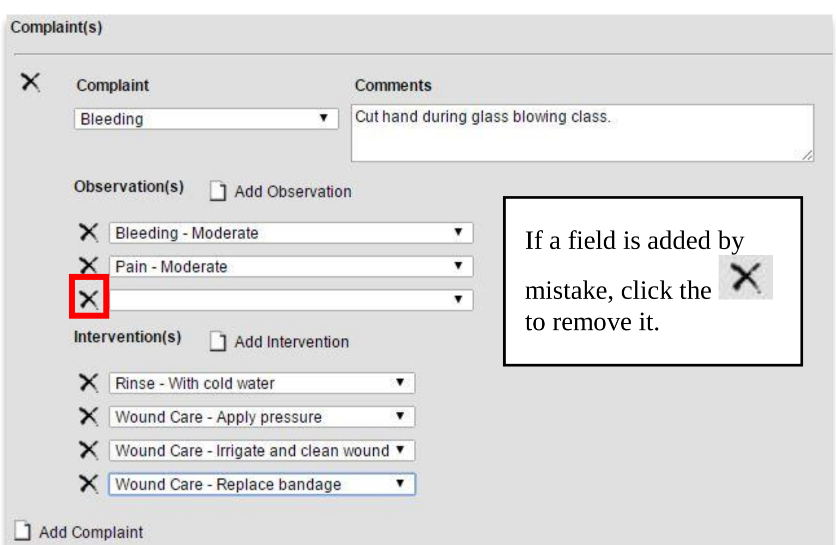
3. To enter an unscheduled Health Office Visit, click on <New>.



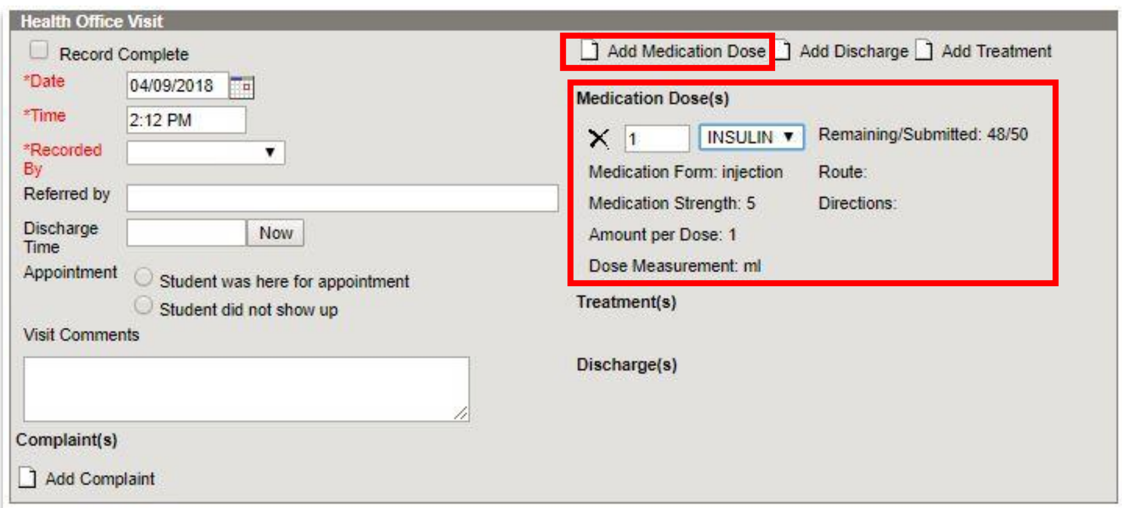
4. A Health Office Visit editor will appear.
5. The Date will automatically populate with the current Date but can be modified. It is a required field.
6. The Time will automatically populate with the current Time but can be modified. It is a required field.
7. Recorded By will default to the current user's name but this can be changed to anyone who has Health designated on their District Assignment in Census. If editing an existing office visit, the Recorded By field will display the person who originally entered the visit.
8. Referred by is a text field where the name of person who referred the student to the health office may be entered.
9. Select <Add Complaint>. Select the appropriate Complaint from the drop-down list. Reminder: The Complaints are created at the district level.
10. Enter any Comments to be associated with the Complaint, if necessary. These can be pulled out in an Ad Hoc report.

Special Note:

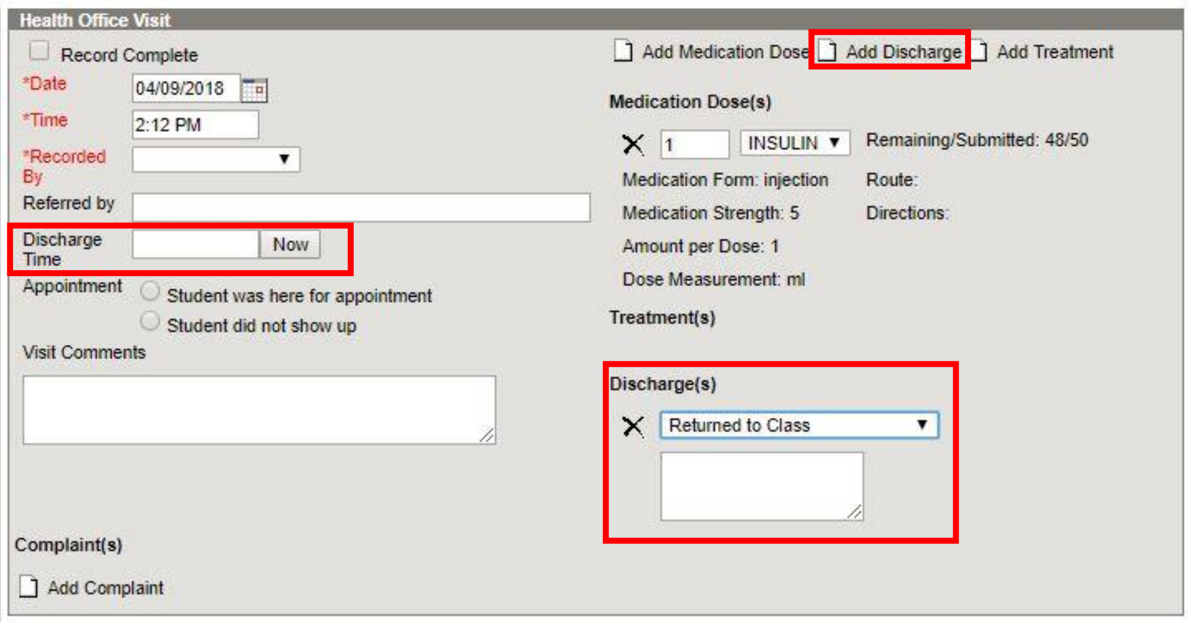
Comments attached to a complaint can be written in a word processing document and then copy/pasted into the Comments section. However, comments in this field cannot include carriage returns, as this will cause an error when saving. A carriage return results from typing "Enter" to begin a new line of text. If a comment is entered which includes carriage returns, either entered by the user or pasted from another document, a warning will appear stating that "Carriage returns are not allowed in this field." The complaint comments must be fixed before the record can be saved.



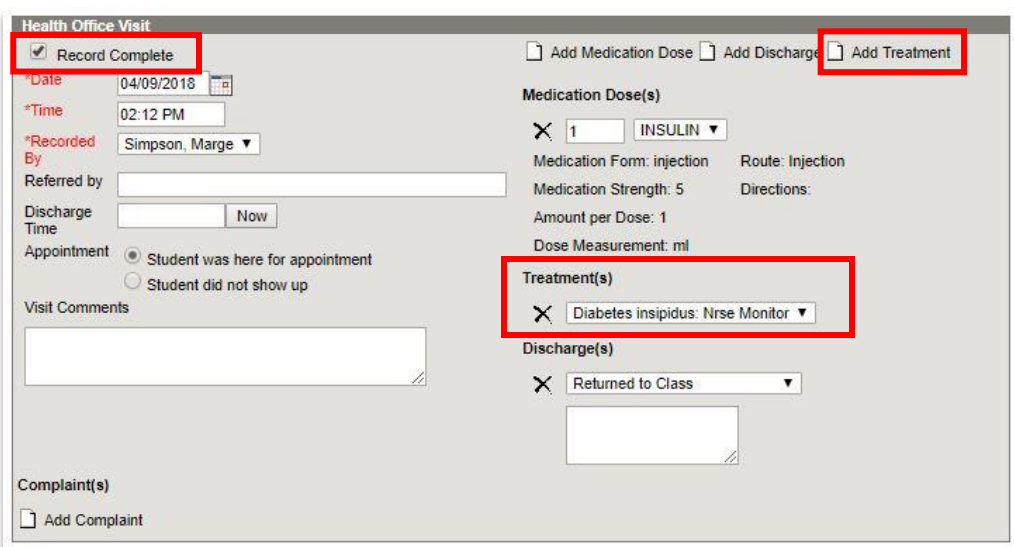
11. Attach Observation(s) to the Complaint by clicking <Add Observation> and selecting the appropriate Observation. Repeat if more than one Observation is needed. Note: Observations that are linked to the Complaint will display in the dropdown. These are determined at the district level.
12. Attach Intervention(s) to the Complaint by clicking <Add Intervention> and selecting the appropriate Intervention. Repeat if additional Interventions were provided. Note: Interventions that are linked to the Complaint will display in the dropdown. These are determined at the district level.
13. If the student's Health Office Visit has been completed and requires no additional information or modification by health staff, skip to step 21. If Medication has to be administered continue on to step 13.
14. Click <Add Medication Dose> near the top of the Health Office Visits editor window to attach medication dose(s).
15. Enter the number of doses in the left field and select the appropriate medication by using the dropdown list. Repeat if more than one medication has to be administered. Note: all medications that are on the student's Medication tab will appear in the drop down.



16. To add a Discharge option, select <Add Discharge> near the top of the Health Office Visits editor.
17. Select the appropriate Discharge from the dropdown list. Repeat if more than one Discharge option is needed. These are created at the district level.
18. Enter any additional comments about the discharge in the field to the right of the dropdown.
19. Enter a Discharge Time, if applicable. By clicking <Now> the current time will populate or health personnel may enter the time the student was discharged.



20. To add a Treatment, click <Add Treatment> near the top of the Health Office Visits editor. These are Treatments for existing Conditions on the student.
21. Select the appropriate Treatment from the dropdown list. Repeat if additional Treatments are needed.
22. If no additional information is needed, check the "Record Complete" checkbox in the upper left side of the Health Office Visit editor. This will place a lock icon next to the record under the Complete section of the Health Office Visits Editor.



23. Click <Save>. This visit will appear at the bottom of the Health Office Visits Editor with a lock next to it. It can still be viewed and modified by clicking on it, if give the proper tool rights.

Printing a Health Office Visits Report

Health personnel can print an individual student's Health Office Visits.

1. Navigate to *Student Information > Health > General > Health Office Visits* tab.
2. There are two print options:
    a. Print All- the printed report includes a summary of all of the student's Health Office Visits for the Active year.

Baker High School 04/09/2018 01:30:49 PM Page 1 of 1	Health Office Visit Report Date Range: - Sort: Total Visits: 4

Baker High School

Student Name	Complaint(s)	Observation(s)	Intervention(s)	Medications(s)	Treatment(s)
Flintstone, Pebbles				1 - INSULIN	
Recorded By: Simpson, Marge	**Date/Time:** 04/09/2018 11:45 AM	**Discharge(s):** 02:11 PM			
Flintstone, Pebbles	Appt: No show			1 - INSULIN	
Recorded By: Simpson, Marge	**Date/Time:** 06/14/2018 11:45 AM				
Flintstone, Pebbles				1 - INSULIN	Nrse Monitor
Recorded By: Simpson, Marge	**Date/Time:** 04/09/2018 02:12 PM	**Discharge(s):** Returned to Class			
Flintstone, Pebbles	Headache	Headache - light sensitivity Headache - Blurred vision	Headaches - Rest Headaches - Water		
Recorded By: Simpson, Marge	**Date/Time:** 04/02/2018 09:20 AM	**Discharge(s):** 09:50 AM Back to class			

    b. Print- when a single Health Office Visit has been selected, this button will appear and will generate a report that includes details for the selected visit only.

Baker High School 04/09/2018 01:32:06 PM Page 1 of 1	Health Office Visit Report Date Range: - Sort: Total Visits: 1

Baker High School

Student Name	Complaint(s)	Observation(s)	Intervention(s)	Medications(s)	Treatment(s)
Flintstone, Pebbles	Headache	Headache - light sensitivity Headache - Blurred vision	Headaches - Rest Headaches - Water		
Recorded By: Simpson, Marge	**Date/Time:** 04/02/2018 09:20 AM	**Discharge(s):** 09:50 AM Back to class			

Viewing and Printing Archived Health Office Visits

Health personnel have the ability to review data in report format from the Health Office Visits tab for individual students. If the district was using Campus before June of 2010, there may be health data that exists in health tables that are no longer used. This report pulls that data. This report can also be generated in batch form by generating the Archived Health Visits Report.

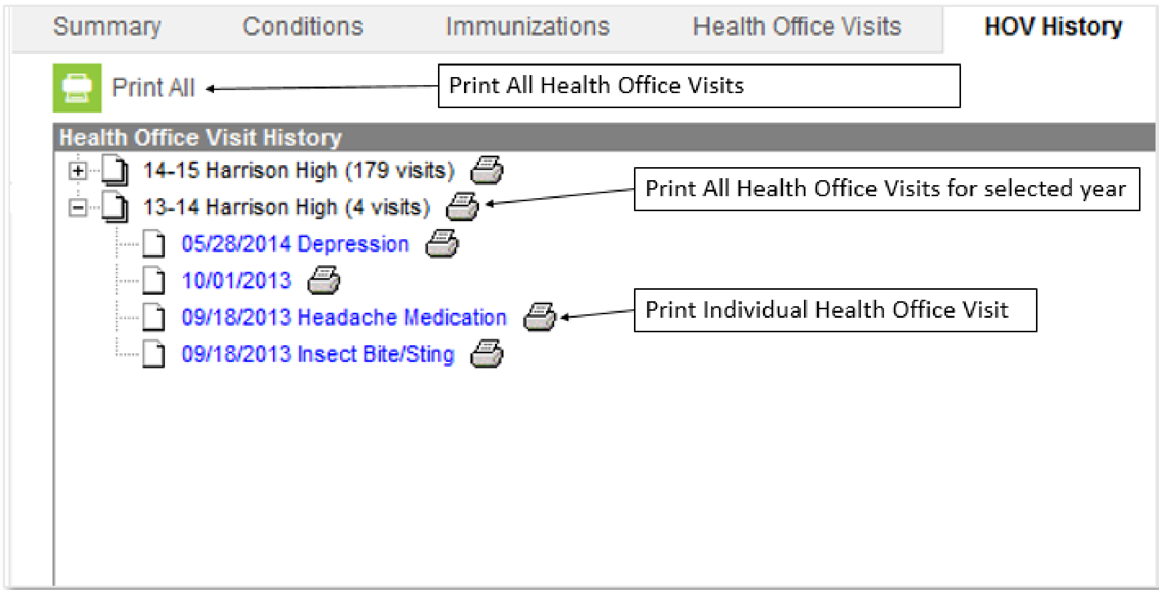
1. Navigate to *Student Information* > *Health* > *General* > *Health Office Visits* tab.
2. Select the "Navigate to Archived Visits Report" radio button.

3. Enter a Start Date for the report in *mmddyy* format.
4. Enter an End Date for the report. These dates are used to find health visits between the entered dates.

5. Click <Generate Report>. The report will appear in a new window in PDF format, listing the students past health visits.

HOV History Tab

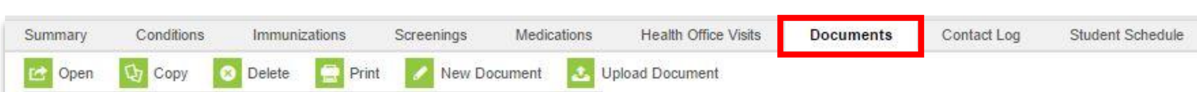
The Health Office Visits History tab displays a read-only view of all the student's health office visits grouped by calendar.



Users will need the **R: Read** right to view the HOV History tab for a student enrolled in a calendar for which the user has rights. **W: Write, A: Add, or D: Delete** do not give any additional rights, as this is a read-only tab and does not require calendar rights to prior years.

Health Documents Tab

The Health Documents tab allows districts to list all health-related forms for a student. Educational documentation found within this tab is determined by the district and added using the forms established in System Administration.

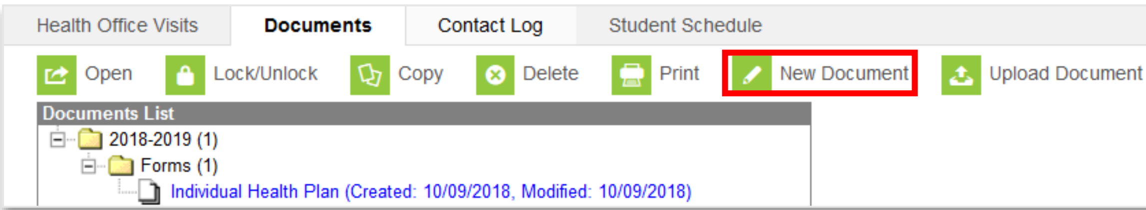


Documents available for uploading or adding must first be created in the Health Form Documents tool in System Administration. If a document is not in the Form Documents list or is in the Form Documents list but is not marked as active, health office staff will not be able to add a document to the student's Documents.

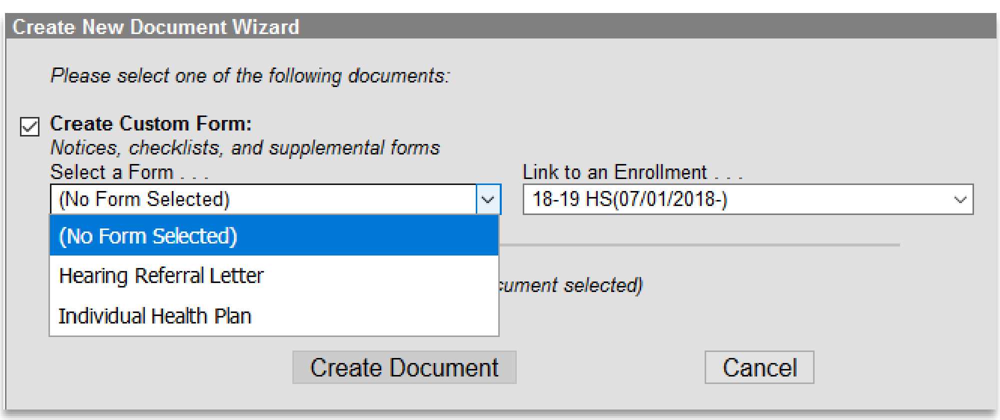
When viewing the Documents List, Documents are separated into different folders based on the form type and the calendar school year.

Adding a Document to the Document Tab from Existing Fillable Forms

1. Navigate to *Student Information* > *Health* > *General* > *Documents* tab.
2. The Documents List appears. If any Documents apply to a student, they will appear in this list.
3. Select <New Document> to add a new document to the student.



4. The Create New Document Wizard appears. Click the radio button to put a checkmark next to “Create New Simple Form” then select which Form to use from the drop down. Reminder: The forms are created by the district in System Administration.
5. Select an Enrollment to which the form will be attached in the Link to an Enrollment dropdown. This determines in which year the document displays. NOTE: When creating new forms, it can be linked to a specific enrollment as long as the enrollment does NOT have an end date. This includes future and current enrollments regardless of the selected Service Type.
6. Click <Create Document>.
7. The document should automatically open in the workspace. Depending on the browser being used, it may need to be downloaded. In which case, click download and check the downloads folder to open the document.



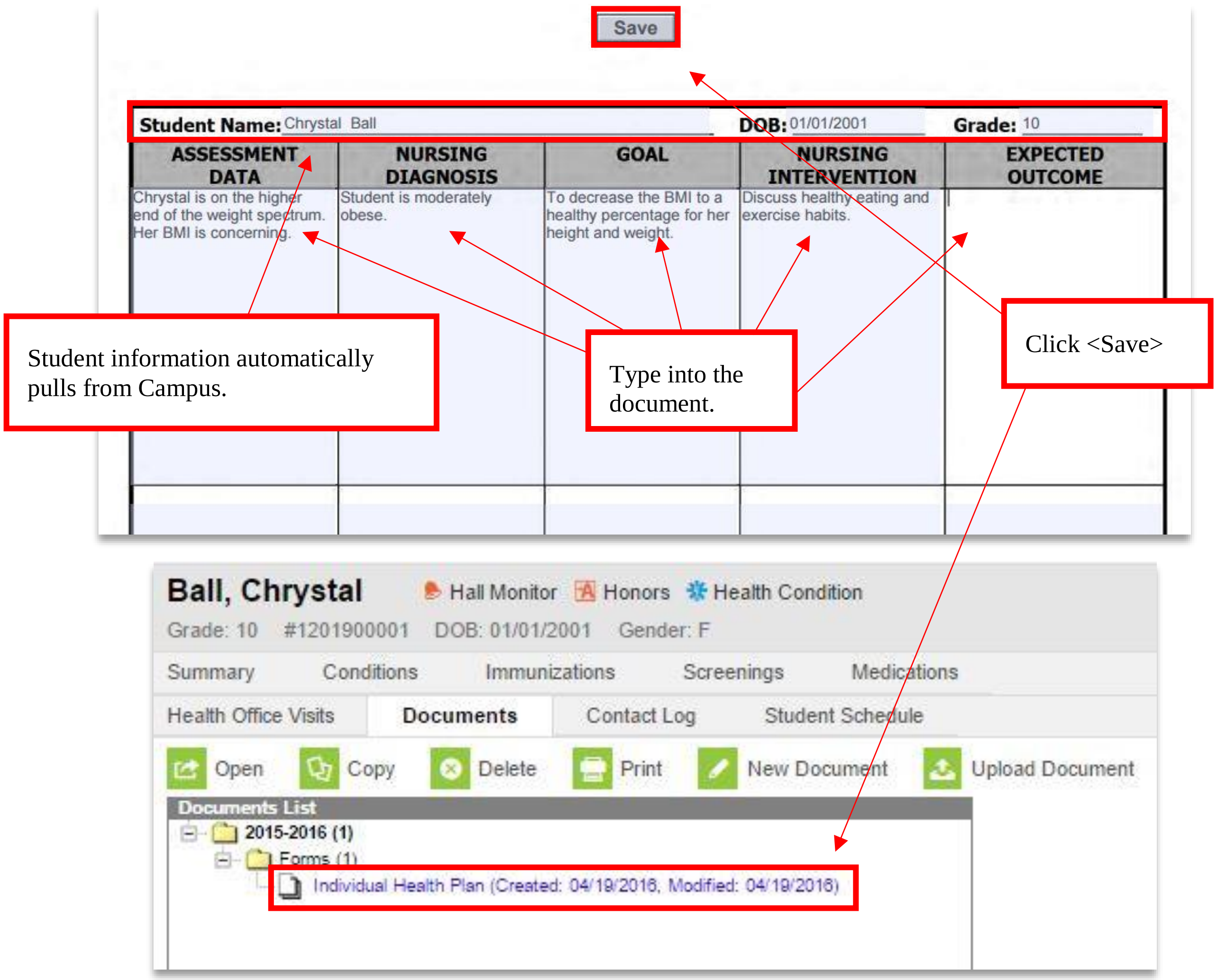
8. Documents that have been created by the district in fillable-format will auto-populate with the student’s name and any information that pertains to the student (DOB, Grade, etc.) as needed on the form.

9. Type in the information to the form as needed. When finished, click <Save>. Note: <Save> appears on the top and bottom of FDF forms. By clicking either of the <Save> buttons it will save it to the students Documents Tab in the Forms folder.

Special Note:

Users can upload PDF, FDF, and MS Word documents. These must be created and be made available by the district. The warning will appear and specify the type of document being downloaded. Certain types of documents require software that may not be available in all districts.

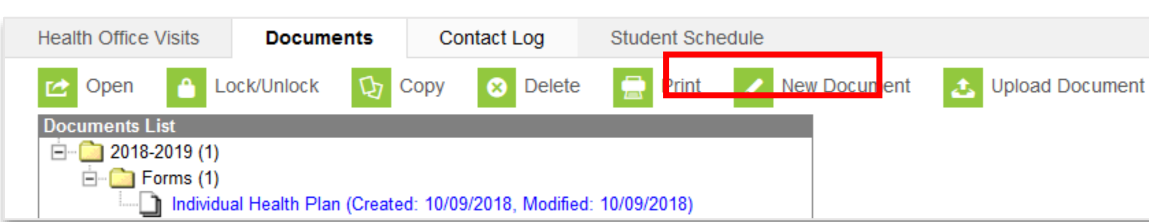
Example FDF document: Individual Health Plan for Chrystal Ball



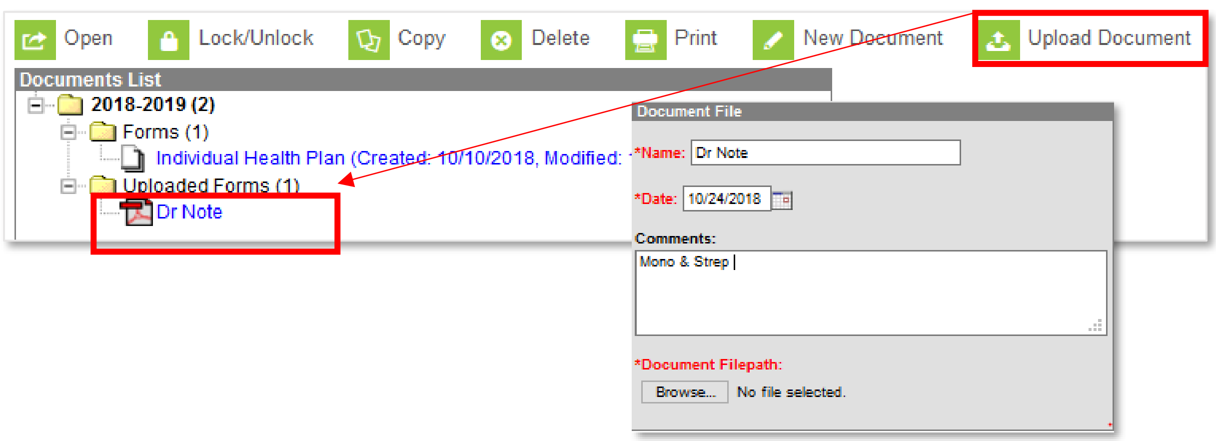
Uploading a Document to a Student's Document Tab

If there are documents that are not created by the district but need to be stored in Health information, such as doctor's notes or other medical documents, these can also be uploaded to the Documents tab.

1. While on the Documents tab, click on <Upload Document>.



2. The Document File editor will appear.
3. Name the document how it should appear in the Documents list. This is a required field.
4. The default Date is the current date but can be modified. It is a required field.
5. May add Comments as needed.
6. Click <Browse> to select the file to upload. In the browse window, click <Open> when the document is selected or double-click on the document name to select it. Only .pdf, .txt, .doc, and .odt file types can be uploaded.
7. Click <Save> when finished. Uploaded documents will appear in the Uploaded Forms folder of the Document List.

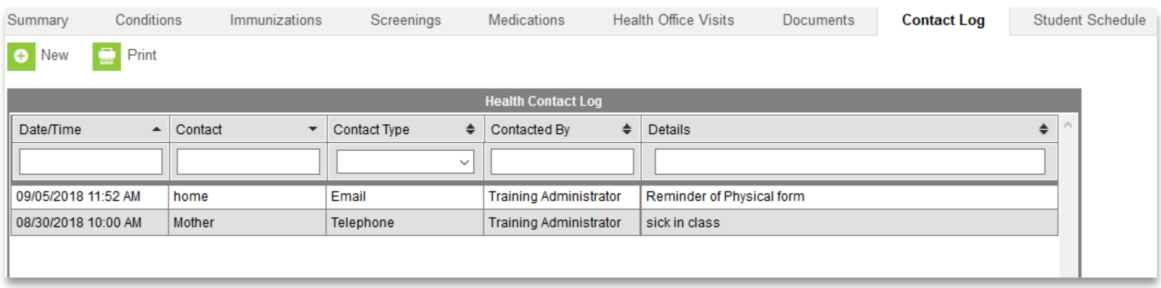


Health Contact Log Tab

The Contact Log offers the ability to store all instances of communication by the health personnel regarding a particular student. This communication can be with the student, their guardians, or others, and could include letters, email, phone calls, and in-person meetings. Contact Types are determined at the district level. There is also the ability to filter and sort the Contact Log entries by date, contact, type of contact, who made the contact, and/or details. The Contact Log can also be printed for any student.

Adding an Entry to the Contact Log

1. Navigate to *Student Information > Health > General > Contact Log* tab. The Health Contact Log will appear.



2. Click <New>. The Contact Log Detail editor will appear.
3. The Date will default to the current date but can be modified to reflect the correct date of contact. It is a required field.
4. The Time of contact will automatically populate with the current time but can be modified to reflect the correct time of contact. It is a required field.
5. Contacted By will be hard coded to the person who is entering the Contact Log entry.
6. Choose a Contact Type. This is how the person was contacted. These options are determined by the district in the Attribute/Dictionary.

7. Contact is who was contacted. This field should be used to record the name of the individual or their relationship to the student, such as Parent/Guardian. It is best practice to have a common format for this field for sorting purposes. For example, if one time the nurse types "Mother" in this field and the next time types "Mom," when the nurse tries to sort the log to see how many times the mother was

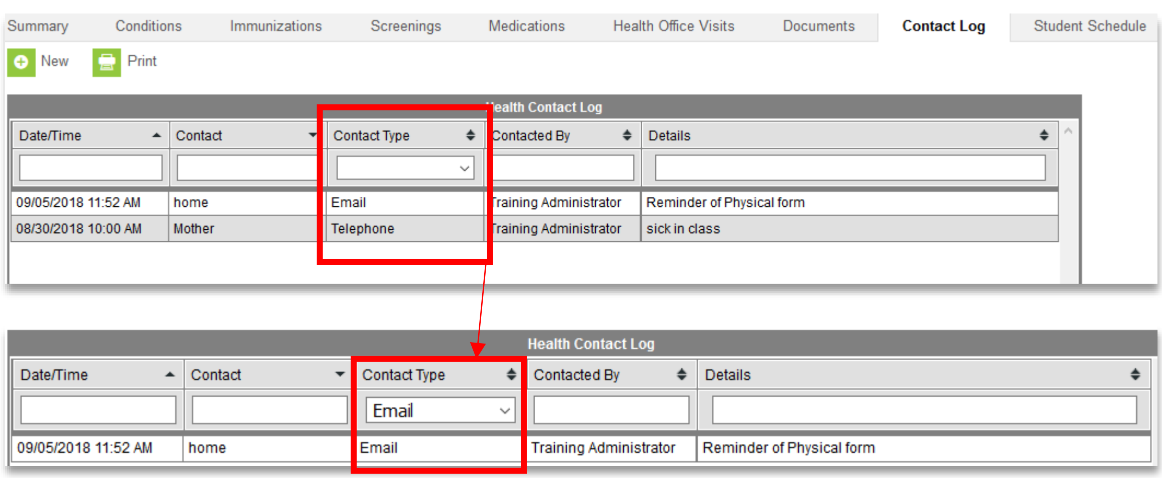
contacted, the system does not recognize “Mom” and “Mother” are the same person. See the Sorting and Filtering section on the next page for more details.

8. Details are additional information regarding the content or purpose of the communication. The field is limited to 500 characters. Only 65 characters show in the log list, but additional text is available upon hover. These can be pulled out in an Ad Hoc report.

9. Click <Save> to save the entry and add it to the Contact Log.

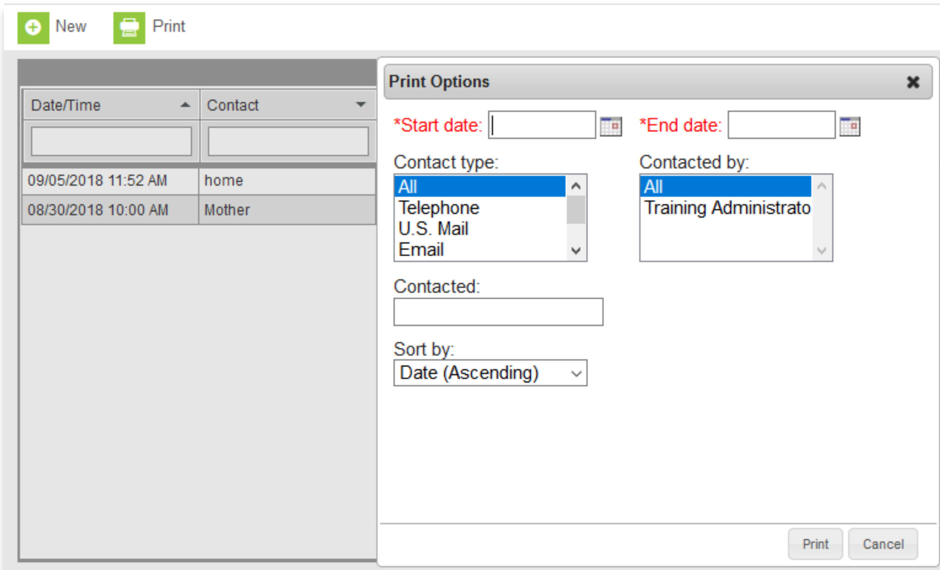
Sorting and Filtering Entries in the Contact Log

1. Entries in the Contact Log can be sorted by clicking next to the header titles.
2. Hold the shift key to sort by multiple columns.
3. Clicking on an entry in the log opens that entry in the detail window below.
4. To filter the log, enter or select a value below the column header. Only entries containing that value will be shown.



Printing Entries from the Contact Log

1. The entries of the Contact Log can be printed by selecting the <Print>.
2. A dialog box will appear with print options.
3. Choose the Date range to print by selecting a *Start date* and *End date*. Start date is the earliest date for which contact records should be included. End date is the latest date for which contact records should be included. These are required fields.
4. If desired, the user can choose a specific Contact Type, multiple Types or all Types. To select more than one but not all Types on a PC hold the Ctrl key and click on the Types to print. On a Mac hold the Command key and click on the Types to print.



5. If desired, the user can choose to print only entries by who initiated the contact by selecting one, some, or all in the Contacted by field. To select more than one but not all Contact initiators on a PC hold the Ctrl key and click on the names to print. On a Mac hold the Command key and click on the names to print.
6. The Contact field allows a user to filter the report to include only who is typed into the text. Caution: This field will only pull what is put in, or similar. For example, if the user wants to pull all contact made to the Mother and someone put Mom instead of Mother, the Contacted report will not display Mom; it will only pull contacts that include Mother.

Aarons, Stephanie
Birth Date:11/23/1998
Student Number:665155
Current Grade:12
Current School: Harrison High

Health Contact Log
01/01/2018 - 12/31/2018
Contact Type: All
Contacted By: All
Contacted:moth
Page 1 of 1

Date/Time	Type	Contacted	Contacted by
01/22/2018 3:30 PM	Telephone	Mother	Kale Abbott
Contacted Mrs. Aarons to let her know that Stephanie's medications are getting low.			
10/14/2018 1:25 PM	email	Mother	Kale Abbott
Emailed Mrs. Aarons regarding Stephanie coming to the nurse's office. She stated she was not feeling			
12/13/2018 10:40 AM	email	Mother	Kale Abbott
Emailed Mother regarding Stephanie coming to the nurse's office regarding a headache.			

What is entered in the Contacted field will be what displays on the report.

Aarons, Stephanie
Birth Date:11/23/1998
Student Number:665155
Current Grade:12
Current School: Harrison High

Health Contact Log
01/01/2018 - 12/31/2018
Contact Type: All
Contacted By: All
Contacted:mom
Page 1 of 1

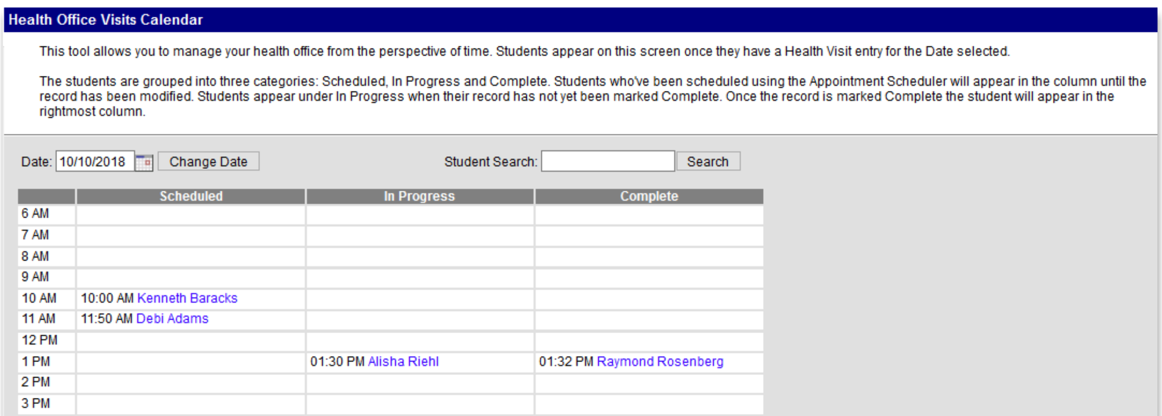
Date/Time	Type	Contacted	Contacted by
09/16/2018 1:30 PM	Telephone	Mom	System Administrator
Stephanie's medication is getting low. Called her mother to let her know.			

7. The user also has the option to sort the entries by Date in ascending or descending order or by who made the contact (Contacted By).
8. When the options have been selected, click <Print>. A PDF report will generate to print and/or save.

Note: To print all Contacts, leaved the Contacted field blank.

HEALTH OFFICE CALENDAR

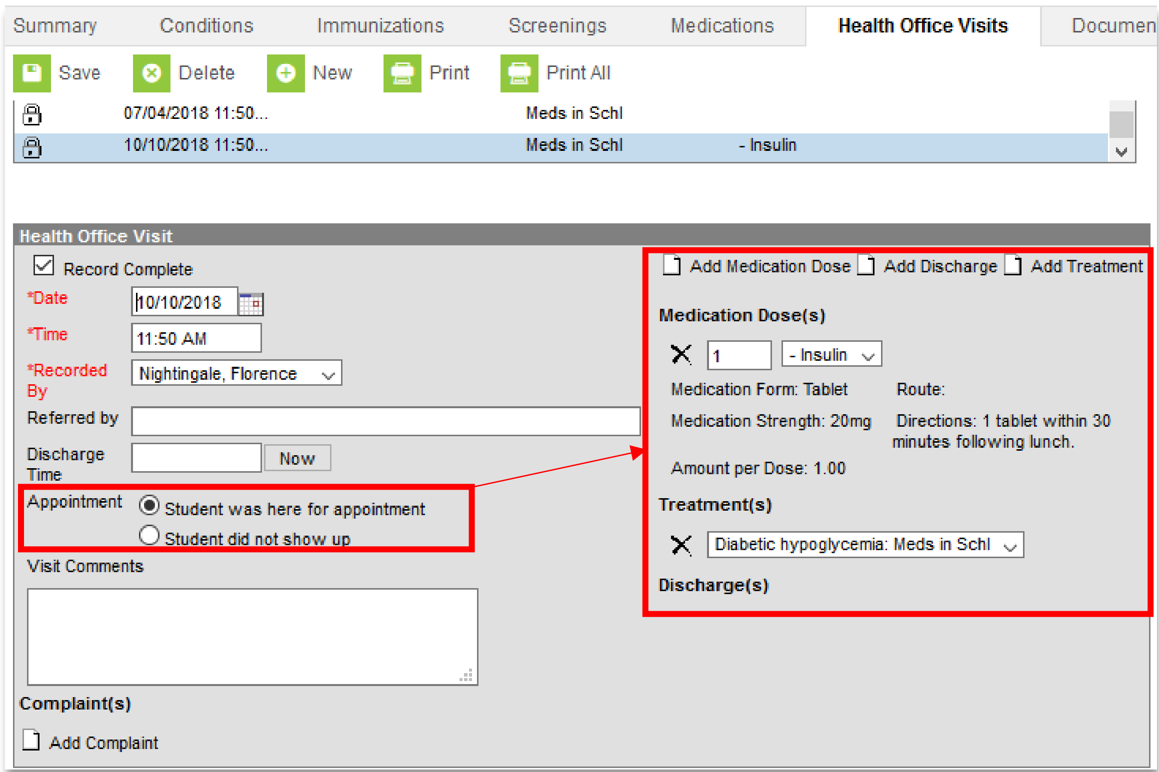
The Health Office Calendar displays all data for a given time, all scheduled visits and any incomplete and completed visits for a specific date. As scheduled visits are made, they will appear on the calendar as a hyperlink to assist the nurse in rapidly entering the actual visit. The Calendar automatically shows health office appointments for the current day. Users can modify the date field to view office visits for another date, either in the future or in the past.



Managing Scheduled Calendar Appointments

Students names display on the Health Office calendar based on the scheduled appointments made when entering treatments for health conditions or made when triaging medications. Visits that have data saved but are not complete will display in the "In Progress" column until they are marked complete, at which time they will appear in the "Complete" column.

1. To Manage Scheduled Calendar Appointments, navigate to *Index* > *Health* > *Health Office Calendar*. The Calendar will appear showing the current date with Scheduled appointments, In Progress office visits, and Complete office visits.
2. Select the student from the Scheduled column to enter their visit details. The student's Health Office visits tab will display with the current Date and Time. These fields may be modified if needed. The Date and time fields are required.
3. Select who is recording the office visit. This is a required field.
4. Select the radio button for "Student was here for appointment" in the Appointment area.



5. Enter medication doses or add treatments, if applicable. Note: These will only show the medications and treatments as applicable for the student. Medication(s) and/or treatment(s) not assigned to the student will not show.
6. Add a discharge as necessary based on the student's presented issue.
7. When finished processing the appointment, mark the Record Complete checkbox. The health office visit record will be moved to the end of the list with a lock icon next to it, meaning the visit has been completed.
8. Navigate back to the Health Office Calendar from the Index. The student's name will appear in the "Completed" column.

Scenario 1: A student with a scheduled appointment comes in for the appointment but before the nurse is able to complete the details of the appointment another student comes in with a more urgent issue. The nurse already has the first student's Health Office Visit tab open. What should the nurse do?

1. Click <Save> without checking "Record Complete."
2. The student's name will move from the Scheduled column to the "In Progress" Column.
3. Find the student with the current issue in one of two ways:
    a. *Student Information* > *Health* > *General* > Search then click on the student's Health Office Visits tab

    OR

    b. *Health* > *Health Office Calendar* > Search for student in the Student Search field (Last Name, First)
4. Select the student from the list (or if there is only one student with that name it will automatically bring the nurse to that student's Health Office Visits tab).
5. Enter the appropriate information (see section on the Health Office Visits Tab for instructions).
6. When finished with the urgent student's record, click on *Health* > *Health Office Calendar* in the Index.
7. The student who was in for an appointment will appear in the "In Progress" Column. Click their name to open and complete their record.
8. Check on "Record Complete" then click <Save>. The student's name will then move from the "In Progress" column to the "Completed" column.

NOTE: The above steps may be taken for students without scheduled appointments who walk in to the Health Office.

Special Note:

If not all records are marked complete for any given day, just change the date on the Health Office Visits Calendar to the date that needs to be completed.

IMMUNIZATION IMPORT

The Immunization Import tool allows districts to import student immunization information from an external file into Infinite Campus rather than entering the data by hand on individual students.

Import File Set Up

The Import file(s) used may be from a State source (TXImmTrac, CSV, or Tab Delimited). The file should include Student identifiers, such as: State ID, Student Number, Birthdate, Last Name, and First Name. It must also include the Vaccine Code (CDC or Campus Codes) and the Date(s) of doses.

Example of a CSV Import File

	A	B	C	D	E	F
1	Student ID	Last	First	Birthdate	Code	Dose Date
2	103708	Adams	Simon	11/22/2000	DTaP-DTP	10/5/2001
3	103708	Adams	Simon	11/22/2000	DTaP-DTP	2/10/2005
4	103708	Adams	Simon	11/22/2000	DTaP-DTP	3/12/2007
5	103708	Adams	Simon	11/22/2000	DTaP-DTP	12/20/2009
6	103708	Adams	Simon	11/22/2000	MMR	11/25/2001
7	103708	Adams	Simon	11/22/2000	MMR	1/15/2002
8	103708	Adams	Simon	11/22/2000	HepB	11/25/2001
9	103708	Adams	Simon	11/22/2000	HepB	1/15/2002

Create, Edit, or Delete an Import Mapping

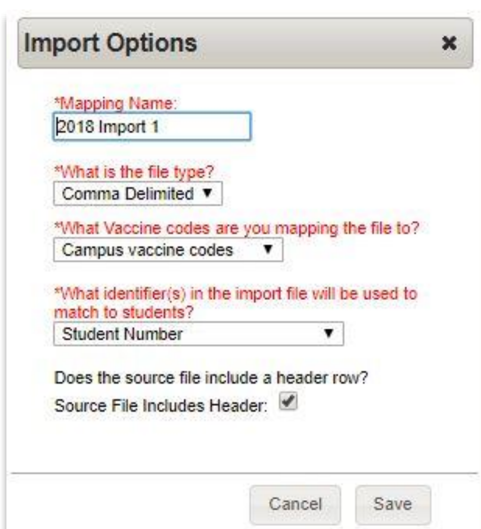
Users can either select an existing Import Mapping to edit or add a new Import Mapping to create new records. Mappings can also be deleted.

Import Mapping Editor Options

1. *Saved Import Mappings*- Lists previously created mappings.
2. *New*- Users are able to create a new mapping.
3. *Edit*- Users can modify the details of an existing mapping in the Saved Import Mappings window.
4. *Delete*- Users can remove an existing mapping from the Saved Import Mappings window.
5. *Find and Upload Source File*- Allows users to select and upload the file that contains the records for the federal program import.
6. *Back*- Allows users to navigate back to the start screen.
7. *Next*- Allows users to proceed to the next screen.

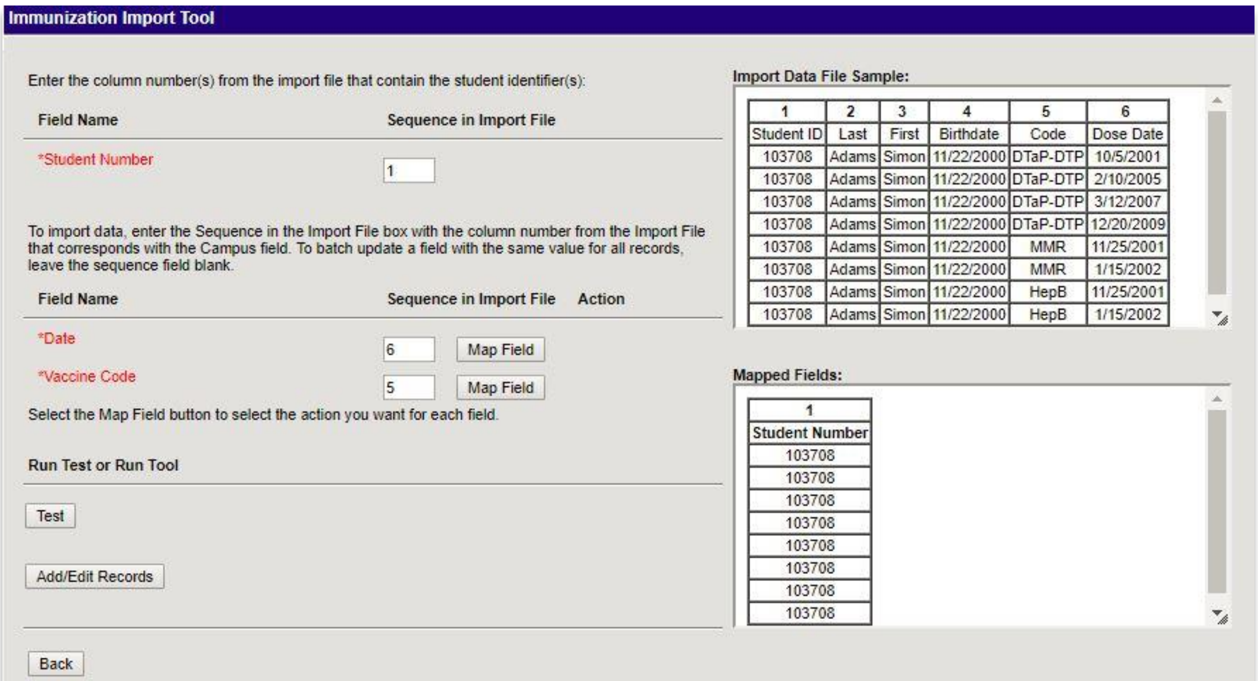
Create a New Import Mapping

1. Navigate to *Health > Immunization Import*.
2. Click <New>.
3. An Import Options editor will appear. Fill in the required information:
    a. *Mapping Name*- This is what will appear in the list of Saved Import Mappings. Ex. Fall 2018 Import or DTap-DTP Import.
    b. *What is the file type?* - Select the file type from the drop-down. Comma Delimited, Tab Delimited, or TXImmTrac are the options.
    c. *What Vaccine codes are you mapping the file to?* - Indicate the vaccine codes to which the file will be mapped in Infinite Campus, either the Campus vaccine codes or CDC codes (CPT or CVX).
    d. *What identifier(s) in the import file will be used to match to the students?* - Indicate the student identifier field that will be used to match students from the import file to Campus fields. Student identifiers are the link that allows importing immunization information to student records. The options are to match either the student's State ID, Student Number, Person ID, Last Name, First Name, Birth Date, or Social Security number.
    e. *Source File Includes Header*- Indicate whether the file being imported contains a header. If this is checked, the first row of the source file will be ignored on import. This is not a required field but should be marked if it applies to the source file.



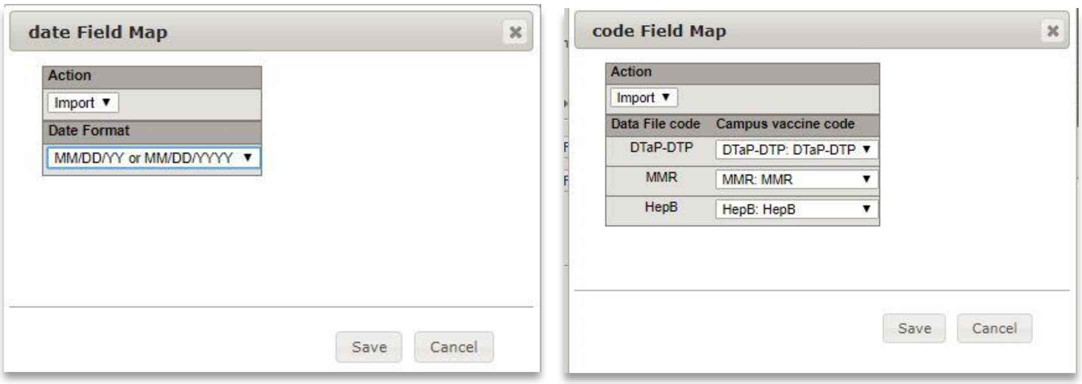
4. Once the Import Options have been saved, click <Choose file> to select the import file. Click <Next>.

5. Enter the Sequence Number for the Student Identifier field(s) selected in the Import Options.
6. Enter the column number from the Import Data File Sample in the “Sequence in Import File” field for the Date and Vaccine Code.



7. Select the <Map Field> button to determine the action to be taken for the field. Select Import from the Action dropdown.
8. Additional information may need to be entered depending on the type of field being mapped. For example, when importing a date, the format of the date in the source file needs to be selected.
9. Click <Save>. The Action column displays 'Import' in read only text. If no action was saved, the field is blank. Once a field has been mapped, the field displays in the Mapped Fields window. Fields that are not being mapped should have the Sequence in Import File field left blank and not have an action selected.
10. Repeat these steps for each field that needs to be mapped.
11. It is recommended a <Test> be performed on the import prior to the actual importing of data. This reduces the amount of cleanup action needed after the data has been imported. No data is written to the database when a test is performed. When testing, a report displays listing the records being imported and any potential issues.

Map Field Action Selection



Import Data Test Report Example

	A	B	C	D	E	F	G	H	I
1	Immunization Import Report					Generated on 02/15/2018 02:18:42 PM			
2									
3	THIS IS A TEST. NO DATA WAS WRITTEN TO THE DB.								
4									
5	Summary								
6	Errors/Warnings								
7	0	2							
8									
9	Ignored doses already on database								
10	2								
11	Inserted doses								
12	6								
13	Error/Warning								
14	State ID	First Nam	Last Name	Birth Date	Message				
15									

12. If no errors appear in the Test file it is safe to perform the import, click <Add/Edit Records>.
13. A results report generates displaying all records that failed and all records that imported.

	A	B	C	D	E	F	G	H	I
1	Immunization Import Report					Generated on 02/15/2018 02:25:09 PM			
2									
3	Summary								
4	Errors/Warnings								
5	0	2							
6									
7	Ignored doses already on database								
8	2								
9	Inserted doses								
10	6								
11	Error/Warning								
12	State ID	First Nam	Last Name	Birth Date	Message				

HEALTH REPORTS

Health Reports provide information about student health related to immunizations, health office visits, alerts, medication summaries, etc. The reports should be generated by a health official at the school. Navigation: *Health* > *Reports*.

The following reports only allow users to pull information from schools and calendars to which the health personnel have rights.

Report	Description
Generic Immunization Extract	The Generic Immunization Extract reports immunizations that have been entered for a student, much like the Immunizations Report. Additional sort options are available, allowing users to determine the format of the report, sort options, and generate the report using Batch Queue functionality. Data returned on this report is based on the information entered on the student's Immunizations tab.
Health Alert Summary	The Health Alert Summary report provides a list of students who have active programs marked as medical between an entered start and end date. The report will output the total number of active medical flags by program name, with aggregate totals, showing the number of students who have the alert and the grand total of all medical alerts.
Health Condition Alerts	The Health Conditions Alerts Report provides a list of students who have the selected health conditions and health alerts. This report can be used to identify all students who have health conditions that also have a health alert. Users can display students by school, grade or course section. Data is returned in alphabetical order by student last name.
Health Condition Summary	The Health Conditions Summary report will allow users to review health conditions, including the ability to view conditions by groupings, such as allergies. This report will consist of aggregate numbers and grand totals on health conditions for students.
Immunization Batch	The Immunization Batch Report will provide a view of selected students' immunizations. This is a very complex report, so try to limit the number of students run per batch. The Immunization Batch report uses data that is entered on a student's Immunization tab. Data should be up to date on this tab for the report.
Immunization Certificate	The Immunization Certificate Report provides a listing of students that have met immunization compliances on the basis of a valid certificate, rather than the dates and numbers of immunizations.

Immunization Compliance Summary Report	The Health Immunization Compliance Summary Report provides a summary of immunization compliance broken out by grade, compliance status, and exemptions with totals for all vaccines selected and each individual vaccine with rules.
Immunization Summary	The Immunization Compliance Summary Report provides a listing of students and their compliance of health vaccinations. This report is organized by grade level, compliance status, and exemptions/waivers.
Immunizations	The Immunizations Report provides a listing of students and their compliance of health vaccinations. This report is organized by grade level, compliance status, and exemptions/waivers.
Medication Summary	The Medications Summary Report lists prescription information for students in the selected calendar or the student list. The Medication Summary Report pulls data from the student's Medications tab. The entered date range specifies the period in which to check if any medications were submitted.

The following health reports are not limited to users based on their school or calendar rights. If a user has rights to only one school or calendar, that person is able to see data from other schools in the district.

Report	**Description**
Screening Compliance	The Screening Compliance Report aids districts in assessing compliance for health. The report finds the following situations: • Students who do not have any screening records; • Student who have a screening record for a particular date; • Students who have a screening record of a particular type; • Students who have a screening record with a particular status. Information returned on this report is stored in the student's Health Screenings area.
Health Office Visits	The Health Office Visit Report generates a list of health visits that occurred on the effective date entered in the current school year.