Health Record Management & Retention

1.0 Objectives

The objective of this document is to describe the process of managing student health record.

2.0 Scope

This process applies to GIIS Dubai.

3.0 Policies

Medical records are a combination of both self-reported student's information and a physician's notes on diagnoses, care, and treatments. These histories involve a variety of information about a child's health history and personal habits including:

- Significant illnesses and medical conditions, including documentation on lab findings, diagnosis, and treatment plans.
- Physical exams, allergies, medications, and any adverse reactions.
- Preventive therapies such as immunizations and screenings.

A personal School Health Record is regularly maintained for each student, where all scheduled vaccinations, annual check-ups (height, weight, BMI etc...) and any other visits to the school clinics are recorded. As part of our policy to promote a healthy lifestyle the school conducts various examinations like vision test, oral check-ups. Parents will be notified in advance about any forthcoming examinations that their child may be involved in. Students Health records will be handled confidentially at all times.

Parents are required to fill and submit medical detail forms, consent form of Vaccination. Parents are requested to complete all due doses of vaccines of their children and required to provide their children updated vaccination cards to school clinics.

MEDICAL REPORTS AND MEDICAL ALERT FORMS

A medical report must be submitted to the School Clinic where there is any change in health condition or a new medical condition for your child and any treatment given by the school clinic.
If your child has a pre-existing condition, (allergies, asthma, convulsions, and diabetic emergencies) the school clinic needs to be notified in advance.

Essential record and reports in the school clinic are

- Clinic daily report
- Incident report
- Students medical condition & allergy report
- Student's referral report
- School health report.
- Individual health care plan

Clinic daily report:-

The student clinic daily report is maintained by the school nurse which includes the student's name , grade, class ,time of the clinic entry, time of leaving, chief complaints ,provided intervention etc .These reports should be used for future reference and identify the particular students visiting the clinic with specific complaints. In case of any students visiting the clinic frequently, it is notified to the parents as well as the class teacher.

Incident report

The school clinic maintains a separate Incident log book which records any accident or health incidents which may have occurred during the day. This should be brought to the notice of the Principal / Sections heads immediately and should include all details of the incident including place, date, time, witness to the incident etc .This form should be signed by the Principal within 24 hours and kept confidential unless for any further medical or enquiry purposes. The report should also include details of the injury, first aid administration and whether hospitalization was provided.

Student medical condition & allergy report

After receiving the health history from the parent, the school nurse should verify the forms and find out the students with medical conditions and are allergic to any medicine or any other substances. This health information should be handed to the class teacher as well. If the child is using school transportation, it should be handed over to the driver as well.

If this child is brought to the clinic with any other condition, the nurse should be vigilant about the child's condition and allergy background. If any abnormalities are found during school hours, the parent as well as class teacher should be informed immediately. If this child is receiving any medication for the conditions, a nurse should be requested to fill up the school medication authorization forms and provide the medication in the clinic with the child name, name of the medicine, dosage, frequency etc. Nurse should be notified of the expiry date and inform the parent prior one month of the medicine expiry.

Student's referral report

Any student's health condition is not improving after giving care in the school clinic or if they need any additional health care rather than the available health services or if the condition is worsen, should transfer the child to the advanced health care area. Referral reports should include the details about the treatment provided, Time of the child arriving in the clinic, Time of the client leaving from the clinic etc and relationship of the accompanied person etc.

Individual health care plan:-

Individual health care plans are essential for any child in the school with medical conditions like asthma, diabetes, epilepsy and other diagnoses. In this case, the nurse should formulate an individual health care plan as per the child's condition and inform the class teacher as well as Principal and Supervisors. This should be updated at regular intervals.

Immunization register:-

As per the rules of DHA, every school should maintain an immunization register which includes student name, grade & name of the vaccine which he/she received in school and outside of the health center. Each student has one

number, it should not be changed until she /he leaves the school. Nurse should update this register and find out if any vaccine is missed according to the age .If any vaccine is missed to date, the nurse should contact the parent and inform them prior.

Principles of Medical Record

1. The medical record should be complete & legible

2. The documentation of each student record should include.

- The date
- The reason for the clinic visit.
- Appropriate history and physical exam in relationship to the student chief complaints.
- Assessment & plan of care.

3. Past and present diagnosis should be accessible to the treating or consulting pediatrician

4. Relevant health risk factors should be identified.

5. Child's progress, including response to treatment, change in treatment, change in diagnosis, child noncompliance should be documented. The written plan for care should include, when appropriate.

- Treatment & medications, specifying frequency & dosage
- Any referrals and consultation
- Health education and specific instruction for follow up.

7. The documentation should support the intensity of the patient evaluation and or the treatment, including thought process and the complexity of the medical decision making as it relates to the child's chief complaints.

8. All entries to the medical record should be dated.

Student Medical Records:

1. A legible, complete, comprehensive, and accurate student medical record is maintained for each student.
2. A record includes a recent history, physical examination, any pertinent progress notes, laboratory reports, imaging reports as well as communication with parents.
3. Records and highlight allergies and untoward drug reactions.
4. The clinic maintains an Immunization record of all students and prescribes and administers immunization in case applicable as per the DHA guideline
5. Documentation of the health care provider's orders, if any, and parental permission to administer medication or medical treatment to be given in school by the school nurse.

Appropriate steps shall be taken for the protection of all student health records, including the provisions for the following:

A) Secure records at all times, including confidentiality safeguards for electronic records.

B) Establish, document and enforce protocols and procedures consistent with the confidentiality requirements.

This record shall be sent in a manner consistent with upholding confidentiality. This protocol entails the Health Record guidelines which is given by DHA website www.dha.gov.ae.

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