SCHOOL NURSING

PAST AND PRESENT

XII.

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CONTENTS

SCHOOL NURSING

I

HISTORY

Early development in Europe and United States

School Nursing is a direct outgrowth of the visiting nurse's association both in England and the United States. It was the first specialized form of visiting nursing to develop.

We can trace the development of public health nursing to Florence Nightingale's work and teaching. It was her hope that nursing would be associated with health and prevention rather than with disease alone.

Up until 1859 when William Rathbone established the first visiting nurse's association in Liverpool, very little public health nursing had been attempted. We do find, however, various types of health supervision being carried on in schools about this time. France, in 1837, instituted compulsory health supervision of school children and sanitary inspection in the school. Brussels, in 1874, established the modern type of school inspection by an appointed school physician. Medical inspection was inaugurated in the United States in Boston, in 1894, following the lead of France, Germany, England, Sweden, Russia, Austria-Hungary, Argentine Republic, Chile and Egypt. The development of school nursing and medical inspection in the public schools was closely correlated. In some instances

school nurses preceded the medical inspector and revealed his need; in other instances, the doctor revealed the necessity of the school nurse to his work.

School nursing first developed in England in 1892. Miss Amy Hughes, then Superintendent of Queen's Nurses in Bloomsberry Square, was asked for advice concerning a feeding problem by a teacher in a small school. Miss Hughes answered the call herself. Seeing the great need she made weekly visits to the school in Drury Lane showing what could be accomplished in the prevention of absences due to minor ailments and their complications. Miss Hughes was so successful in her work that 7 years later the London School Nurse's Society was founded. This organization which was a voluntary one, served as an example of what might be done even though its work was not intensive. One of the members of the London County Council, Honner Morton, aided in establishing school nursing as a system. As a result, in 1904 the London County Council appointed 7 school nurses under the direction of a superintendant.

The Henry Street Settlement nurses in New York kept a record of the children with whom they came in contact during their work. Many were found playing in the streets with other children after being excluded from school due to the presence of an infection or disease. No attempt in many cases had been made to obtain treatment for the malady. Miss Wald, the superintendant, presented these records to the health

Commissioner of New York and persuaded him to permit the experiment of placing a nurse in the four schools showing the greatest number of exclusions. The Visiting Nurse's Association contributed the nurse and her salary. Miss Lina Rogers was selected for the position. As a result of this experiment in 1902, New York may claim the honor of being the first city in the world to place school nursing under municipal control. Miss Roger, with her great initiative, was not discouraged by the lack of proper room or equipment. A small janitor's closet was utilized. A broken chair was repaired to serve as an examining chair, while a near by window sill was used as a dressing table. The twofold purpose for this experiment was to aid in the care of minor skin diseases due to which many children were denied an education, due to no instruction or aid in their cure; and secondly, to visit the homes to interest the parents in the better care of their children. As a result of the tact and skill of Miss Rogers in her task, the attendance increased 50%. The next month 25 additional nurses were appointed by the commissioner of health. Most programs in this country and in Canada have been patterned after that initiated in the New York schools.

The Philadelphia Visiting Nurse's Society next repeated the experiment in the Philadelphia public schools. The movement continued to spread from city to city and from state to state.

School Nursing

Recent Developments in the United States

The history of school health work may be divided into the three following phases: medical inspection for the control of contagion, medical inspection directed to the general physical condition of the child, and a workable health education. These phases have tended to fuse and become a part of one program in the last few years instead of remaining each as an individual project.

School nursing has undergone tremendous changes during the last ten years. It has been said it is due to an enlightened public and the new philosophy of education. As I have stated before, school nursing today is a fusion of the old type of health service and modern health education, which by trial was found to be necessary for a good piece of work. Someone has suggested that we use child health as a criterion to judge the adequacy of the entire school situation: the building, equipment, services, length of school term, hours of attendance, recesses, rest periods, content of instruction and methods of teaching. The main objective is a healthy sane childhood for every child.

In 1929 the White House Conference made a survey of the school health work in the various size cities in the United States. This study revealed varying degrees of health instruction and care in the different schools throughout the country.

In some of the larger cities a fairly adequate service was being conducted while in many of the small rural schools very little was being attempted.

When school nursing was first placed in the school it was thought of in terms of serving the needs of the grammar school child as his needs were more apparent at that time. During the last few years and at the present time it is being realized that health supervision of the high school and college student is imperative. As the child grows older and is made to assume more responsibility for his own health he is in constant need of advice and guidance, thus making a full time school nurse a necessity. Many schools throughout the country are working towards this goal.

Development of School Nursing in Portland and Oregon

Let us consider the development of school nursing in Oregon and in the city of Portland. The report of the Health Commissioner of Portland in 1901 stresses the importance of medical inspection in the schools in the prevention of contagious diseases and suggested the instituting of such in the Portland Schools. It was not however, until 1907 that it was organized with four doctors giving only general examinations. The children rolled their sleeves above their elbows and passed in line before the doctor. They threw their heads back and opened their mouths. If the doctor felt there was a suggestion that the child needed attention the child was asked to step aside and was

later given a more thorough examination. Cards were sent home to the parents informing them of their child's condition with instructions for them to write on the reverse side of the card what they were doing for their child and whether they were financially able to pay for treatment. These cards were returned to the doctors and they acted accordingly. It was then that the doctors made use of the nurse's service. She visited the homes and, if necessary, took the child to the free dispensary. As skin diseases were quite common, the children were taught to be clean. It was found to be a difficult lesson for many of them to learn when they had known nothing but poverty and filth for generations and no opportunity for taking baths." Teachers and the nurse were in constant warfare with nits. The children were told they must have their heads cleaned at home. If this wasn't successful, home calls were made explaining the necessity to the parents. All sorts of answers and excuses were given: "it was the water in this country, their children would not carry umbrellas, others thought you couldn't raise children without them." With constant work and effort the nits were decreased.

In October 1913, the Oregon State Board of Health started a three month's experiment of the inspection in rural schools and a survy of sanitary conditions of the surroundings. Mrs. Katherine Kelly, who was appointed, was asked to secure some definite knowledge as to whether the common drinking cup law was being

enforced, and to inspect the children for: 1-body cleanliness, 2-presence of vermin, 3-manifest skin diseases, 4-deformaties, including clubfoot, hare lip, cleft palate, tubercular joints, as well as any other defect, 5-marked defects in vision and hearing.

Mrs. Kelly's first monthly report as published in the Oregonian November 1913 reads as follows: "Some of the rural schools are in poor sanitary condition. In Lincoln County the Parrish school is reported as having 17 pupils, the teacher an old man and the school unsanitary. In Benton County, the Sunnyside school which has 11 pupils has patent toilets that are out of order and so reported to the school board before opening the school. One out-house building is used for both boys and girls.

In Corvallis the school has 225 pupils. There is one boy 11 years old backward and abnormal who has been in the second grade two years without learning to read. In the Island school with 10 pupils there are no doors on the out-house.

In Linn County in the Davis school with 22 pupils the sanitation is said to be bad and the out-houses in poor condition. In the Millersberg school with 26 pupils, the out-houses are reported to be in need of attention. The pupils use bottled water because of no water supply in the school. An attempt was made some time ago to move the building from a bog in which it stands to a more sanitary location but

the attempt only resulted in a neighborhood row.

At the East Knox Butte school where there are 45 pupils, the out-house is reported to be in need of attention and is without doors. Altogether 42 schools were visited and 2000 pupils inspected."

The county School Superintendents were opposed to Mrs. Kelly and her work. They said her work was superficial and her reports were often unfair. They cited instances of cases where she condemmed the sanitary conditions in the schools. They felt she should include in her report the good points of the schools. They felt also she was not justified in naming children either physically or mentally unfit.

By constant effort and education we do feel marked improvements have been made but the ideal has not yet been reached. We can look to the future for more adequate school nursing for the rural schools.

In 1917 three nurses were added to the Portland school nurses staff. Up until this time one nurse had been responsible for 30,000 school children.

In 1925 the Oregon Tuberculosis Association financed four public health nurses in nine schools as a demonstration of what could be done towards improving school health by teaching the children correct health habits. This was so effective that the Board of Education cooperated with the Health Department and financed the employment of 11 new school nurses. The Health Department added a Supervisor and an Assistant Supervisor.

Five nurses were added in 1926 so as to make one nurse responsible for not more than 2,500 children or three or four schools. A field supervisor was added to the staff. A routine contagion inspection was instituted, also a program for physical examination and weighing and measuring. Goitre work was carried on in all the schools. A Toxin Antitoxin campaign was instituted. Pre-school examinations in connection with the Parent Teacher's Association were started. A marked improvement in home contacts and increased confidence in the nurse was shown by the increase in the number of calls from the parents concerning health problems of their children.

Portland has today a school health department of which it can be justly proud. The staff is now composed of 21 school nurses, 2 field supervisors, one supervisor, 1 medical director, 4 examining physicians, 2 women and 2 men, and one eye,ear and throat consultant. The average pupil load per nurse is now about 2000. The aim of the department is to carry on a well rounded health type and educational program in school and home. This includes control of contagion, correction of defects, the guiding, teaching and supervising of social, physical and emotional health. Physical examinations are given to students in the 1st, 3rd, and 6th grades. A three fold preventive program is carried on namely, goiter prevention: 355,000 goiter tablets were given out last year; diptheria prevention: was instituted in 1926.

From that time to January 1st only 4 cases with one death had been reported; and last but not least small pox vaccination was started 4-5 years ago.

CHAPTER II

HEALTH DEPARTMENT VS. BOARD OF EDUCATION IN ADMISTRATION OF SCHOOL NURSING

There is a marked difference of opinion as to whether school nursing should be under the control and guidance of the Board of Health or under the Board of Education. One can find advantages and disadvantages in both set ups. Those in favor of Board of Health administration maintain that it is the proper place due to the type of program carried on. They feel that contagion and its prevention play such an important role that the school nurse should be a part of the department whose support is essential for her successful work in its control. The school nurse has a background more of medical than educational matters, thus making her professionally more akin to the Board of Health. The nurse's work in the school differs from that of the teacher. She should be in a position to serve and advise the whole school set up rather than being a definite part of its curriculum. The nurse, by being a part of the Health Department, prevents any duplication of effort on contagion control. The arguments used in favor of the Board of Education are somewhat similar. When the school nurse is not a part of the Department of Education, as are all the teachers, it makes for some difficulty in interpteting the nurse's place in the school. She is consistently looked upon as an outsider, thus making it difficult, many times, to gain the cooperation necessary to her work. She is thought of as representing an

outside agency in the school. If the nurse were under the Board of Education, the board would feel a deeper sense of responsibility for the development of her program and gain a clearer understanding of what is being attempted, and the best methods to be employed. Lina Rogers believed that nursing should be under the Board of Education until disease or contagion actually enters. This would lead to the need of a joint administration. Most school nursing departments are under the guidance of the Department of Health. Cleveland, however, is an outstanding example of Board of Education administration. The nurse must have the backing of her Department of Health at all times. She must also have the cooperation, backing, and understanding of her school authorities. If either branch is lacking she must then work under a handicap and the aimed for, well-rounded program may easily become one sided. The suggestion has been made for a definite coordinating committee to plan the program. The authority for administration would be from both departments. The board or committee could consist of 2 school board members, city health officer and a medical advisor, thus making for the realization of the advantages of each and doing away with the disadvantages of either.

CHAPTER III

PLACE IN THE SCHOOL

The scope of school nursing has been greatly increased during the last few years. We see from the past to the present a gradual development in the importance, to the school, of a school nursing program. The school nurse has gained the esteem and condfidence of the students, teachers, parents, and the community by proving her worth until various new trends have been and are being developed. Various gaps are found in the educational system for the development of a well rounded personality. Often there has been some question as to whom is best fitted to carry on this work. The nurse has never been thought of in the sense of a teacher, but there is a feeling that she should be so equipped to conduct classes in such subjects as personal hygiene, which would give the students an adequate knowledge of the mechanisms of their own bodies and its care. She is being asked more and more to teach first aid classes and the care of the sick or little mother's classes. The school nurse has a clearer understanding of the needs of the child and is becoming an important factor in helping secure optimum health for every child through intelligent cooperation of the child, parents, teachers, and other health and social workers in the home, school and community. She serves as the connecting link between the home, school and health resources of the community. The nurse interptets the

the home environment to the teacher and the school environment to the parent. The school nurse is capable of acting in this capacity, due to her special training is psychology, medicine and the social sciences. The teachers are recognizing the value of the assistance the school nurse is eager to give. She is able to advise the teacher on scientific health material for her classes and where it can be obtained. She helps work out any plans for the developing and maintaining of sound bodies and minds as well as improving the health condition of the school personnel. The school nurse works hand in hand with the nature study teacher and the physical education director towards the objectives of their departments.

The school health department has shown the needs of the handicapped child and makes every effort to help develop adequate facilities for his care and adjustment. The school nurse has cooperated with the P.T.A. organizations in instituting pre-school clinics, hot lunches and cafeterias and arranging for milk for those who need it. She often interests various organizations in supplying funds for such purposes. The nurse in the last few years has often recommended children on relief who need extra food at noon. As a result of the child's physical needs being placed before the proper authorities various special schools have developed throughout the country. Lina Rogers states in her book that many a child is backward physically or mentaly defective, vicious or criminal, because of uncleanliness, improper feeding,

disease and neglect. Open air schools have been established throughout the world for children below par physically. The first one was established in Germany in 1904. The general set up is the same with slight variation in management in the individual school. The child is placed under close medical supervision upon entrance. He is first taught how to live, observing the rules of personal and general hygiene. The child spends anywhere up to 10 hours out of the 24 hours in the open. The school periods are only about ½ the time of the regular day school. At one school the children are given their 3 meals at the school. They have only a glass of milk in the morning at home. The children are given a 2 hour rest period after dinner. Special attention is paid to personal cleanliness such as washing before meals and brushing teeth after meals. A tub bath is given once a week. This is an example of only one such school. The aim is the same in all, "to produce order out of chaos, a disciplined mind as well as body and give new hope to these children." Portland points with pride to its Mills Open Air School. All children who are below par physically, but normal mentaly are eligible except those with tuberculosis. Every child is given a physical examination before extrance. Seventy five children are enrolled. A weekly visit is made by one of the health service physicians. The school nurse is in attendance one and a half days a week. A daily routine is made out for the student and sent home for his care after school hours and on weekends. The

children are weighed once a month if there is no regular gain they are weighed weekly. The children have supervised play. There is a 1 hour rest period after lunch, each child having his own cot. The children are given milk at 10 A.M. A hot dish is served at noon. The weekly menu is sent home with advice as to what the child should bring from home to complete his lunch. The children are given special instruction in the proper health habits. They are a happy, hopeful group, each one eager to lead a normal boyhood and girlhood.

Portland has also a special school for the hard of hearing. Thirty six children are admitted, 9 to a room. These children are taught to enter into the social group and become a part of it, due to their instruction in lip reading and the aid of the "radio ear." The older students take great pride in their ability to do all the things that the normal child takes as a matter of course.

These are only a few of the various places that school nursing has gained in the joint effort to give each child help in his every need.

CHAPTER IV

THE IDEAL PROGRAM

Most every school system, urban and rural, has a health program. The aim of every school health service is an extended, well rounded service. Let us consider what would constitute an ideal program. This is of importance in evaluating the existant services, as well as serve as a goal for those being established.

The White House Conference of 1929 sets down nursing services in the school under eight groupings.

1. to assist in health examinations. The ideal being an annual health examination for all pupils by the family physician, using a uniform routine and record card.

2. Conferences with individuals. This included a follow-up service for the correction of the remedial defects which were discovered in the health examination.

3. Inspection of pupils. The control of communicable disease by cooperating in daily health inspection of pupils for signs of health disturbances, excluding all pupils showing signs of acute illness and by promoting immunization.

4. Readmission after illness. Every child should be examined after abscence to determine the cause. This also enables the nurse to keep a closer check on the individual child and the various illnesses present. It also helps insure the enforcement of quarantine laws.

5. Promotion and maintance of Hygiene and Sanitation of the school plant. The nurse should be alert to notice such conditions as the following: type of ventilation, method of sweeping, temperature of school room, cleanliness of toilets and lavatories, presence of soap, towels and hot water, type of drinking fauntains and source of water supply, playground equipment, facilities for play on rainy days, school lunch arrangements, adjustment of desks to fit the child, lighting, heating plant and general appearance and cleanliness of rooms and personnel.

6. Cooperation in the health education program. The nurse can aid by remembering that one of the objectives of the health program is the education of the child about his own health. She should foster favorable attitudes in the child towards the value of health. The nurse should be instrumental in the instituting of routine physical examinations of all teachers and applicants with complete personal histories of each.

7. Parent education. By means of the Parent-Teachers Association and home calls, the nurse should aid the parents in giving each child the benefit of an ideal home environment. She should also stress the importance of immediate remedial care of all physical defects present. Home calls should also be made to explain exclusions and aid in securing needed care.

8. Nursing supervision of physical hanicapped in special classes. The nurse should help guard against any unhealthful over activity and the modification

of individual programs whenever the physical condition requires such. She should cooperate in the adjustment of the exceptional child.

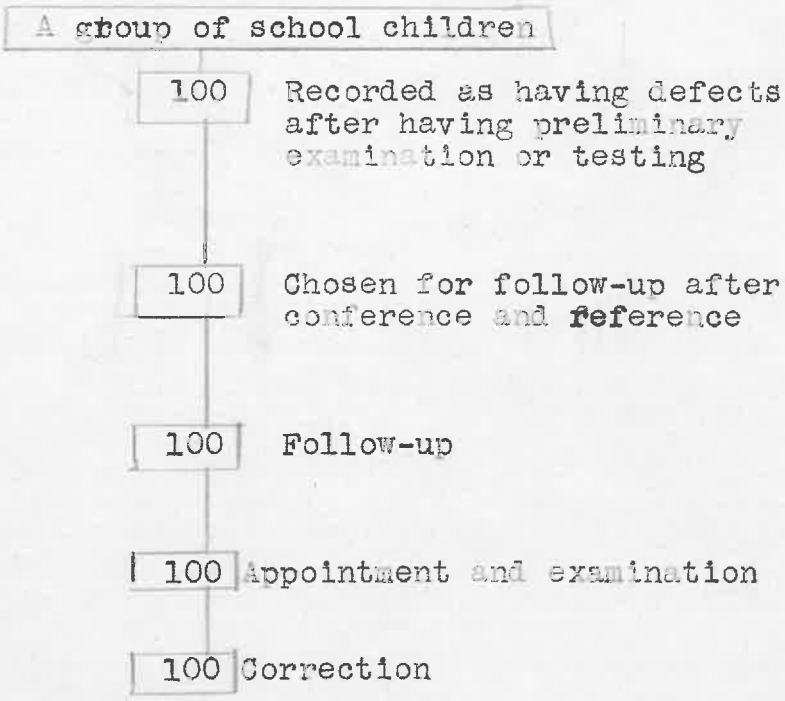
Upon mentioning a school health program the immediate thought includes: vision and hearing testing, nutrition, with measuring and weighing, physical examinations, contagion control and immunization. Let us consider each of these items to determine the nurse's responsibility in carrying on an ideal program of which these are a part. In many cases in the past defects have been found by health examinations conducted by the nurse and doctor. Often the stress was placed on the attempt for an examination of every child, necessarily neglecting adequate follow-up. The end result in many cases was extensive records of the defects of the school child with few corrections or relief from adverse conditions.

The recent publication "Physical Defects- The Pathway to Correction" is the result of a study made of 24,833 children in 121 schools, representing 95 nurses and 579 teachers. The purpose of this study was to find out the percentage of defects not corrected and the reasons for the school's failure to obtain these. It serves also as a valuable aid in pointing out the pitfalls found in any school nursing department. I shall refer to this study in evaluating various divisions of the ideal program.

(see charts I II and III)

CHART I

PATHWAY TOWARDS CORRECTION UNDER OPTIMUM CONDITIONS



This shows 100 true defect cases following an optimum pathway towards terminal correction.

(The following charts are taken from the study Physical Defects- The Pathway to Correction.)

CHART II

METHOD OF CLASSIFICATION OF UNCORRECTED DEFECT CASES

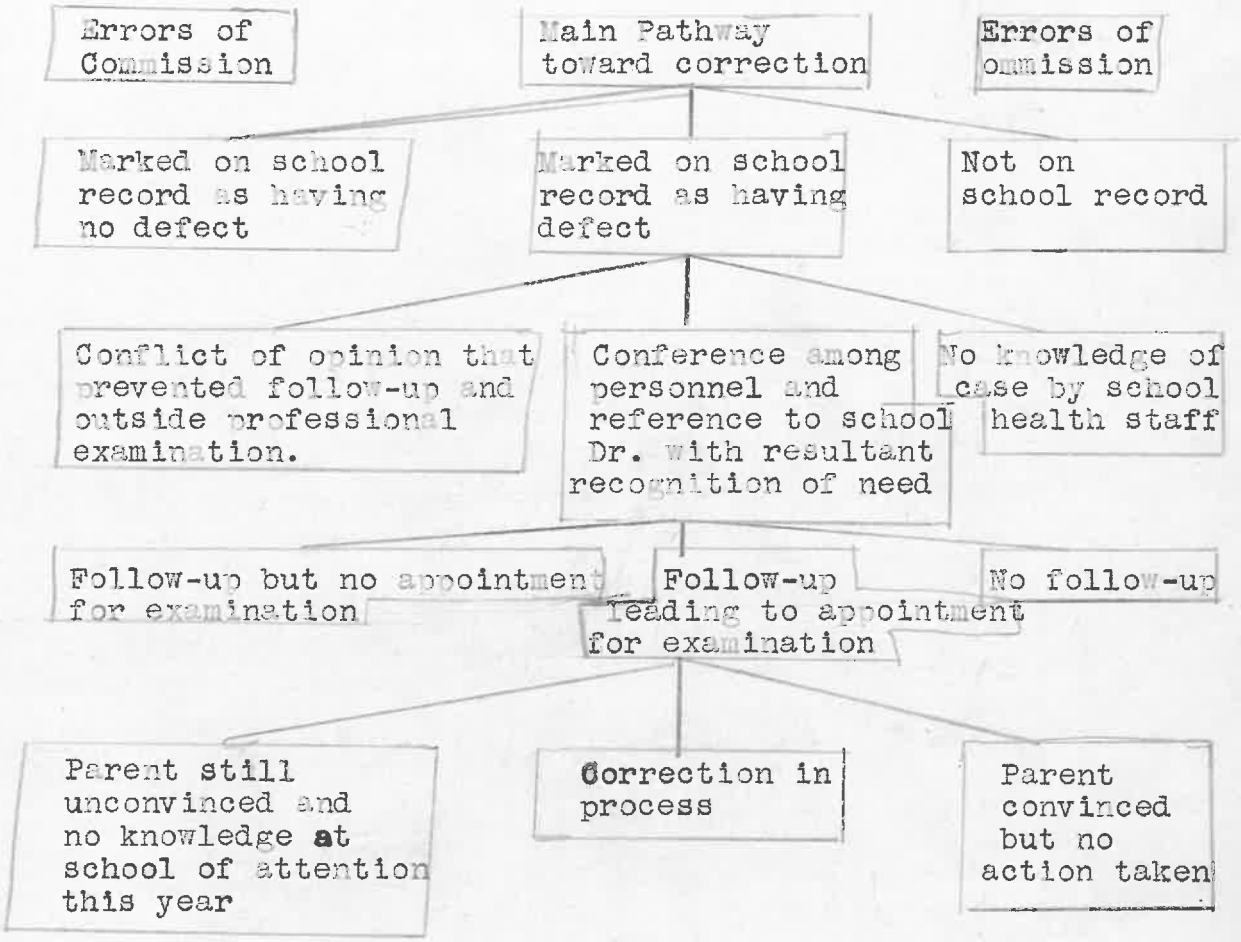


CHART III

MANNER IN WHICH SCHOOLS INFLUENCE IS EXERTED

Method of Procedure	High economic Status	Average status	Low status
Message by child	48%	37%	55%
Home visit	24%	26%	21%
School visit by parents	19%	32%	18%
Undetermined	9%	5%	6%

CHART IV

SOURCES OF PRESCRIPTIONS FOR GLASSES

FROM	High	Medium	Low
Optometrist	60%	42%	48%
Clinic	27%	48%	41%
Private Ophthalmoligist	13%	10%	11%

VISION

The standard method for vision testing is the use of the Snellen eye chart. Every child should be given vision tests at regular intervals throughout his school experience with additional check ups in the presence of any symptoms of eye strain, such as reddened or discharging eyes, styes, squinting, holding book close or bending over work and headaches.

The test card should be kept out of sight when not in use so as to prevent the students becoming familiar with the letters. It should be placed preferably, so that the child can stand 20 feet from it. The child should never face the light in having this test, but instead the chart should be placed at about the height of the eyes in a good light that comes either from the side or by means of a special shaded light over the chart. The room should be quiet to insure against distraction. The child is placed at the desired distance from the chart and a stiff piece of paper is held in fron of (not against) one eye. By means of a black paper window, one letter at a time is exposed. He is asked to read each letter in order, beginning with the larger ones. If the child reads all the letters, including those for the distance at which he is placed, (if 20 ft. away) his vision is normal and is expressed as 20/20. Any fraction over I will indicate a keener vision than average, 30/20 for example. Clinically defective vision, the inability to read the test lines above those for the

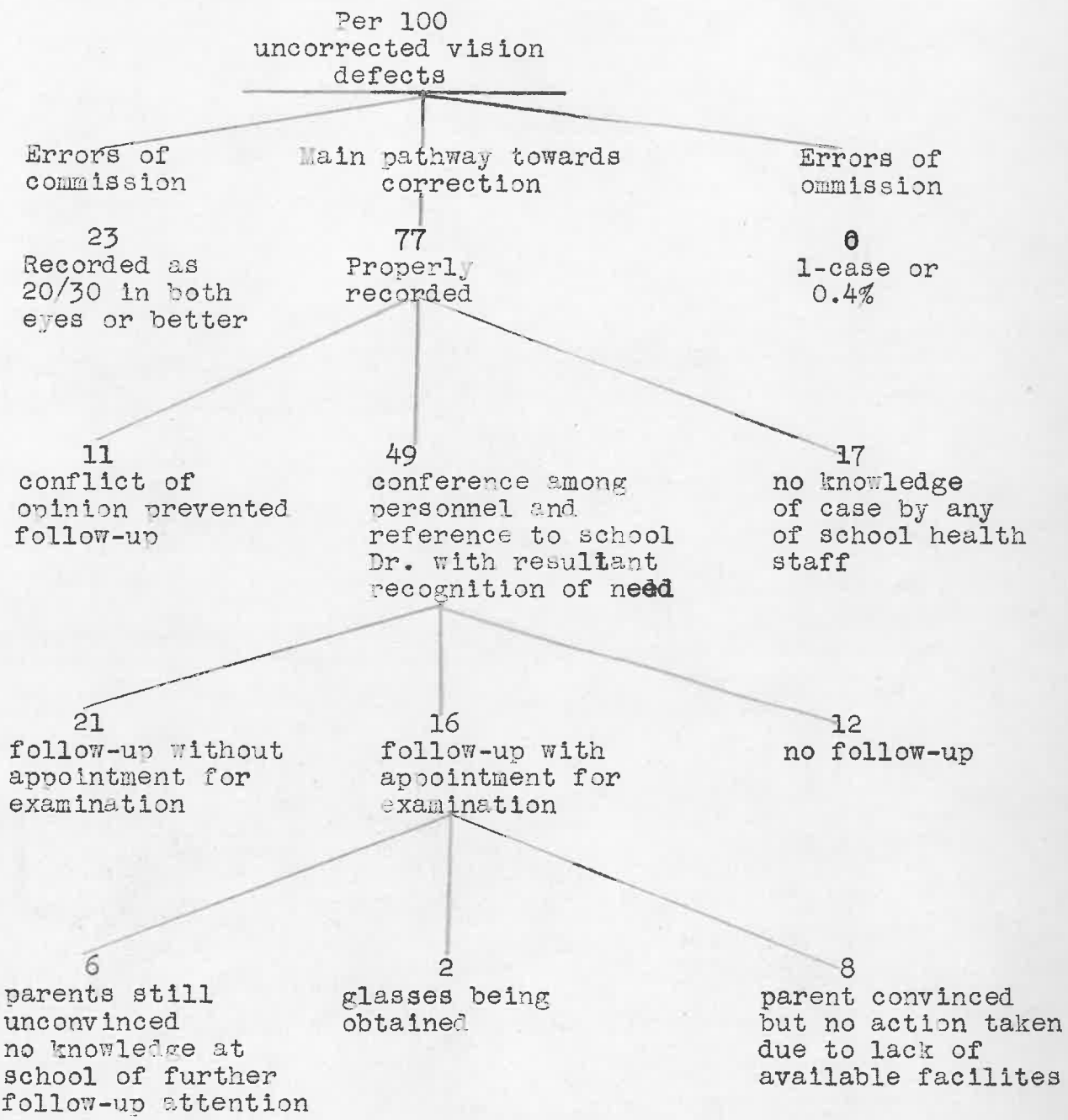
prescribed distance is expressed in a fraction less than I, for example 20/70, 20/40 etc. 20/30 vision is regarded as within the limits of normal. A test of 20/40 or less should serve as an indication for the need of an examination by the family doctor or eye specialist. Both eyes are tested in this way with a clean card for each eye. It is often a good plan to recheck the student within a few days to see if his vision remains the same. It must be remembered that the Snellen test does not show all the defects of the eye. It is very difficult to test the vision in the primary grade youngster even though the special E chart is used. The test must be repeated for accuracy if any marked deviation from normal is noted. If the student wears glasses he should have each eye tested with and without his glasses and both results recorded.

In the study just mentioned, made on the 5th and 6th grade children it was found that 14% of all the children had severe vision defects and only about one-half of these wore glasses. It was found that about two-thirds of the total number of children who were wearing glasses were wearing them due to the school's influence in their getting them.

An investigation was made as to the adequacy of corrections. Re-examinations were obtained for 28 cases. Twenty two of whom had obtained their prescription from an optometrist and six from ophthalmologists. Re-examinations at the health department clinic changed the

CHART V

UNCORRECTED VISION CASES



prescriptions for 26 children out of the 28. This shows the urgent need for more complete investigation of the adequacy of the prescriptions issued. It also shows the need for reliable corrective facilities and continued follow up.

(see chart IV and V)

The resume and interpretation of the study on vision stated that 14% of the five thousand 5th and 6th grade children had a visual acuity of 20/50 or worse, measured without glasses. About half of these were wearing glasses. The failure to secure correction for the rest was due to:

1. The attempt of the school health work to choose too many cases for follow-up and correction when the staff was not large enough. This scattered effort resulted in many severe cases remaining uncorrected.

2. About 1/5 of the severe cases were measured and recorded as normal due to inaccuracy of measurement. These two groups include about 2/3 of the failures for corrections.

3. The ineffective follow-up and lack of facilities.

Every nurse should strive above all else to do what she does do well as the end result will be of much more value than a multiple program poorly done.

HEARING

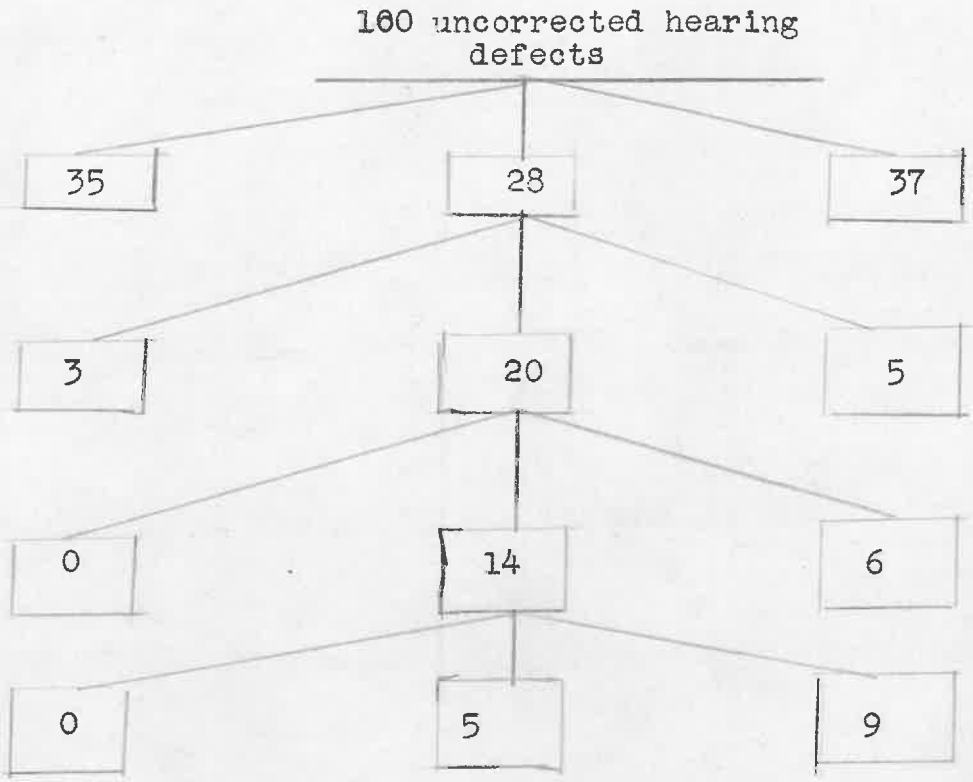
Perhaps hearing is one of the most difficult tests for the nurse to make accurately. She should, with the aid of the teacher, be on the look out for any symptoms displayed in the classroom such as inattention or

dullness on the part of the pupil. Two methods may be used for testing hearing. The watch-tick test is used by some. An Ingersoll watch is preferable. It is at a distance of 48 inches that a person with normal hearing can hear the watch tick. For this reason this distance is considered as a standard in this method of testing. The test is given in a quiet room, any watch not being used should be removed from the person of the examiner or the examined. The child stands side ways with his hand over the ear not being tested. The nurse places the watch close to the ear and gradually withdraws it directly sideward until the child is unable to hear it. If the point of hearing extends only 15 inches then the hearing is 15/48. The test is then reversed, commencing at a distance of not less than 48 inches and bringing the watch slowly towards the child. The test is stopped at the distance the child can hear the tick. The average of the two tests should be taken. This test should be repeated to make sure the child's desire to please and imagination has not come into play. The difficulty in using this test is the difficulty in obtaining watches with ticks of the same volume, thus making it difficult to set a standard.

The whisper test is no doubt more widely accepted. The nurse uses a whisper voice by emptying the lungs of all normal air and then whispering distinctly with residual air. The room must be very quiet. For an average whisper the distance is about 40 feet. The

CHART VI

UNCORRECTED HEARING CASES



child stands about 20 ft. away from the nurse with face away and closing the ear not being tested. If the child can not repeat the numbers whispered to him the nurse comes nearer until he is able to. This distance is noted. When the hearing rating is from 10/40 to 15/40 the child is considered in need of special attention.

The audiometer is by far the most successful method in use. The audiometer is an electric phonograph which transmits sounds to receivers which each child holds to his ear. A phonograph record of a series of three digit numbers with decreasing volume of sound is played. The child writes down the numbers as he hears them. This test to be accurate, should be given in a sound proof room. The test must be repeated to insure correct results. This is also a much more rapid method as 100 to 150 children can be accurately tested an hour with a complete set up.

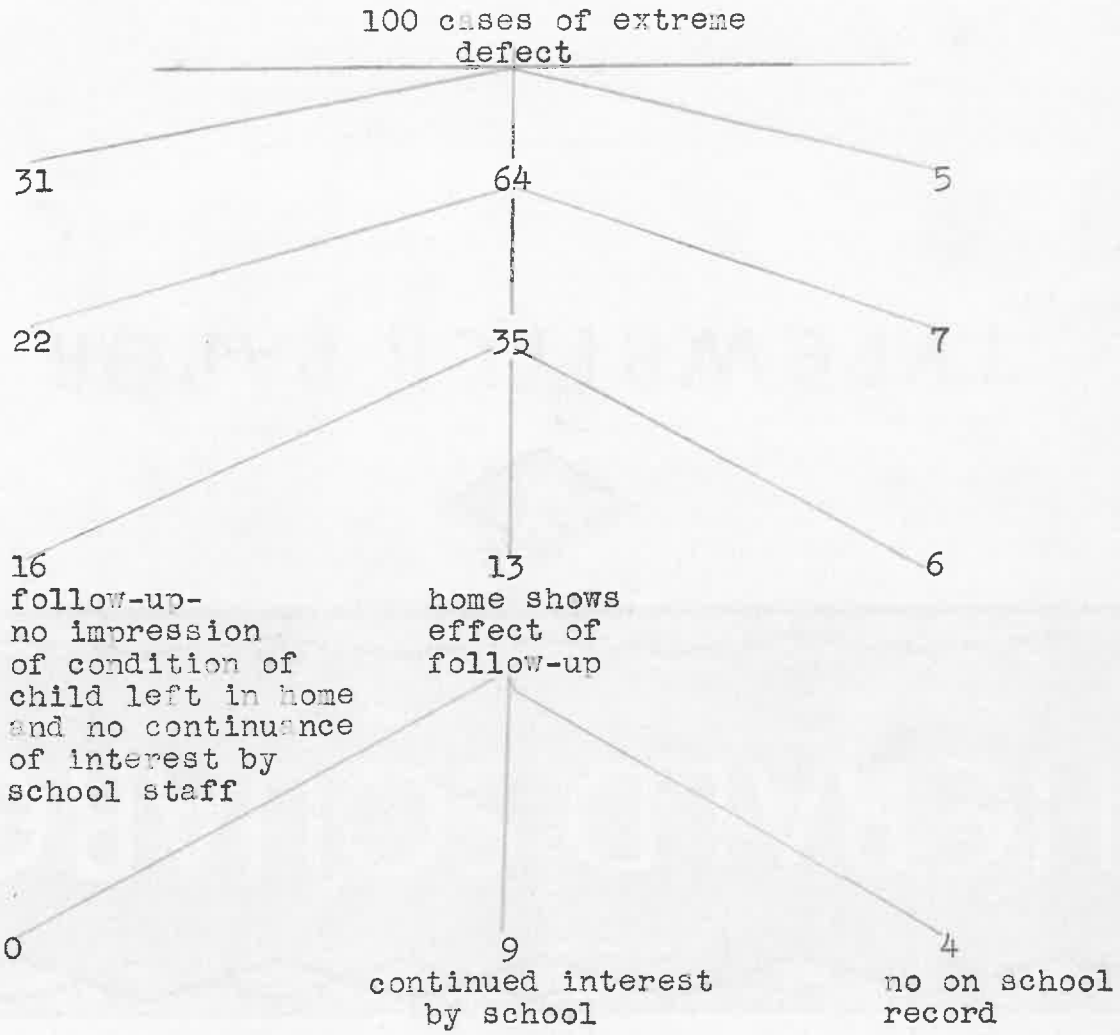
What degree of correction in the case of hard of hearing that can be obtained is questionable. The school nurse should strive to have the child given an adequate examination to determine if any treatment can be instituted. She should also select those students in need of admission to a hard of hearing class with special instruction.

(see chart VI)

In Philadelphia in 1923 inspectors reported from 0.2 to 1.5 per cent of children as hard of hearing and the average of 70 examiners was 0.5 per cent. In the

CHART VII

NUTRITION



Detroit school 1925-26 the average was reported as 0.8 percent of children. Among the boys examined by the Public Health Service in Porter County, Indiana 1916, "13% suffered from impaired hearing which ranged from total loss in one ear to the ability to hear (the watch) at nine-tenths of the normal distance in one ear."

NUTRITION

Every child should be weighed at least three times during the school year and once a month if no regular gain is noted. The child should also be observed as to posture and general muscle tone and any abnormalities noted, for further follow-up. The accepted standard for weight measurement is to use a standard scales, weighing the children without shoes, coats, or sweaters.

(see chart VII)

The nurse must use every means available to interest the P.T.A. and other organizations in the importance of the proper diet for the school child, often gaining their interest in supplying mid-morning milk and hot lunches.

PHYSICAL EXAMINATIONS

There is a wide variance in the type of health examination carried on in individual schools. When no medical examiner, employed or voluntary, can be secured the school nurse must make inspections for contagious diseases and examinations for physical defects, including condition of the eyes, ears, nose, throat, skin,

breathing, posture, general physique and mentality. She should make recommendations to parents for competent professional advice for any child showing abnormal conditions. The school nurse should have built up a friendly relationship with the child and parent to insure the interest of both in health examination.

The nurse working in a school health department with examining physicians should arrange for a date for examination well in advance. She should gain as complete a previous health history of the child as possible, as well as of his mental habits and behavior. The child should be weighed, measured, vision and hearing tested and consent gained from the parents previous to the physical examination. Due to the lack of funds and personnel there is a variance as to the frequency of examination. A complete examination should be given every two to three years with added examinations in the presence of any abnormalities. A week or ten days before the examination is to be given a written notice should be sent home inviting the parents to attend the physical examination of their child. The name of the doctor and the time the examination will take place should be stated on the invitation. The nurse should have developed in the child the proper attitude towards the examination. It should be one of eagerness and anticipation to him to secure his health status. The nurse should have her work so planned that with the assistance of trained P.T.A. members she may be free to act as overseer to welcome and aid the parents and to assist the

doctor if needed. She should strive to make the parents feel at home and act as interpreter for the doctor in case of misunderstanding of his advice and instruction. The child's parents should be encouraged to ask the doctor any questions they might have at this time.

The set up for physical examinations is essentialy a simple one. If possible, a waiting room for parents with an adjoining room for dressing and undressing the children, and a room in which the doctor conducts the examination should be available. This insures privacy which is to be stressed at this time most of all. A table covered with a clean white sheet is needed, with tongue depressors, alcohol, cotton, and the various forms needed by the doctor to be used in making his recommendations. Various kinds of literature on immunization, health habits, posture, exercise, sleep, rest, etc, should be near at hand. Some facility must be provided for the doctor to wash his hands between examinations. If there is not running water in the room a basin, pitcher and waste basin should be supplied, as well as towels and a waste basket.

If the children are asked to strip to their waist, "nightingales" or some sort of covering should be supplied.

The ability to conduct a well organized clinic which moves smoothly without hurry or interuptions is certainly to be strived for by every school nurse.

CHART VIII

PERCENTAGE OF 11 YEAR OLD CHILDREN WITH CONTINUOUS DENTAL ATTENTION

High economic status	Medium	Low
8%	5%	4%

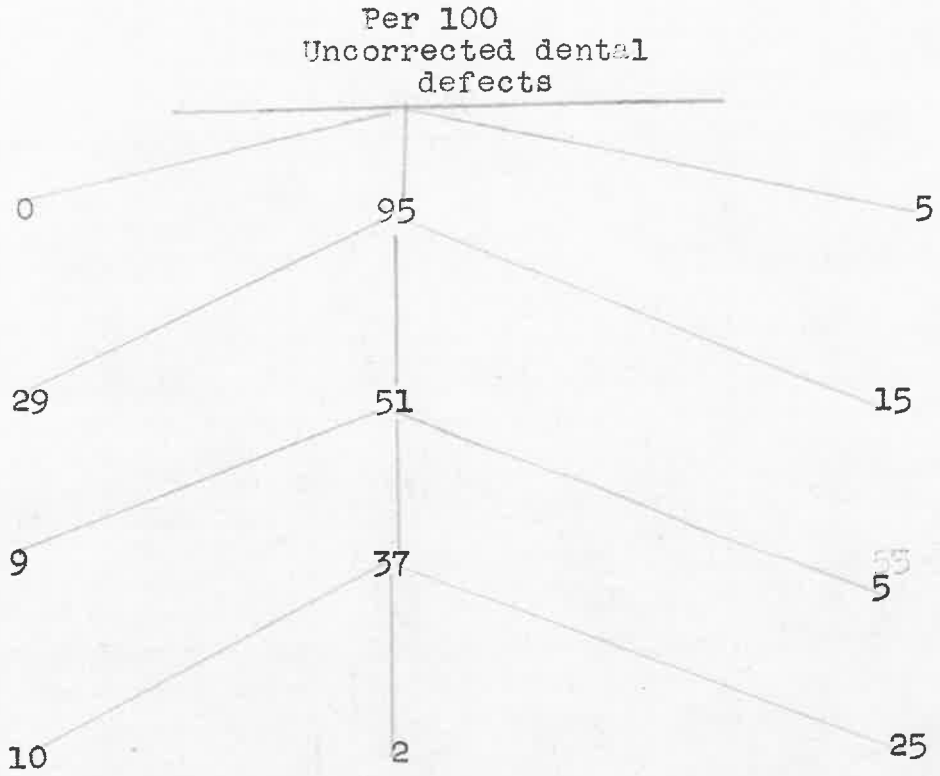
CHART IX

OCCURENCE OF EXTREME DENTAL CONDITIONS IN DIFFERENT ECONOMIC STATUS

High	Average	Low
3%	6%	13%

CHART X

UNCORRECTED DENTAL DEFECTS



CONTAGION CONTROL

The school nurse is responsible for the admitting and excluding of all pupils suffering from infections or contagious diseases. All children with an evidence of skin eruptions, inflamed eyes, sorethroats, running noses or general malaise should be referred to the nurse by the teacher. The nurse is the one person responsible in the school to see that quarantine laws are enforced as well as to report any cases she suspects to the Health Department for diagnoses. She takes throat cultures, excluding the child until the report is received. She must isolate from the group, any student with a temperature, rash or evidence of infection, in order to insure the health of the group. The nurse is often a valuable aid in helping the mother at such a time with the needs of her child and stress the importance of proper care and treatment.

The nurse has the opportunity for carrying on immunization of all the children. By child and parent education as to the health and economic value involved, she can make it an established part of the school health program. Every school should have included as a part of its program small pox vaccination, diphtheria immunization, and tuberculin testing of all children. Statistics show the marked decrease in the number of cases and deaths after such a program has been instituted.

Records

Every school nursing department has its own form of records. The purpose of any record is to present a complete picture of the work that has been carried on and the future needs of the child. The records of a school health department should present a complete record of the child's health status, past illnesses, and physical defects, corrections and treatments secured, records of mental habits, behavior, and health habits including rest, diet, exercise, how far the child has to walk to school, and his use of the hours out of school. Any consultation made between the nurse and parents should be noted on the record. This record card is a permanent history of the child's school experience and give a complete picture in case the child chages school or when used for reference.

TREATMENT IN EMERGENCIES

Every school nurse should have standing orders compiled by an advisary committee for all treatments given in school. In the case of accidents she is expected to render first aid, contacting the parents immediately, notifying the family doctor if urgent. In case of failure to contact the parents she is to care for the child until they can be reached. Any child that becomes injured or ill at school should never be allowed to go home alone.

THE IDEAL SCHOOL NURSE

WE should always have an aim or goal in everything we do. Let us consider a few of the qualifications or standards the school nurse should strive to fulfill in order that she might be better fitted to carry on her chosen work. First let us consider her educational background. She should be a graduate registered nurse from an accredited hospital. She should be a graduate of a recognized Public Health Nursing course or meet the requirements set out by the National Organization of Public Health Nursing. The nurse should be in good standing with all her nursing organizations. Any added educational background or experience is to her advantage as she will find use for it all in meeting various situations as they confront her in her work. The school nurse must be healthy and in good physical condition. Certainly she would not serve as a good example if she herself were not up to par physically. She must at all times appear well groomed, paying close attention to cleanliness of hair, nails, and clothing. She should appear neat and tailored in her uniform, omitting elaborate hairdress, excessive make-up, ear rings, or any form of jewelry. A pleasing personality is a great asset to the school nurse. She must have acquired the ability to get along with people so they don't irritate her or she them. She must be understanding at all times, and have a real interest in people and her work.

Lina Rogers sets forth the qualifications for a school nurse as follows:

1. She must have a tenacity of purpose.

2. She must have deep human love for all children.

3. She must be able to gain confidence.

4. Her disposition must be cheerful but earnest, bright not frivolous.

5. She must be sincere.

6. She must have good sense, not easily disgusted by crudeness.

7. She must have a natural curiosity and tact.

8. The school nurse becomes the child's ideal through:

   a. training
   b. ability
   c. keen observation
   d. good sense
   e. sound judgment
   f. highest ideals and sesitive vision of her influence on the impressionable developing child.
   g. love of achievement
   h. initiative
   i. honor
   j. mercy
   k. truth
   l. naturally kind
   m. character blameless

CHAPTER VI

LOOKING FORWARD

School nursing has made such rapid advance in the past half century that we can only hope that it can advance to even a greater degree in the future. We can look to the future for an extended health program in high school and college, and with a full time public health nurse in every school. We can look to the day when the community will look to a school nurse as essential to the education of the child as the geography or history teacher. The future should bring a more firmly established school nursing program, integrated in the whole school program. It is hoped that the nurse will not be pressed for time as in the past and that she will be able to establish a stronger relationship between the home, and the school, correlating the work of each to best serve the development of the child.

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