Nursing Documentation: Health Records and Health Forms

Rationale for Nursing Documentation

Nursing documentation is a vital component of safe, ethical, and effective nursing practice, regardless of the context of practice or whether the documentation is paper-based or electronic. Standards of nursing practice also require adherence to the nursing process and systematic and continuous documentation of care. Additionally, these components also define the practice of nursing to include the recording and reporting of the nursing assessment, plan of care, care given and client's response to that care. Documentation includes subjective data, objective data, nursing diagnosis (judgment) based on the collected data, a management plan, and ongoing reassessment and revision of the plan as needed. Professional standards for documentation and correction of records should always be used. Rationale for nursing documentation include accountability, legal protection, quality assurance, professional responsibility, communication with other health professionals, and assurance of required components for service reimbursement.

Federal legislation and nursing licensure mandate confidentiality in all record-keeping. Records must be maintained in a manner that supports health care services in school while protecting the student and family from unauthorized release of personal health information. The storage and management of all health records and forms should be addressed in the LEA policies and procedures.

Components of the Student Health Record

The NC *Student's Permanent Health Record (PPS-2P)* is an optional document available from the Department of Public Instruction. This document, or a similar district specific form, may be stored within the cumulative education record. The purpose of this abbreviated record is to provide ready access to health-related information that will further a student's academic achievement and/or support a safe and orderly teaching environment. It should contain information that all school staff working with a student might need to access, such as student health status, immunization information, emergency health information, notations that an EAP or IHP exists, and results of screenings and follow-up disposition. As with all student records, it is a component of the student's total education record and follows the cumulative folder within the system and upon student transfer to another system.

An individual student health record is an individually retrievable record generated by the school nurse and/or other specialized instructional support personnel. The nursing component of the record should be established for documentation of health room visits, assessment data needed for developing the plan of care, and/or individual health care plan, management of chronic condition concerns and other mental and physical health issues. To limit access and protect confidentiality, this record should be stored separately from the cumulative education record. Information is shared with others, on a need-to-know basis within the school setting as necessary to support student health and safety. This sharing is limited to those who have a legitimate educational interest in the information or a specific "need to know."

Medical Records from outside providers that have been obtained by parental consent, should be stored in the individual student health record. Pertinent records should be maintained by the school and become part of the education record, governed by the Family Educational Rights and Privacy Act (FERPA). Only portions needed to support student health and safety in the school should be retained. When information is sent from an outside provider that is not needed for this purpose, it should be immediately destroyed or returned to the provider. A release of information should explicitly list the types of information being requested and indicate when a summary is sufficient. The purpose of the request should be clear. Health information generated by schools for data collection purposes should be non-student specific, with no personally identifiable information, this information does not need to be stored in a student's record.

Health Room Visit Documentation

"A global transmittal of students' health issues that contains identifiable, personal information is not permissible under privacy laws and does not constitute best practice. (The Network for Public Law, 2019). The use of multi-student logs that list the names of students with other information is **not recommended** due to compromised confidentiality and lack of ability to individually retrieve records. All health room visits by students should be documented. In the absence of an electronic documentation system, the school nurse should have a paper process in place to record the nursing process, document sensitive health issues, and file episodic health room visits as care is provided.

General Principles of Documentation

The following information can be found in *School Nursing: A Comprehensive Text* (Brous, E., 2019, p. 149). NASN's basic principles of documentation have been incorporated into state and local board policies. They state that nursing documentation should be accurate, objective, concise, thorough, timely and well organized.

1. All entries should be legible and written in ink or on a computer. Typically, ink should be black or blue.
2. Computerized records must be secure, and password protected.
3. The date and exact time should be included with each entry.
4. Documentation should include any nursing action taken in response to a student's problem.
5. Assessment data should include significant findings, both positive and negative.
6. All records, progress notes, IHPs and flow charts should be kept current.
7. Documentation should include only essential information; precise measurements, correct spelling, and standard abbreviations should be used.
8. School nursing documentation should be based on nursing classification and included uniform data sets.
9. The frequency of documentation should be consistent over time and based on district policy, nursing protocols and the acuity of the student's health status.
10. Standardized health care plans increase efficiency of documentation and are acceptable to use so long as they are adapted to the individual needs of each student.

11. Student symptoms, concerns, and health maintenance questions (subjective data) should be documented in the student's own words.
12. Only facts (objective data) relevant to the student's care and clinical nursing judgments based on such facts should be recorded; personal judgements and opinions of the nurse should be omitted.

Use of Abbreviations, Acronyms & Symbols

The use of abbreviations in charting is a timesaver, but the practice can lead to confusion and serious mistakes, particularly in a non-healthcare-oriented setting like a school. Any abbreviations used in a practice setting must be shared and understood. Each school district should adopt a list of common abbreviations and avoid the use of abbreviations not on that list. The Joint Commission on Accreditation of Healthcare Organizations recommends that certain abbreviations never be used in charting. at www.jointcommission.org/facts_about_do_not_use_list.

Confidentiality of Health Information in Schools

Family Education Rights and Privacy Act (FERPA)

Managing school health records is a challenging responsibility for school nurses and school administrators. These responsibilities should follow system-wide policies and procedures for documentation that include the generation and maintenance of records, protection through secured storage and access, and disclosure and destruction of students' school health records. School systems generally have a student records policy and procedure. School nurses should ensure that the policy and procedures address health records, whether integrated within the existing policy or added as an additional "health records" section.

FERPA allows for health information to be shared with other individuals within a school system who have been determined to have a legitimate educational interest. Sharing is allowed when the information will benefit the student academically, when it is needed for the individual to carry out their duty related to that student, or when necessary for the health/safety of the student. This type of disclosure does not require parental consent. FERPA permits school districts to define who in their district has a legitimate educational interest in accessing and disclosing various types of student records. The U..S Department of Education provides a link to FERPA requirements. Please see that program page for a detailed description of FERPA requirements.

Any individually identifiable student health information contained in an "education record" as defined by FERPA is subject to FERPA's privacy protections. An education record is any form of information directly related to a student that is collected, maintained, or used by the school or a party acting on behalf of the school or district. Records generated by the school nurse are considered education records, whether the school nurse is employed by the school system or by a contracted agency (health department, hospital, other agency) providing school health services.

FERPA allows for the transfer of educational records without parental consent to another school where the student seeks to enroll. Procedures for the transfer of student health records should address each type of health record maintained. Some items may no longer be considered relevant, or may be summarized, for the purpose of record transfer.

All school districts receiving federal funds must follow FERPA's provisions governing the disclosure of records and prevent unauthorized disclosure. The Health Insurance Portability and Accountability Act (HIPAA) imposes no additional privacy requirements concerning educational records and has a broad exemption for education records. HIPAA is generally not applicable to school health records as described.

School Boards governing public, private and charter educational facilities should adopt policies and procedures that govern the way confidential student health information will be protected. Ultimate accountability for maintaining the confidentiality of student records resides with district/school administration.

Recommended Health Record Procedures

Generation and Maintenance

- Inform students and families regarding the handling of health information in schools. (Clearly state in the student handbook/other parent information sources.)
- Per local policy, determine the types of health records utilized in the district and clarify what will go in each record.
  - Student's Permanent Health Record maintained in Cumulative Folder (if applicable).
  - Individual Student Health Record.
- Schedule staff training (annually and as needed) on school district policy/procedures regarding the privacy and confidentiality of student health information.
- Define, by title, individuals that have access to each type of student health information.

Secured Storage and Access

- Storage of health records should be addressed.
- Electronic health records should be maintained with overwrite protection, multi-user passwords, multi-level access, and automatic back up.

Recommendations for Releasing/Disclosing Student Health Information

Internally: Within the School System

- Direct access to the Individual Student Health Record should be limited to school health professionals and staff with a defined need for access.
- As the primary health care provider, the school nurse may recommend how much and

under what circumstances school staff would have access to individual health information. Limit disclosure to the details necessary to benefit the student.

- Health information that may impact the child's academic achievement must be shared with school staff that work directly with the student and who have a legitimate need to know the information.
- Clearly define and implement measures to ensure that school health records (both the Student Permanent Health Record and the Individual Student Health Record) move with the student to other schools within the district.
- Avoid circulating lists or creating logs with multiple student names or diagnoses for general distribution. Providing school staff with a list of student names and diagnoses is also considered a global transmission of health information. A name and a diagnosis alone do not provide enough information for school staff to effectively respond to a health concern and may not limit disclosure to those with a "need to know".

Note: School Based or Linked Health Centers are separate from the school system and are often operated by independent agencies. According to FERPA regulations, such centers are considered "outside agencies" and consent is required to disclose student records to them. The center's health records are subject to the HIPAA rules and regulations.

Externally: Transferring to Another School System

- Outline how health records will be transferred to another school system.
- The *Student's Permanent Health Record* (PPS-2P and its content) is part of the cumulative educational record and should be forwarded with the standard educational records.
- The *Individual Student Health Record* (separate health record) may be sent to another system without consent and is a part of the student's complete education record. Measures should be taken to identify the health record as confidential health information directed to the receiving school nurse.
- Medical records obtained from an outside provider through a "release of information" process may be forwarded to another school system if important to the academic success of the student or to meeting the health/safety needs of the student.
- If there are other types of health records maintained for students, they should be addressed in the procedures.

Externally: Releasing/Receiving Health Information Outside School System

The school system is responsible for protecting personally identifiable student health information and may not release it beyond a student's school system without written parental consent (or student's consent if 18 or emancipated) except as described above in transfer to a student's new school system. FERPA's definition of disclosure includes release, transfer, or communication by any means including oral, written, or electronic. System-wide procedures for releasing health information should address the following.

- Obtaining written parental consent before releasing Individual Healthcare Records or the

Student's Permanent Health Record outside a school system except as allowably by FERPA.

- Consent to disclose information should include:
    - name of the agency releasing the information,
    - identification of the person or agency to whom the disclosure will be made,
    - name of the student,
    - specific information regarding what is to be disclosed,
    - purpose for disclosure,
    - statement that consent may be revoked (until acted upon),
    - date or condition when the consent expires,
    - signature of the parent and the student (if applicable),
    - date the consent is signed, and
    - statement that the signer has a right to a copy of the release.

- Establish an interagency memorandum of agreement that addresses confidentiality issues with other agencies that provide services to students. Contracted agency employees working in the school are bound by FERPA.
- If transmitting information by fax, use a cover page, address the fax to a specific individual and label it confidential. Call ahead to ensure that the recipient is present.
- Avoid using emails to transfer health information. When necessary, take measures to maintain confidentiality such as encryption.

There are some allowable **exceptions** to obtaining parent (or student) consent prior to releasing information outside the school system:

- Reporting suspected child abuse/neglect.
- If there is reason to believe that the student may be a danger to themselves or others, which may be shared per school guidelines.
- Reporting communicable diseases.
- Releasing to law enforcement agencies/juvenile courts.
- Complying with subpoenas and court orders (the system must make a reasonable effort to notify the parent of receipt of the subpoena).
- State and federal officials responsible for supervising and auditing school funds.
- Contractors providing education or support services for a student.
- During an emergency, information may be released to appropriate parties providing emergency care.
- In the event of a health or safety threat to students or other individuals, such as the COVID-19 public health emergency, public health officials and trained medical personnel are among the types of appropriate parties to whom information may be released.

Externally: Receiving Health Information from Outside Sources

The U.S. Department of Education has ruled that medical records sent to schools are subject to FERPA regulations and treated as other education records.

- To obtain information from an outside source, the school district should send an

individual cover letter explaining why specific information is needed along with a signed parent consent form. (The consent form should contain the same elements listed under releasing health information).

- Only appropriate school health professionals should receive confidential health information, even if requested for educational planning purposes.
- Unrequested health information should be returned to the sender or shredded.

Archiving and Destruction

When archiving or destroying student records, the guidelines found in the *Health Records Retention and Disposition Schedule*, issued by the NC Department of Cultural Resources, Division of Historical Resources must be followed. Questions may be directed to the School Health Nurse Consultant.

Reference

Brous, E. (2025) The law and school nursing practice. In Shannon, R. A. & Yonkaitis, C.F, *School Nursing: A comprehensive text* (4th edition, pp. 106-125). Philadelphia: F.A. Davis Company.