TREATMENT GUIDELINES FOR HEALTH STAFF

ACNE

Authorized health and wellness staff may treat acne as follows:

1. Encourage the student to:

   - Wash the area gently one to two times per day. "Acne soaps" are not necessary. Never scrub or use abrasive washes. Allow the skin to dry completely before applying medication.

   - Avoid wearing hats, headbands, or other garb that rests upon the forehead. This may aggravate acne.

   - Avoid or minimize the use of hair oils, gels, or greases. This will increase the oiliness of the skin and worsen acne.

   - Never pick at acne lesions.

2. Administer benzoyl peroxide 5% gel, applied lightly to affected areas twice daily.

WHEN TO REFER TO THE CENTER PHYSICIAN

- If acne does not begin to improve after 6-8 weeks of daily use of the medication
- If there are large areas of involvement (e.g., chest, shoulders, back)
- If acne is pustular
- If there are deep lesions that are causing scarring and pitting
- If female students with significant acne have other signs of possible hormonal problems (hirsutism, infrequent or absent menses, acanthosis nigricans, etc.)

TREATMENT GUIDELINES FOR HEALTH STAFF

ACUTE ALLERGIC REACTION

Authorized health and wellness staff may treat a suspected acute allergic reaction as follows:

1. If swelling of the lips, tongue or throat tightness occurs, with or without trouble breathing, administer an EpiPen and call 911 to transport the student to the nearest Emergency Department.

2. Associated symptoms requiring EpiPen and EMS transport include any of the following:

    - Hypotension with systolic blood pressure < 90 mm Hg
    - Shortness of breath, wheezing, stridor, cyanosis, respiratory distress
    - Chest pain, palpitations, tachycardia, flushing
    - Dizziness, syncope, headache, altered mental status
    - Severe abdominal cramping, nausea, vomiting

3. Albuterol can be administered by nebulizer or metered dose inhaler (MDI) with oxygen via face mask for difficulty breathing, wheezing, stridor or cyanosis.

4. For skin manifestations, like itching or hives, administer a non-sedating H1 blocking antihistamine such as loratadine (Claritin) 10 mg po or fexofenadine (Allegra) 60 mg po. Diphenhydramine (Benadryl) 50 mg po or IM can be used, but will be sedating.

5. Consider the addition of an H2 blocking antihistamine such as famotidine (Pepcid) 40 mg po and/or prednisone 60 mg po for severe itching or extensive rash.

6. Observe for no less than 1 hour for improvement or worsening symptoms.

7. Any students with a history of anaphylaxis should be allowed to carry an EpiPen on their person at all times.

WHEN TO REFER TO THE CENTER PHYSICIAN

1. Any student who has required use of an EpiPen

2. Any student transported to the Emergency Department

3. Any student with a reaction to a newly identified allergen

TREATMENT GUIDELINES FOR HEALTH STAFF
ASTHMA

Authorized health and wellness staff may treat asthma as follows:

All students with asthma should be managed according to current NIH Guidelines. The 2020 focused update is available at: https://www.nhlbi.nih.gov/health-topics/asthma-management-guidelines-2020-updates. The full update report is available at: https://www.nhlbi.nih.gov/health-topics/all-publications-and-resources/2020-focused-updates-asthma-management-guidelines.

Acute Management

1. Severe Bronchospasm

   Obtain vital signs and pulse oximetry. Any student with severe wheezing, muscle retractions, gasping, blue color or other signs of respiratory distress requires immediate medical attention - call 911 for emergency transport. Administer oxygen by facemask if available and initiate Rescue Therapy:

   Provide the Inhalation of a short-acting β_2-agonists (albuterol). It is advisable to administer a nebulizer solution with a concentration of 2.5 to 5 mg every 20 minutes for three cycles, or if treating with a metered-dose inhaler, have the student administer 4 to 8 puffs of 90 mcg (albuterol base) every 20 minutes.

2. Mild-moderate Bronchospasm

   In the absence of signs of severe respiratory distress needing immediate medical attention, students with asthma who experience acute mild to moderate bronchospasm should be instructed initiate Rescue Therapy:

   Administer inhalation of a short-acting β_2-agonists (albuterol) at a dose of 2 to 4 puffs of 90 mcg (albuterol base) every 20 minutes.

Chronic Management

1. CLASSIFICATION: classify all students with asthma according to the National Heart, Lung, and Blood Institute (NHLBI) severity guidelines:

   Intermittent
   - symptoms ≤ 2 days a week
   - nighttime awakenings ≤ 2 times a month
   - use of short-acting β_2-agonist ≤ 2 days a week

- no interference with physical activity

Mild Persistent
- symptoms > 2 days a week but not daily
- nighttime awakenings 3-4 times a month
- use of short-acting β_2-agonist > 2 days a week, but not daily, and not more than once on any day
- minor limitation of physical activity

Moderate Persistent
- symptoms daily
- nighttime awakenings > 1 time a week but not nightly
- use of short-acting β_2-agonist daily
- some limitation of physical activity

Severe Persistent
- symptoms throughout the day
- nighttime awakenings often 7 times a week
- use of short-acting β_2-agonist several times a day
- extreme limitation of physical activity

2. TREATMENT: treat all students with asthma according to the NHLBI guidelines:

Long-Term Control: **STEP 1** (intermittent asthma)
- daily medication is not needed
- as-needed short-acting β_2-agonist (albuterol) for rescue therapy

Long-Term Control: **STEP 2** (mild persistent asthma)
- daily low-dose inhaled corticosteroid
- as-needed short-acting β_2-agonist (albuterol) for rescue therapy

— OR —

- as-needed concomitant use of low-dose inhaled corticosteroid and short-acting β_2-agonist (e.g., 2-4 puffs albuterol immediately followed by 80-250 Mcg beclomethasone equivalent) every 4 hours

Long-Term Control: **STEP 3** (moderate persistent asthma)
(SMART: Single Maintenance And Rescue Therapy)
- daily (1-2 puffs once to twice daily) and as-needed (1-2 puffs every 4 hours) combination low-dose inhaled corticosteroids and long-acting β_2 agonists (fomoterol) (to a maximum total daily maintenance and rescue dose of 12 puffs (54 Mcg)

Long-Term Control: **STEP 4** (moderate-severe persistent asthma)
(SMART: Single Maintenance And Rescue Therapy)
- daily (1-2 puffs once to twice daily) and as-needed (1-2 puffs every 4 hours)

combination medium-dose inhaled corticosteroids and long-acting β_2 agonists (fomoterol) (to a maximum total daily maintenance and rescue dose of 12 puffs (54 Mcg)

Long-Term Control: **STEP 5** (severe persistent asthma)

- daily medium- to high-dose inhaled corticosteroids combined with long-acting β2 agonists (fomoterol) plus an add-on long-acting muscarinic antagonist
- as-needed short-acting β_2-agonist (albuterol) for rescue therapy

Long-Term Control: **STEP 6** (severe persistent asthma)

- daily high-dose inhaled corticosteroids combined with long-acting β2 agonists (fomoterol) plus oral corticosteroids
- as-needed short-acting β_2-agonist (albuterol) for rescue therapy

Exercise-induced bronchospasm/asthma

- short-acting β2-agonist (albuterol) for prevention
- use 5 to 20 minutes (optimally 15) minutes before exercise
- bronchodilation is rapid in onset and can last 2 to 4 hours
- tolerance can develop with frequent use but preferred as first-line treatment with limited side effects

3. At each visit monitor adherence to treatment plan, efficacy of the current treatment plan, inhaler use technique, environmental factors, and any comorbid conditions.

4. All students known to have asthma should have access to an albuterol inhaler **at all times** for Rescue Therapy on center and for off center trips.

5. Increasing use of Rescue Therapy to > 2 days per week for symptom relief (not prevention of exercise-induced bronchoconstriction) generally indicates inadequate control and the need to step up treatment.

6. The differences of albuterol (ProAir, Ventolin and Proventil) compared to levalbuterol (Xopenex) for rescue are negligible. It is recommended to prime the rescue inhaler before using for the first time and in cases where the inhaler has not been used for more than 2 weeks by releasing four “test sprays” into the air. Also, it is important that the mouthpiece be washed and dried thoroughly at least once a week.

7. Formoterol is a long-acting β_2 agonists but because it has a fast onset of action it can also be used as a rescue medication. Salmeterol causes bronchodilation in a slower manner. Both drugs are long-acting.

8. The combination of inhaled corticosteroids and a long-acting β_2 agonists (fomoterol) is available and preferably used in a single inhaler.

9. Cromolyn, nedocromil, leukotriene receptor antagonists (zileuton and montelukast), and theophylline were not considered for the 2020 update; limited availability and increased need for monitoring side-effects make their use less desirable. The FDA issued a black-box warning for montelukast in March 2020 due to adverse serious behavior- and mood-related changes.

10. Consult with asthma specialist if Step 4 or higher is required.

WHEN TO REFER TO THE CENTER PHYSICIAN

- If the student's wheezing does not respond within 10-15 minutes to 2-3 inhalations from an albuterol inhaler
- If the student presents with severe wheezing, muscle retractions, gasping, blue color or other signs of respiratory distress
- Students with increasing use of short-acting inhaled β_2 agonists
- Students who require daily medication for asthma management should be seen at least monthly

Refer to the Asthma Chronic Care Management Plan for additional guidance.

TREATMENT GUIDELINES FOR HEALTH STAFF

BACTERIAL VAGINOSIS

Authorized health and wellness staff may treat symptomatic, clinically confirmed bacterial vaginosis as follows:

1. Administer metronidazole 500 mg orally with fluids or snack twice daily for 7 days **or** metronidazole gel 0.75%, one full applicator (5 g), intravaginally once daily for 5 days **or** clindamycin cream 2%, one full applicator (5 g), intravaginally at bedtime for 7 days.

2. Alternative treatments with lower efficacy: administer clindamycin 300 mg po twice daily for 7 days **or** clindamycin ovules 100 mg intravaginally at bedtime for 3 days.

3. Symptomatic bacterial vaginosis (BV) has been associated with adverse pregnancy outcomes. Oral therapy has not been reported to be superior to topical therapy for treating symptomatic BV in effecting cure or preventing adverse outcomes of pregnancy. Pregnant women can be treated with any of the recommended regimens for nonpregnant women, in addition to the alternative regimens of oral clindamycin and clindamycin ovules.

4. Instruct student to return for re-treatment if vomiting occurs within 4 hours of treatment with oral regimens.

5. Caution student that many vaginal creams and ovules are oil-based and may weaken latex condoms and diaphragms for 5 days after cream use.

6. Discuss screening for STIs as appropriate, health department reporting requirements, and prevention of STIs and pregnancy (offer condoms and contraceptives as appropriate).

7. Routine treatment of sex partners is not recommended.

WHEN TO REFER TO THE CENTER PHYSICIAN

- If the student needs additional STI or pregnancy screening
- If the student reports failure of the above treatment
- If persistent vaginal discharge
- If onset of pelvic pain

TREATMENT GUIDELINES FOR HEALTH STAFF

BITES AND STINGS

Authorized health and wellness staff may treat bites and stings as follows:

For human bites:

1. Irrigate the open wound with saline solution.

2. Debride the wound as indicated.

3. Assess for possible presence of an imbedded foreign body.

4. Assess the need for surgical closure (steri-strip or sutures).

5. Consider the need for tetanus-diphtheria-acellular pertussis (Tdap) booster immunization if status unknown or last dose given more than 5 years ago.

6. If signs of infection are present or bite wound is on the hand, consider antibiotic treatment with amoxicillin/clavulanate (Augmentin) 875 mg every 12 hours for 5 days **or** doxycycline (Vibramycin) 100 mg twice daily for 5 days (contraindicated if pregnant).

7. Evaluate if human bite is indicative of abuse and/or assault and should be reported to authorities.

For animal bites:

1. Irrigate the open wound with saline solution.

2. Debride the wound as necessary and evaluate for surgical closure.

3. Consider the need for the Tdap booster immunization as with human bite.

4. If signs of infection, consider antibiotic treatment as indicated for human bites.

5. Report animal bites to local authorities and manage in consultation with state or local health department.

6. Examine the wound in 48 hours and again at the end of antibiotic treatment (if initiated at onset).

For insect and arthropod bites and stings:

1. For generalized urticaria, wheezing, chest or throat tightness, syncope, or dizziness, stabilize airway and give epinephrine (1:1,000, 0.3 ml) subcutaneously, diphenhydramine (Benadryl) 50 mg IM, nebulized albuterol for bronchospasm, and transport to emergency center as soon as possible.

2. Remove the stinger and cleanse the skin with a disinfectant.

3. Administer supportive measures, i.e., cool compresses and elevation of the body part.

4. For mild itching, systemic therapy with antihistamines, e.g., diphenhydramine (Benadryl) 25-50 mg po as a single dose or hydroxyzine (Atarax/Vistaril) 25 mg po as a single dose, may be given.

5. Antibiotics are **not** normally given unless there are obvious signs of bacterial infection. Local erythema and swelling are usually due to the chemical envenomation.

For snake bites:

1. Consult and manage in consultation with state or local health department.

WHEN TO REFER TO THE CENTER PHYSICIAN

- If cat bite, refer to center physician for consideration of antibiotic prophylaxis
- If the wound may require suturing
- For black widow spider or scorpion bite
- If lesions are not improving on antibiotics or there are signs of cellulitis (surrounding erythema, streaking from the lesions, local tenderness) or abscess
- If the wound is not healing **on** antibiotic therapy

TREATMENT GUIDELINES FOR HEALTH STAFF

BURNS

Authorized health and wellness staff may treat burns as follows:

1. Remove the student from the source of the burns.

2. Ensure an open airway is present and proceed with CPR if indicated.

3. If the burn involves the face, head, neck, fingers, toes, genitalia or more than 25 percent of the trunk or an extremity, call 911.

4. Irrigate the burn wound with sterile saline solution for one to two minutes.

5. Cover the burn with sterile gauze soaked in sterile saline solution. Use cling gauze to secure the saline soaked gauze. Leave blisters intact. Have the wound evaluated by the center physician as soon as possible.

6. Check immunization status and give tetanus-diphtheria-acellular pertussis (Tdap) booster immunization when indicated. Refer to Immunization Technical Assistance Guide.

7. If the wound has a broken blister or if only the dermis is injured, apply Silvadene cream bid until the center physician evaluates the patient within 48 hours. Call the center physician regarding the use of medication for pain relief.

WHEN TO REFER TO THE CENTER PHYSICIAN

- If the injury appears deeper than the dermis or contaminated with dirt, debris or chemicals despite irrigation, refer to the center physician or the emergency room immediately. Call the center physician regarding the use of medication for pain relief prior to transport.

- If inadequate pain relief

- If evidence of a secondary infection

TREATMENT GUIDELINES FOR HEALTH STAFF

CHLAMYDIA INFECTION

Authorized health and wellness staff may treat laboratory-confirmed chlamydia* infection as follows:

1. Recommended regimen: administer doxycycline 100 mg po twice daily for 7 days directly observed therapy with fluids or snack.

2. Alternative regimens: administer azithromycin 1 g po once as a single dose or levofloxacin 500 mg po once daily for 7 days.

3. If pregnant administer azithromycin 1 g po once as a single dose. Alternative regimen: amoxicillin 500 mg po three times a day for 7 days.

4. Instruct student to return for re-treatment if vomiting occurs within 4 hours of treatment.

5. Discuss contact(s) treatment, screening for other STDs as appropriate, health department reporting requirements, and prevention of STDs and pregnancy (offer condoms and contraceptives as appropriate).

6. Consider expedited partner therapy (EPT) if permitted by state law. A summary of state EPT laws can be found at: http://www.cdc.gov/std/ept

7. Instruct student to abstain from sexual intercourse for 7 days and until all sex partners have been treated.

8. Schedule chlamydia retesting in 1-3 months due to high prevalence of repeat infection in people recently diagnosed and treated for chlamydia.

9. Due to the risk of chlamydia infection during pregnancy, perform a test of cure 1 month after treatment and repeat testing 3 months later due to high prevalence of repeat infection.

* Extragenital chlamydia screening (rectal) should be considered based on sexual behavior.

WHEN TO REFER TO THE CENTER PHYSICIAN

- If the student has rectal pain suggestive of proctitis
- If the female student has pelvic pain suggestive of pelvic inflammatory disease
- If the male student has scrotal pain suggestive of epididymitis or lower back pain suggestive of prostatitis
- If the student has an allergy or other contraindication to listed medications and the use of a fluoroquinolone antibiotic needs to be considered

TREATMENT GUIDELINES FOR HEALTH STAFF

CONJUNCTIVITIS

Authorized health and wellness staff may treat conjunctivitis as follows:

1. When exudate is not present and the conjunctiva is red and irritated re-evaluate the student in 24 hours. If the condition is not resolved, have the center physician see the student.

2. Take a careful history for trauma, toxins and irritants in the eye. If the history is positive, irrigate the eye(s) and call the center physician.

3. In the presence of exudates, begin ophthalmic antibiotic treatment until the center physician evaluates the student.

4. In the presence of allergic conjunctivitis, begin ophthalmic anti-allergy treatment until the center physician evaluates the student.

5. Swelling and redness of the eyelids may indicate the presence of a serious infection and requires immediate evaluation by the center physician.

WHEN TO REFER TO CENTER PHYSICIAN

- If the condition does not resolve in 24 hours after treatment
- If there is eye pain or change in vision
- If there is a history of trauma, toxins, or irritants in the eye
- If swelling and redness of the eyelids are present

TREATMENT GUIDELINES FOR HEALTH STAFF

CONSTIPATION

Authorized health and wellness staff may treat constipation as follows:

1. Educate student about diet and the importance of fiber (increase dietary fiber to 20 to 35 grams per day). High fiber foods include: beans, whole grains, fresh fruits and vegetables. In addition, reduce foods that have low or no fiber: cheese, meat, processed foods.

2. Encourage an increase in water intake: 8 full glasses of 8 oz of water daily.

3. Educate about the importance of exercise. Lack of physical activity is associated with constipation.

4. Review medications as many medications can cause constipation as a side effect.

5. Encourage regular bowel habits by advising sitting on the toilet for 10 minutes twice daily (especially after breakfast).

6. Many people will respond to lifestyle changes alone. If further intervention is necessary – implement short term treatment (not to exceed three days) with ONE of the following medications:

    a. Miralax 17 gm (1 capful) orally daily
    b. Bisacodyl (Dulcolax) 5-10 mg in a single daily dose orally or 10 mg in a single dose by rectal suppository
    c. Milk of magnesia 30 cc (2 tbsp) orally at bedtime
    d. Mineral oil 30 cc (2 tbsp) orally twice daily (refrigeration may improve palatability)

7. May start fiber supplement to reduce risk of recurrence with one of the following: barley malt (barley cereal, Maltsupex); cellulose (Citrucel); psyllium (Metamucil, Fibercon) 1-2 rounded teaspoonfuls or 1-2 packets 1-2 times daily.

WHEN TO REFER TO CENTER PHYSICIAN

- If student is on a prescribed medication that causes constipation. Dosage may need to be adjusted or medication changed if the problem persists.

- If the student reports failure of the above treatment regimen to resolve the constipation within 48 hours.

- If the student has vomiting, abdominal pain or fever.

- If the student experiences rectal bleeding or hemorrhoids are present.

Treatment Guidelines for Health Staff
COVID-19

Authorized health and wellness staff may treat COVID-19 as follows:

1. Students testing positive for SARS-CoV-2 virus require isolation and can cohort with other COVID-19 positive students in a dorm or Health and Wellness Center ward. Food and beverages will be delivered by food services.
2. The health staff must follow the COVID-19 Protocols when a student is determined to have COVID-19.
3. In the event that the student reports difficulty breathing, chest pain, the lips appear blue, or pulse oximetry is below 93%, call emergency medical services (EMS) for immediate transport to the hospital.
4. The student will have twice daily assessment by the Health and Wellness staff including temperature, symptom screen, and pulse oximetry.
5. Bed rest is indicated if the student has symptoms. If no symptoms, student may participate in virtual learning and other activities while remaining isolated to room.
6. Encourage oral hydration. Adequate fluids are necessary to prevent dehydration and adequate nutrition fosters recovery.
7. For fever and muscle pain, offer the student acetaminophen 650-1000 mg orally every 4 hours [MDD 4 g] or ibuprofen 400-600 mg po every 6 hours [MDD 2400 mg] as needed. Aspirin should not be given to students under age 18, as its use with influenza is associated with Reye Syndrome.
8. For sore throat, offer the student analgesic throat lozenges or throat spray for relief of symptoms, in addition to the medications listed above.
9. For nasal congestion, offer saline nasal spray OR nasal decongestant spray OR pseudoephedrine (Sudafed) 30 mg – 60 mg every 8 hours. Note that nasal decongestant spray should not be used for more than 3 days.
10. For earache, offer the student acetaminophen or ibuprofen as listed above, and refer to the clinician for further evaluation.
11. Symptomatic students will be instructed to call residential staff if symptoms worsen overnight or on weekends and the residential staff should be trained in and follow the COVID-19 Symptomatic Management Guideline.
12. Ending isolation for students with confirmed COVID-19 infection should follow the procedures outlined in the current Job Aid posted on the Health and Wellness website to reflect current protocols.
13. Preventive measures should be stressed with well students and staff, including face coverings, physical distancing and frequent hand washing/sanitizing.

WHEN TO REFER TO THE CENTER PHYSICIAN

- If any student tests-positive for SARS-CoV-2 virus

- If any student requires transportation to the hospital
- If the student has persistent symptoms for more than 72 hours
- If pneumonia is suspected
- If sinusitis is suspected
- If the student has a persistent earache
- If diarrhea or vomiting occur

TREATMENT GUIDELINES FOR HEALTH STAFF

DEPO-PROVERA
(medroxyprogesterone contraceptive injection)

Authorized health and wellness staff may administer Depo-Provera to a student as follows:

1. Student has been thoroughly counseled by the center physician and nursing staff regarding the benefits, risks, alternatives and side effects of using Depo-Provera, as well as the efficacy of the method and STI counseling.

2. To be certain that the patient is not pregnant administer the initial injection only during the first five days of a normal menstrual period.

3. Blood pressure and weight is documented in the student health record for each Depo-Provera visit.

4. Calcium and Vitamin D (600mg/200 units or 500mg/200units tablets) should also be prescribed for student twice daily.

5. Administer Depo-Provera 150 mg IM in either the deltoid or gluteus maximus every 12-14 weeks or administer Depo-subQ-Provera 104 mg subcutaneously into the anterior thigh or abdomen every 12-14 weeks.

6. Depo-Provera injections may be given earlier if needed – as often as 11 weeks apart.

7. Students who present for Depo-Provera more than 14 weeks since the last injection must have a urine pregnancy test performed to exclude pregnancy before administering the injection.

WHEN TO REFER TO CENTER PHYSICIAN

- Moderate to heavy vaginal bleeding
- Prolonged breakthrough spotting (> 7-10 days)
- Significant weight gain (>10-15 lbs)
- Significant loss of scalp hair or increase in body hair
- Onset or worsening episodes of migraine or severe headaches
- Positive urine pregnancy test

TREATMENT GUIDELINES FOR HEALTH STAFF

DERMATITIS (ALLERGIC/CONTACT)

Authorized health and wellness staff may treat allergic or contact dermatitis as follows:

1. Determine the agent/exposure that triggered the rash (e.g., plants, soaps, lotions, jewelry, make-up, chemicals).

2. Instruct the student to avoid any further contact with the trigger.

3. Have the student wash all affected areas, as well as bedding and clothing that may contain the offending agent (e.g., oil from poison ivy or poison oak).

4. Apply hydrocortisone 1% cream to the rash twice per day until resolved if the rash is localized.

5. Administer diphenhydramine 25-50 mg po every 4-6 hours if there is itching. **Warning:** Diphenhydramine may cause sedation.

6. Alternative treatment with a non-sedating antihistamine such as loratadine 10 mg po or certrizine 10 mg po once a day may be considered.

WHEN TO REFER TO THE CENTER PHYSICIAN

- If the student is experiencing difficulty swallowing or breathing, call 911
- If the rash involves the student's eyes or mucosal areas
- If the rash is not improved in 2 days
- If the rash spreads despite treatment

TREATMENT GUIDELINES FOR HEALTH STAFF

DIABETES (TYPE I/II)

Authorized health and wellness staff may treat diabetes as follows:

1. All students with newly diagnosed diabetes and all newly enrolled students who report that they have diabetes should be referred to the center physician as soon as possible. If the center physician is not on center at the time of the discovery of diabetes, he/she should be called in order to discuss what is known about the student prior to the appointment.

2. Each student with diabetes should have a chronic care management plan developed which includes at least the following:

    - The insulin or oral hypoglycemic medication dose and administration schedule
    - The prescribed meal plan to include appropriate snacks
    - The recommended activities/exercise program
    - Healthy sleep hygiene and minimal stress are recommended
    - The blood glucose self monitoring plan
    - The schedule of follow up in the health and wellness center
    - The medical monitoring plan, including glycohemoglobin measurements, urine microalbumin screening, and annual ophthalmologic evaluation.
    - Documentation of which staff have been notified about the student's diagnosis
    - A specific plan of how to manage the student if he/she becomes sluggish, confused, or disoriented (i.e., may have excessively low or high blood sugar – and whom to notify immediately)

WHEN TO REFER TO THE CENTER PHYSICIAN

- If the student has newly diagnosed diabetes or newly enrolled and reports that he/she has diabetes
- Students with diabetes should be monitored immediately once the diagnosis is identified and at least twice weekly thereafter until the student's condition is stable.

Refer to the Diabetes Chronic Care Management Plan for additional guidance.

TREATMENT GUIDELINES FOR HEALTH STAFF

DYSMENORRHEA

Authorized health and wellness staff may treat dysmenorrhea as follows:

1. Determine whether or not the bleeding is at an appropriate time for menses and similar to previous periods. If it is not and/or there is a question of possible pregnancy, perform a pregnancy test.

2. Administer non-steroidal, anti-inflammatory medication for relief of pain: Ibuprofen 400-600 mg po every 6 hours prn [MDD 2400 mg] **or** naproxen sodium 440 mg po every 8 hours prn [MDD 1320 mg] with fluids or snack.

3. If dysmenorrhea is recurrent, ensure that student has easy access to medication during each period. The first dose of medication should be given as soon as the student is aware that the period is beginning. Scheduled doses of medication should then be taken continuously during the time the student typically experiences pain (usually the first 2-3 days of bleeding).

4. Encourage participation in normal activities. Routine daily exercise may be helpful with recurrent episodes.

WHEN TO REFER TO THE CENTER PHYSICIAN

- If student appears ill with other symptoms including fever, nausea and/or vomiting, or difficult mobility

- If student is pregnant

- If heavy bleeding or cramping persists beyond 3 days

- If student's dysmenorrhea is not relieved by the above medications or interfering with program participation

TREATMENT GUIDELINES FOR HEALTH STAFF

EMERGENCY CONTRACEPTION

Authorized health and wellness staff may administer emergency contraception (EC) to a student as follows:

1. Student reports an unprotected sexual encounter within the past 5 days and desires not to become pregnant.

2. A brief history will be documented, to include LMP, date and time of unprotected sex, current or past use of a contraceptive method, and risk assessment for STDs.

3. A pregnancy test will be performed as indicated if history raises concern for an established pregnancy. If student is already pregnant, EC is not effective and therefore contraindicated.

4. Student will be counseled on the use, effectiveness, potential side effects and safety of available methods of EC.

5. Student will be offered STD testing, as indicated.

6. EC can be used at any time during the menstrual cycle.

7. Administer a single oral dose of levonorgestrel 1.5 mg tablet or two 0.75 mg tablets taken at the same time. This has been shown to be as efficacious as two 0.75 mg tablets taken 12 hours apart and taking a single dose improves adherence.

8. An alternative to levonorgestrel is to administer ulipristal acetate 30 mg tablet in a single oral dose.

9. Both levonorgestrel and ulipristal may be less effective in women with a body mass index (BMI) of > 30 kg/m^2, but ulipristal has a lower pregnancy rate than levonorgestrel among obese women. Levonorgestrel may also be less effective for EC in overweight women with a BMI of > 25 kg/m^2.

10. The third and most effective EC option is referral for insertion of a copper intrauterine device (IUD), which has the added advantage of providing ten years of pregnancy prevention as a long acting reversible contraceptive (LARC).

11. Student is advised to return for pregnancy test if no bleeding has occurred within 3 weeks.

12. Student should be counseled that EC is for emergency use only. Discuss reasons for previous failure or non-use of contraception. Discuss more reliable contraceptive options with student, such as long acting reversible methods.

13. EC should be available in the Health and Wellness Center for prompt access, since efficacy declines with time since exposure.

WHEN TO REFER TO THE CENTER PHYSICIAN

- Positive pregnancy test
- Positive STD test
- Request for hormonal contraception
- Referral for IUD insertion
- No menses within 3 weeks of using EC

TREATMENT GUIDELINES FOR HEALTH STAFF

EMERGENCY RESPONSE EQUIPMENT AND SUPPLIES

The equipment, medication and medical supplies listed below are intended to stock a minimum of two “grab and go” emergency response kits located in the Wellness Center and in Security or other location accessible when the Wellness Center is closed.

Equipment

- Automated external defibrillator (AED) – may be located separately from “grab and go” kits
- Ambu bag with oral airways
- Glucometer
- Oximeter
- Oxygen source
- Stretcher/backboard

Medication

• Albuterol HFA inhaler	Wheezing
• Adult aspirin, 325 mg – chew one tablet for an adult	Suspected heart attack
• Injectable epinephrine (EpiPen and/or injectable Adrenaline) • Injectable diphenhydramine (Benadryl), 50 mg *(optional)*	Allergic reaction
• Intranasal naloxone (Narcan)	Suspected Opioid Overdose
• Oral glucose source • Glucagon *(optional)*	Suspected Hypoglycemia

Medical Supplies

- Ace wraps
- Bandages
- Blood pressure cuff
- Eye irrigation bottle
- Eye patches
- Gauze pads
- Gauze roll bandages (Kling)
- Needles/syringes
- Stethoscope
- Tape
- Tourniquet
- Tweezers

Personal protective supplies (disposable)

- Gloves (non-latex)
- Face masks
- Gowns

All emergency response equipment and supplies must be readily accessible 24/7/365. Contents should be inspected monthly, including medication expiration dates and the oxygen tank gauges.

TREATMENT GUIDELINES FOR HEALTH STAFF

FEVER

Authorized health and wellness staff may treat fever as follows:

1. Obtain a history to identify infection, inflammation or other origin for the fever. If a source is determined, refer to the appropriate treatment guidelines.

2. If fever is less than 104°F with no specific origin, offer the student acetaminophen 1000 mg every 4 hours [MDD 4 g] **or** ibuprofen 400-600 mg every 6 hours [MDD 2400 mg] and re-evaluate within 24 hours. Encourage oral hydration.

WHEN TO REFER TO THE CENTER PHYSICIAN

- If fever does not respond to acetaminophen or ibuprofen in appropriate dosage
- If fever is associated with altered mental status
- If fever is ≥101°F for more than 24 hours
- If fever rises ≥ 104°F, refer within 1-2 hours
- If student is pregnant

TREATMENT GUIDELINES FOR HEALTH STAFF

FRACTURES

Authorized health and wellness staff may treat suspected fractures as follows:

1. Assess the extent of injury and minimize movement of the bones. If the bone protrudes through the skin the fracture is compound and needs immediate treatment. Irrigate the wound with sterile saline solution and cover loosely with a dry sterile dressing. For compound limb fractures, splint the extremity across the joints above and below the fracture and transport the patient to the emergency department.

2. If the skin is not broken, but there is extensive bruising, subcutaneous bleeding or a firm, tender bulge surrounds the injury, a hematoma may be present. Apply an ice pack, elevate the limb, and immobilize the extremity across the joints above and below the fracture and call the clinician for further treatment.

3. If the injured bone is painful, tender or associated with muscle spasm, with normal motion but without swelling or bruising, immobilize, restrict activity of the extremity, and refer to clinician within 48 hours.

4. For pain, apply an ice pack, elevate the limb, and administer acetaminophen 650-1000 mg every 4 hours [MDD 4 g] **or** ibuprofen 400-600 mg every 6 hours [MDD 2400 mg].

5. An x-ray should be ordered only after consultation with the clinician.

WHEN TO REFER TO THE CENTER PHYSICIAN

- If there is obvious deformity suggesting a fracture or dislocation in need of reduction

TREATMENT GUIDELINES FOR HEALTH STAFF

FROSTBITE

Authorized health and wellness staff may treat frostbite as follows:

1. Immediately cover the affected areas (usually toes, feet, fingers, nose, cheeks, and ears) with another warmer body surface and with warm clothing while seeking shelter.

2. Once indoors where there is no danger of refreezing, rapidly rewarm the affected areas in tepid water (105^{o} F-110^{o} F) for 20-40 minutes. Do **not** use local dry heat as it can cause further tissue damage.

3. Damaged skin should **never** be massaged, as this leads to mechanical trauma.

4. Administer/offer pain medication as needed, e.g., acetaminophen 650-1000 mg orally every 4 hours [MDD 4 g] **or** ibuprofen 400-600 mg orally every 6 hours [MDD 2400 mg].

5. Seek professional medical care to determine if medical and/or surgical intervention is necessary for prevention of infection or tissue debridement/amputation.

WHEN TO REFER TO THE CENTER PHYSICIAN

- All students with frostbite should be evaluated by the center physician

TREATMENT GUIDELINES FOR HEALTH STAFF

FUNGAL SKIN INFECTIONS

Authorized health and wellness staff may treat fungal skin infections as follows:

There are many OTC and prescription antifungal agents available for the treatment of tinea pedis, corporis and cruris. Only one, clotrimazole (e.g., Lotrimin) is mentioned below.

Athlete's Foot (tinea pedis)

1. Clotrimazole 1% cream should be applied to affected areas twice each day for at least 21 days. It may take up to 4 weeks for successful treatment and subsequent maintenance therapy once each day may be necessary.

2. Students should keep feet as dry as possible at all times. Feet should be dried thoroughly after bathing before putting on socks. Socks made of synthetic materials are best at wicking away excess moisture and keeping feet dry. Socks made of wool or cotton tend to trap in excess moisture. When possible, slip-on shoes and open shoes are recommended. When possible, sweaty feet should be washed and dried, and footwear replaced by cool, clean, dry socks and shoes. The infection is contagious and shower shoes are recommended for use in public showers or locker rooms. Light, breathable shoes are best and footwear should be alternated on successive days to give each pair a chance to fully dry between uses. Treatment of shoes with antifungal powder may reduce recurrence.

Ringworm (tinea corporis)

1. Clotrimazole 1% cream should be applied to affected areas and one inch around the area twice each day for at least 21 days. It may take up to 4 weeks for successful treatment.

2. It can spread on contact to other parts of the body, or to other people. Students should be told not to share towels, clothing or athletic equipment.

3. If extensive or not improving with topical treatment, consider oral antifungal treatment, such as terbinafine 250 mg once daily for 1-2 weeks, or itraconazole 200 mg once daily for one week.

Jock Itch (tinea cruris) and other intertriginous fungal infections

1. Clotrimazole 1% cream should be applied to affected areas twice each day for at least 21 days. It may take up to 4 weeks for successful treatment.

2. It can spread on contact to other parts of the body, or to other people. Students should be told not to share towels, clothing or athletic equipment.

3. Students with jock itch and other fungal rashes in areas where skin meets skin should keep these areas as cool and dry as possible at all times. The areas should be dried thoroughly after bathing and before dressing. Loose fitting underwear and clothing are preferable when possible. Use moisture-wicking synthetic underwear and be sure to shower and put on a fresh pair after working out.

Tinea Versicolor

1. First line options for treatment include the following:

   - Clotrimazole 1% cream applied to affected area once daily for two weeks OR
   - Selenium sulfide 2.5% shampoo or lotion applied daily to affected areas for 7 days. Wash off after 10 minutes.

2. Educate student that skin color change (hypo or hyperpigmentation) can continue for months despite effective treatment.

3. If frequent recurrence, widespread involvement or resistant cases (defined as ongoing scale and KOH positive skin scraping), oral treatment options include:

   - Itraconazole 200 mg once daily for 5 days **OR**
   - Fluconazole 300 mg once per week for two weeks

Note: Students should not be excluded from class or recreational activities due to fungal skin infections.

WHEN TO REFER TO THE CENTER PHYSICIAN

- If the rash/lesion(s) does not clear after 4 weeks of therapy
- If unsure whether the diagnosis is fungal infection

TREATMENT GUIDELINES FOR HEALTH STAFF

GASTROENTERITIS/ENTERITIS

Authorized health and wellness staff may treat gastroenteritis/enteritis as follows:

1. For vomiting, encourage careful hand washing, and offer clear, non-caffeinated liquids in small amounts frequently.

2. For diarrhea, encourage careful hand washing, encourage fluids and introduce solid foods as tolerated.

3. For mild abdominal cramps caused by diarrhea, offer the student loperamide caplets (Imodium AD), 2 caplets initially, then 1 caplet with each subsequent loose stool, not to exceed 4 caplets in 24 hours. Take caplets with 8 ounces of water.

4. If febrile, the student may be given acetaminophen, 650-1000 mg, every 4 hours [MDD 4 g]. **Avoid** aspirin and/or non-steroidal anti-inflammatory medications, which may lead to further GI upset.

5. No student with gastroenteritis/enteritis should be permitted to work in food services until all symptoms have completely resolved.

WHEN TO REFER TO THE CENTER PHYSICIAN

- If the student has blood in the emesis or stool
- If the student has bilious emesis
- If the student has diminished urine output
- If the student has a temperature $\geq$101°F
- If the student has more than mild, crampy abdominal pain
- If the symptoms persist more than 3 days

TREATMENT GUIDELINES FOR HEALTH STAFF

GENITAL HERPES INFECTION

Authorized health and wellness staff may treat genital herpes infection as follows:

1. First clinical episode: administer valacyclovir 1 g po twice per day for 7-10 days **or** acyclovir 400 mg po three times per day for 7-10 days.

2. Recurrent episodes: administer valacyclovir 1 g po once per day for 5 days **or** acyclovir 800 mg po twice per day for 5 days, best if started within one day of onset.

3. Suppressive therapy to prevent recurrence (if ≥ 6 episodes per year): administer valacyclovir 1 g po once daily **or** acyclovir 400 mg po twice per day. Reassess the need for continued prophylaxis by discontinuing therapy after 1 year.

4. Discuss contact(s) treatment, screening for other STDs as appropriate, health department reporting requirements, and prevention of STDs and pregnancy (offer condoms and contraception as appropriate).

5. Asymptomatic sex partners should be counseled but need not be treated.

WHEN TO REFER TO THE CENTER PHYSICIAN

- If the student has symptoms suggestive of another sexually transmitted infection
- If the student has HIV infection
- If the student is pregnant
- If the student needs suppressive therapy

TREATMENT GUIDELINES FOR HEALTH STAFF

GONOCOCCAL INFECTION

Authorized health and wellness staff may treat laboratory-confirmed uncomplicated urogenital, rectal* and pharyngeal* gonococcal infection as follows:

1. Administer intramuscular ceftriaxone 500 mg once for persons < 300 lb or 1 g for persons > 300 lb.

2. If ceftriaxone IM is not available, substitute cefixime 800 mg po once, though oral cefixime treatment has limited efficacy for pharyngeal gonorrhea.

3. If chlamydia infection has not been excluded, concurrent treatment with doxycycline 100 mg po bid for 7 days is recommended. During pregnancy, azithromycin 1 g as a single dose is recommended to treat chlamydia.

4. If there is cephalosporin allergy, a single 240 mg intramuscular dose of gentamicin plus a single 2 g po dose of azithromycin is an option.

5. Instruct student to return for retreatment if vomiting occurs within 4 hours of treatment with oral doxycycline or azithromycin regimens.

6. Discuss contact(s) treatment, screening for other STIs as appropriate, health department reporting requirements, and prevention of STIs and pregnancy (offer condoms and contraception as appropriate).

7. Instruct student to abstain from sexual intercourse for 7 days and until all sexual partners have been treated.

8. Schedule gonorrhea and chlamydia retesting in 1-3 months.

* Extragenital gonorrhea screening (rectal or pharyngeal) should be considered based on sexual behavior.

WHEN TO REFER TO THE CENTER PHYSICIAN

- If the student has rectal pain suggestive of proctitis

- If the female student has pelvic pain suggestive of PID

- If the male student has scrotal pain suggestive of epididymitis or low back pain suggestive of prostatitis

TREATMENT GUIDELINES FOR HEALTH STAFF

HEADACHE

Authorized health and wellness staff may treat headache as follows:

1. Obtain a careful history and vital signs.

2. Tension (stress) is the most common origin of headache in teenagers and adults. Offer the student with frequent headaches a referral for counseling regarding stress management.

3. Provide ibuprofen 400-600 mg po every 6 hours [MDD 2400 mg] or acetaminophen 650-1000 mg [MDD 4 g] po every 4 hours as needed for headache.

4. Offer bed rest for 2-4 hours until headache medication takes effect.

WHEN TO REFER TO CENTER PHYSICIAN

- If trauma, migraine, hypertension, sinus infection, fever, or other specific problems exist

- If the headache is associated with visual disturbances, nausea and/or vomiting, sensitivity to light or sound, or does not respond to the treatment recommendations

- If the headache persists for more than 24 hours or frequently recurs

- If a student is taking ibuprofen more than 3 days a week for consideration of rebound headache

- If the headache is severe enough to interfere with routine activities even after the treatment prescribed above

- If the headache is asymmetrical in its location

TREATMENT GUIDELINES FOR HEALTH STAFF

HEAD INJURY (CLOSED HEAD TRAUMA)

Authorized health and wellness staff may treat a head injury, which is a common problem with the potential for rare, but serious complications, as follows:

1. Observation is key. Keep the student at the health and wellness center for at least one hour after head injury. Monitor vital signs and neurological status.

2. Call 911 and/or immediately transport patient to the hospital if consciousness is lost or any of these six findings are present: (1) ataxia, (2) double vision/loss of vision/altered visual fields, (3) progressive incapacitating headache, (4) repetitive projectile vomiting, (5) declining level of alertness/consciousness or inability to arouse, (6) change in mood and increased combativeness.

3. The use of medication is discouraged during the initial observation period. Acetaminophen 650-1000 mg [MDD 4 g] **or** ibuprofen 400-600 mg [MDD 2400 mg] may be administered if the patient complains of headache. No other analgesic or psychotropic medication should be given. If the patient complains of severe pain requiring narcotic medications, refer to the clinician.

WHEN TO REFER TO THE CENTER PHYSICIAN

- If the headache is progressively worse and/or does not respond to acetaminophen or ibuprofen in appropriate doses

TREATMENT GUIDELINES FOR HEALTH STAFF

HEAT INJURIES

Authorized health and wellness staff may treat heat cramps, heat exhaustion, and heat stroke, which are progressive forms of hyperthermia, as follows:

Heat Cramps (painful muscle cramps especially in legs)

1. Removal to cool environment and rest from exercise.

2. Gentle massage and stretching of cramping muscles.

3. Oral replacement with cool water and electrolytes with an electrolyte-based sports drink such as Gatorade, Powerade, or equivalent.

Heat Exhaustion (core body temperature greater than 100^{o}F but less than 104^{o}F with complaints of fatigue, anxiety, feeling faint, weakness, muscle cramps, pale and moist skin, headache, anorexia, diarrhea, nausea, and/or vomiting)

1. Removal to cool environment and rest from exercise.

2. Remove clothing and apply cold packs, wet sheets, or wet cold towels to neck, head, abdomen, and inner thighs.

3. Use a fan or fanning motion to circulate air over the patient.

4. Oral replacement of water and electrolytes with an electrolyte-based sports drink such as Gatorade, Powerade, or equivalent is **urgent**.

5. In cases involving vomiting, may require intravenous replacement of fluid and electrolytes with normal saline solution. Contact the clinician for further advice.

Heat Stroke (core body temperature 104^{o}F or above with tachycardia, hypotension, warm and dry skin, nausea, vomiting, headache and fatigue, and mental changes – often incoherent and combative)

1. Remove from source of heat and call 911 to transport for emergency care.

2. Remove clothing and apply cold packs, wet sheets, or wet cold towels to neck, head, abdomen, and inner thighs.

3. Use a fan or fanning motion to circulate air over the patient.

4. Maintain airway and be alert for vomiting to prevent aspiration.

5. If authorized to do so, administer intravenous normal saline solution and monitor cardiac function, urinary output, and core temperature.

Follow up by teaching prevention strategies (maintaining hydration; acclimatizing to and avoiding overexertion in hot, humid climates; using appropriate clothing such as sunshades, hats, and light reflective shirts that allow ventilation) to prevent recurrence.

WHEN TO REFER TO THE CENTER PHYSICIAN

- If the student does not respond to supportive treatment
- If oral rehydration is not possible
- If temperature is above 100^{o}F
- If there are mental status changes (e.g., confusion, incoherence, altered consciousness)

TREATMENT GUIDELINES FOR HEALTH STAFF

HYPERTENSION

Authorized health and wellness staff may treat elevated blood pressure as follows:

1. When a systolic blood pressure ≥ 140 mm or diastolic blood pressure of ≥ 90 mm is recorded for a student, repeat the blood pressure at three 10-minutes intervals, making sure that proper technique and cuff size are used.

2. If the blood pressure reading remains elevated, schedule the student to return to the health and wellness center on three separate occasions in the following 3-4 weeks for repeat blood pressure readings, then schedule an appointment with the center physician.

3. Students with "borderline" blood pressures (blood pressure readings are systolic between 125 and 139 and diastolic between 81 and 89) or who have a family history of hypertension should be encouraged to have their blood pressure checked every 3-6 months.

Each student with hypertension should have a chronic care management plan developed and implemented.

WHEN TO REFER TO THE CENTER PHYSICIAN

- If any one systolic reading ≥ 180 mm has been recorded

- If any one diastolic reading ≥110 mm has been recorded

- If systolic blood pressure readings of ≥140 mm have been recorded on three separate occasions

- If diastolic blood pressure readings of ≥ 90 mm have been recorded on three separate occasions

- Students with "borderline" blood pressures should be counseled on the meaning of high blood pressure, its consequences, and lifestyle choices that can alleviate the problem (such as lowering salt intake, smoking cessation, proper exercise, and weight management)

Refer to the Hypertension Chronic Care Management Plan for additional guidance.

TREATMENT GUIDELINES FOR HEALTH STAFF

IMPETIGO

Authorized health and wellness staff may treat impetigo as follows:

1. Check the student's temperature.

2. Cleanse the lesion with a topical antiseptic.

3. Cover exposed lesions, if possible. Caution the student to avoid direct skin-to-skin contact with other students while the lesions remain.

4. Initiate oral antibiotics to cover staphylococcal and streptococcal skin infections, with cephalexin (Keflex) 500 mg po twice daily for 10 days.

5. Alternative treatment with mupirocin (Bactroban) cream/ointment applied 3 times a day for 10 days may be considered for small lesions.

6. If methicillin-resistant *Staphylococcus aureus* (MRSA) is suspected, administer trimethoprim/sulfamethoxazole (Bactrim DS) twice daily for 10 days.

7. Question the student about whether or not he/she is aware of other students with similar lesions. If so, call affected students into the health and wellness center for evaluation and treatment.

WHEN TO REFER TO THE CENTER PHYSICIAN

- If lesions are not improving on antibiotics or there are signs of cellulitis (surrounding erythema, streaking from the lesions, local tenderness) or abscess

- If the student has a fever $\geq$101°F

TREATMENT GUIDELINES FOR HEALTH STAFF

INFECTIOUS MONONUCLEOSIS

Authorized health and wellness staff may treat infectious mononucleosis as follows:

1. All students with a diagnosis of acute mononucleosis should be referred to the center physician for evaluation and development of a management plan. MSWR can be discussed at that time.

2. Screen the student for simultaneous streptococcal throat infection.

3. Advise the student to avoid sharing drinks, utensils, or toiletries, and to avoid exchange of bodily fluids (e.g., no kissing and no unprotected sexual behavior).

4. Avoid contact sports and heavy exertion for 6-8 weeks after onset of infection, until cleared by the center physician.

Note: Steroids are useful only in patients with complications as determined by the center physician; antiviral medications have no proven benefit.

WHEN TO REFER TO THE CENTER PHYSICIAN

- If the student has difficulty breathing

- If the student cannot swallow and maintain adequate hydration

- If the student's symptoms (malaise, fatigue) worsen, and the student is unable to attend class

TREATMENT GUIDELINES FOR HEALTH STAFF

INFECTIVE ENDOCARDITIS PROPHYLAXIS PRIOR TO DENTAL PROCEDURES

Authorized health and wellness staff may provide antibiotic prophylaxis for the prevention of infective endocarditis in certain dental patients as follows:

1. Follow the American Heart Association (AHA) and American Dental Association (ADA) Guidelines which recommend that patients take antibiotic prophylaxis if there is a history of total joint replacement within two years, artificial heart valves, a previous history of infective endocarditis, certain congenital heart conditions and certain heart transplant patients. The AHA and ADA do not recommend antibiotic prophylaxis for the following conditions: mitral valve prolapse, certain congenital heart conditions such a ventricular septal defect, atrial septal defect and hypertrophic cardiomyopathy.

2. For those students at high risk of infective endocarditis, the ADA recommends antibiotic prophylaxis before invasive dental procedures such as teeth cleaning and extractions. The following dental procedures do not require endocarditis prophylaxis:

    - Routine anesthetic injections through noninfected tissue
    - Taking dental radiographs
    - Placement of removable prosthodontic or orthodontic appliances
    - Adjustment of orthodontic appliances
    - Placement of orthodontic brackets
    - Bleeding from trauma to the lips or oral mucosa

3. Administer amoxicillin 2 grams orally in a single dose 30-60 minutes before the procedure.

4. Alternative treatment if allergic to penicillin: administer clindamycin 600 mg orally OR azithromycin 500 mg orally OR clarithromycin 500 mg orally in a single dose 30-60 minutes before the procedure.

5. Instruct the student to return for re-treatment if vomiting occurs before dental treatment is completed.

6. If the antibiotic dose is inadvertently not administered before the procedure, the dose may be administered up to two hours after the procedure.

WHEN TO REFER TO THE CENTER PHYSICIAN

- If the student's need for endocarditis prophylaxis is unclear
- If the student needs endocarditis prophylaxis for respiratory, gastrointestinal or genitourinary tract procedures (i.e., other than dental).

TREATMENT GUIDELINES FOR HEALTH STAFF

INFLUENZA

Influenza outbreaks commonly occur in the winter months, from December through March. Authorized health and wellness staff may treat influenza as follows:

1. Bed rest is indicated. In case of a center-wide outbreak, centers may wish to confine symptomatic students to their dormitory rooms and to provide supportive care on site in the dorms.

2. Symptomatic students wishing to return home should not travel via public transportation. Family members or center staff should provide transportation if practical, otherwise symptomatic students should remain on center.

3. Encourage oral hydration. Adequate fluids are necessary to prevent dehydration and adequate nutrition fosters recovery.

4. For fever and muscle pain, offer the student acetaminophen 650-1000 mg po every 4 hours [MDD 4 g] or ibuprofen 400-600 mg po every 6 hours [MDD 2400 mg] as needed. Aspirin should not be given to students under age 18, as its use with influenza is associated with Reye Syndrome.

5. For sore throat, offer the student analgesic throat lozenges or throat spray for relief of symptoms, in addition to the medications listed in #4 above.

6. For nasal congestion, offer saline nasal spray OR nasal decongestant spray OR pseudoephedrine (Sudafed) 30 mg – 60 mg every 8 hours. Note that nasal decongestant spray should not be used for more than 3 days.

7. For earache, offer the student medications listed in #4 above, and refer to the clinician for further evaluation.

8. Indications for testing and antiviral medications vary annually; refer to the Annual Job Corps Influenza Information Notice for guidelines, which may be found at: https://supportservices.jobcorps.gov/health/Pages/InfoNotices.aspx. Antiviral treatment should be started within 2 days of illness to be most effective.

9. Preventive measures should be stressed with well students and staff, including annual vaccination, avoiding close contact with symptomatic patients, frequent hand washing, plus adequate sleep and nutrition.

WHEN TO REFER TO THE CENTER PHYSICIAN

- If the student has a persistent fever $\geq$ 101°F for more than 48 hours
- If pneumonia is suspected
- If sinusitis is suspected
- If the student has a persistent earache

TREATMENT GUIDELINES FOR HEALTH STAFF

INSOMNIA

Insomnia is the chronic, recurrent inability to fall asleep or remain asleep for an adequate length of time. The National Sleep Foundation recommends 7 to 9 hours of sleep each night for students in the Job Corps age group. Inadequate sleep interferes with work and/or school.

Authorized health and wellness staff may treat insomnia as follows:

1. Obtain a baseline sleep history – advise students to keep a journal of their sleep pattern for one week

    - time required to fall asleep
    - number of nighttime awakenings
    - total duration of sleep including nap times
    - quality of sleep

2. Assist students in assessing and improving sleep hygiene

    - Assess sleep environment – noise, temperature, lighting
    - Nothing to eat after 7 pm
    - Drink only water
    - Reduce or avoid use of sugar, caffeine and/or nicotine
    - Avoid electronic screens (TV, tablet, laptop, smartphone) and LED “blue lights” 1 hour before sleep
    - Exercise daily but do not exercise 2 hours before sleep
    - Maintain the same sleep cycle 7 days a week

3. May offer melatonin 3 mg-5 mg by mouth, once at bedtime.

4. May offer Benadryl (diphenhydramine) 25 mg-50 mg once at bedtime as needed for insomnia. Short-term use of Benadryl only if melatonin did not help. Caution daytime drowsiness.

5. Re-evaluate in 1-2 weeks. Prescription sleep medication is rarely needed and should only be prescribed for short-term use.

WHEN TO REFER TO THE CENTER PHYSICIAN

- Signs associated with sleep apnea, such as BMI $\geq$ 30, reports of snoring or reports of falling asleep in class

- Lack of sleep is affecting performance in class, trade or social settings after health staff has provided insomnia counseling and treatment

- Symptoms of mental health comorbidity such as anxiety, depression, bereavement

TREATMENT GUIDELINES FOR HEALTH STAFF

USE OF INTRANASAL NARCAN FOR SUSPECTED OPIOID OVERDOSE

Administer first aid and CPR as indicated. Where permitted by state law, properly trained and authorized center health and non-health staff may administer intranasal naloxone (Narcan) for suspected opioid overdose.

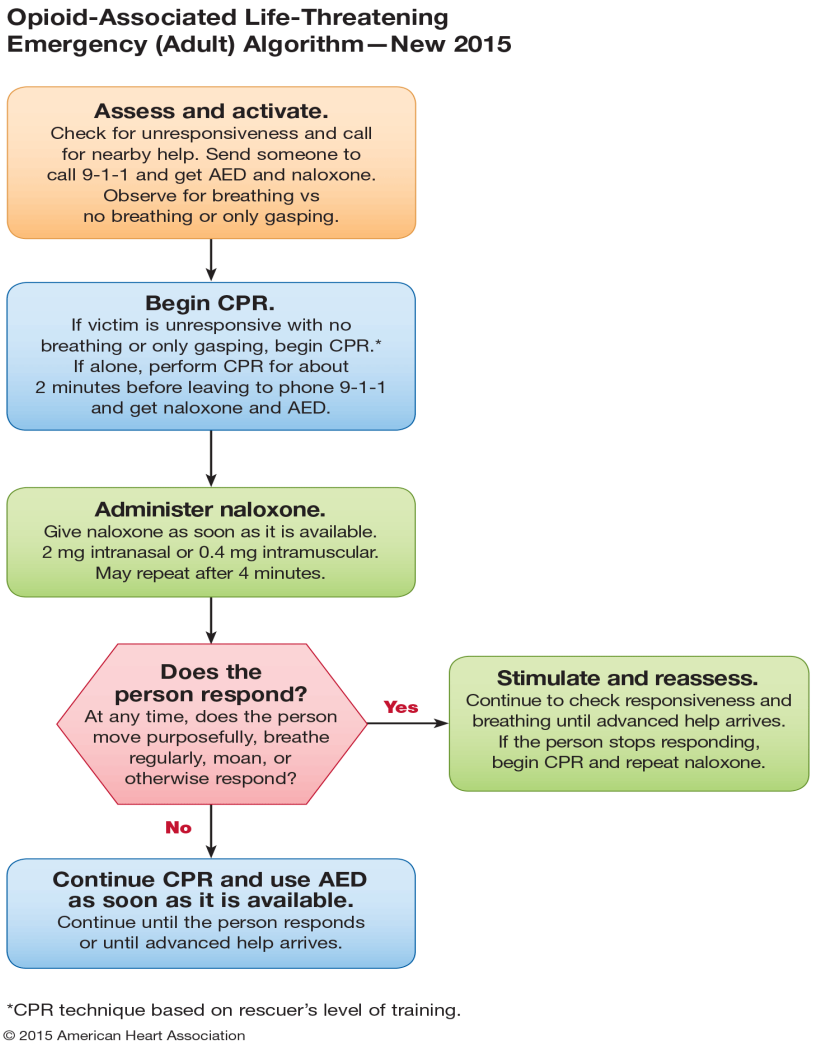
Identifying an overdose

1. Suspect if student is unconscious or excessively sleepy and cannot be aroused with a loud voice or sternal rub (a painful stimulus induced by pressing and rubbing the knuckles up and down the victim's breastbone).

2. Suspect if slow or shallow breathing or no breathing. A "death rattle" from respiratory secretions may be mistaken for snoring.

Responding to an overdose

Call 911 immediately and report a suspected drug overdose.



Administer intranasal naloxone (brand name Narcan)

Naloxone is a life-saving, short-acting drug for emergency use in opioid overdose. It should be administered as soon as possible. Naloxone can precipitate opioid withdrawal, but this is not life threatening.

- Using Narcan nasal spray 4 mg in a prepackaged atomizer, depress the plunger to administer a single dose in one nostril only. Do not test or prime the device prior to use. This is easiest formulation for non-health staff to use. May repeat after 4 minutes.

- Using naloxone hydrochloride 1 mg/mL solution (requires preparation by staff at time of use)

    1. If the person isn't breathing, do rescue breathing for a few quick breaths *first*.

    2. Next, attach the nasal atomizer (the soft white cone) to the needleless syringe and then assemble the glass cartridge of naloxone solution.

    3. Tilt the person's head back and spray half of the naloxone up one side of the nose (1 mL) and half up the other side of the nose (1 mL). Don't worry if it isn't exactly half per side.

    4. If the person isn't breathing or breathing continues to be shallow, *continue to perform rescue breathing* while waiting for the naloxone to take effect or EMS to arrive.

    5. If there is no change in about 4 minutes, administer another dose of naloxone following the steps above and continue rescue breathing for the person.

If the second dose of naloxone is not effective, then something else is wrong—either it has been too long and the heart has stopped, there are no opioids present, non-opioid drugs are the primary cause of the overdose (even if opioids were also taken), or the opioids are unusually strong and require even more naloxone (as with Fentanyl, for example).

If naloxone is mistakenly administered, no adverse effects will occur in a healthy individual. Naloxone does not alter mental status, produce tolerance or cause physical or psychological dependence. When administered in usual doses in the absence of opioids, naloxone exhibits essentially no pharmacologic activity.

Do not give the victim anything to drink. Do not induce vomiting. Do not put the victim in a bath. Do not apply ice to the victim. Do not try to stimulate the victim in a way that could cause harm, such as slapping, kicking, or burning.

WHEN TO REFER TO THE CENTER PHYSICIAN

- The center physician should be informed of all suspected drug overdose events, but notification should not delay treatment.

TREATMENT GUIDELINES FOR HEALTH STAFF

LACERATIONS

Authorized health and wellness staff may treat lacerations as follows:

1. Stop bleeding by direct compression to the wound with sterile gauze. Elevate the extremity with the laceration.

2. If bleeding does not slow or stop with 5 minutes of direct pressure, call 911.

3. Irrigate the laceration with sterile saline, cover the wound with clean gauze, and have the student evaluated by the center physician as soon as possible. Address any other injuries.

4. For small wounds with straight edges, gently pull the edges together narrowing the gap of the wound and apply steri-strips or butterfly adhesives to keep the edges approximated. Larger wounds will likely require local anesthesia for debridement and suturing.

5. Check immunization status and give tetanus-diphtheria-acellular pertussis (Tdap) booster immunization when indicated. Refer to Immunization Technical Assistance Guide.

6. For wounds on the extremities, if you are alone and CPR is needed, assess the airway, place a tourniquet on the bleeding extremity and resume CPR.

7. For wounds on the trunk and head, assess the airway, stop or control bleeding, and resume CPR.

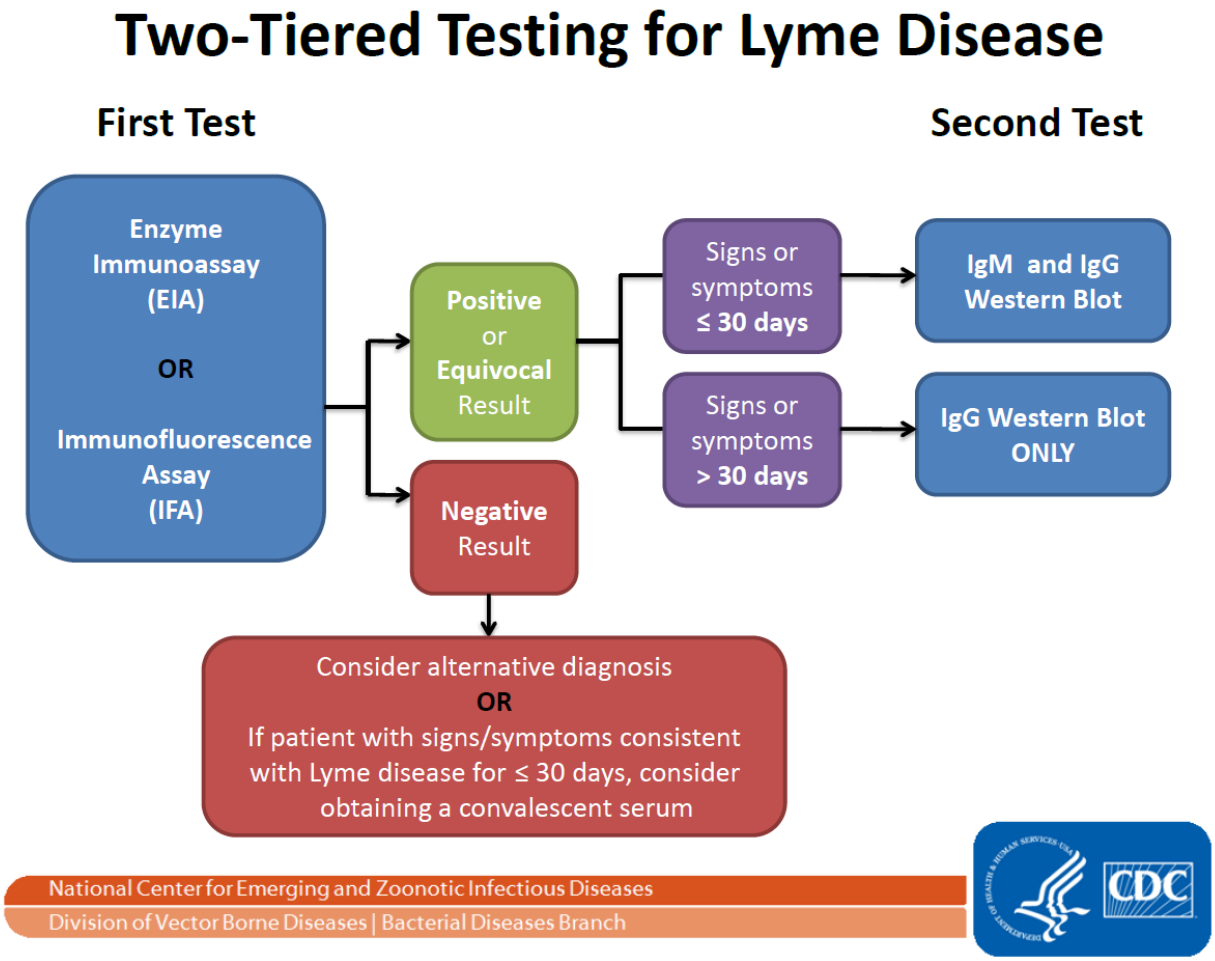
WHEN TO REFER TO THE CENTER PHYSICIAN

- If the wound appears contaminated with dirt, debris, or chemicals despite irrigation

- If it is a large or deep wound needing sutures

TREATMENT GUIDELINES FOR HEALTH STAFF

LYME DISEASE



Authorized health and wellness staff may treat clinically-confirmed Lyme disease as follows:

1. Administer doxycycline 100 mg po twice daily for 21 days **or** cefuroxime axetil 500 mg po twice daily for 21 days **or** amoxicillin 500 mg po three times daily for 21 days.

2. Instruct student to return for re-treatment if vomiting occurs within 4 hours of any dose.

3. Any student with the characteristic “bull’s eye” rash of erythema migrans should be treated presumptively, regardless of serologic testing results.

4. Instruct female students that Candida vaginitis may occur as a result of the 3-week course of antibiotic therapy. Refer to Treatment Guideline for Candida Vulvovaginitis if necessary.

Note: Lyme disease vaccine is no longer available.

WHEN TO REFER TO THE CENTER PHYSICIAN

- If the student has symptoms suggestive of neurologic involvement such as confusion, neck stiffness, blurred vision, or facial weakness
- If the student has signs of arthritis or carditis

TREATMENT GUIDELINES FOR HEALTH STAFF

MUSCLE INJURY

Authorized health and wellness staff may treat muscle injuries as follows:

1. Assess the extent of muscle injury and any associated injuries.

2. Apply basic first aid for musculoskeletal injury: Rest, Ice, Compression, Elevation (RICE)

3. Assess the muscle for a firm, tender bulge indicating a possible hematoma. When present, immobilize the muscle, apply an ice pack, and refer to the clinician for evaluation of the injury.

4. If limb motion is compromised, immobilize the muscle, apply an ice pack, and refer to the clinician or emergency department within 24 hours. Administer ibuprofen 400-600 mg every 6 hours [MDD 2400 mg] as needed for pain.

5. If the muscle is tender or in spasm without hematoma and with full range of adjacent joint motion, apply an ice pack, restrict activity for two days and administer ibuprofen 400-600 mg every 6 hours [MDD 2400 mg]. If pain does not resolve within 48 hours or fever occurs post injury, refer to the clinician for evaluation.

WHEN TO REFER TO THE CENTER PHYSICIAN

- If swelling or limited mobility increases
- If pain relief is inadequate with ibuprofen

TREATMENT GUIDELINES FOR HEALTH STAFF

NICOTINE REPLACEMENT THERAPY

Authorized health and wellness staff may provide students with a weekly supply of Nicotine Replacement Therapy product under the following conditions:

1. Nicotine Replacement Therapy (NRT) risks, benefits, alternatives and side effects should be thoroughly reviewed with student before initiation of therapy.

2. NRT is indicated for students with physiologic dependence on nicotine, generally defined as smoking 10 cigarettes (1/2 pack) or more daily.

3. The student should be counseled on the potential for nicotine withdrawal.

4. Student should be actively enrolled in Tobacco Use and Prevention Program (TUPP).

5. Student should verbalize a serious commitment to cease use of tobacco products.

6. Student should understand the correct use of nicotine replacement product (nicotine patch, gum, inhaler, nasal spray or lozenge).

7. Student should be educated in the proper and safe disposal of nicotine patches (as these can be toxic to children and pets).

8. Students should be routinely scheduled for weekly follow-up visits for monitoring and tapering of NRT.

9. Although students aged 16 to 21 years may be prohibited from purchasing or possessing tobacco products, depending upon state law, a physician may prescribe NRT to students of any age.

WHEN TO REFER TO THE CENTER PHYSICIAN

- If the student experiences any side effect from NRT

- If the student is reported to continue the use of any tobacco product while concurrently using NRT

- If the student becomes pregnant while using NRT

- If the student expresses a desire to try oral medication assistance with nicotine cravings

TREATMENT GUIDELINES FOR HEALTH STAFF

NOCTURNAL ENURESIS

Authorized health and wellness staff may treat nocturnal enuresis as follows:

1. Non-Pharmacologic regimens (patient education) include:

    - Restrict fluid intake 2 hours or more before bedtime, especially drinks with caffeine, which stimulate urine production.

    - Empty bladder fully at bedtime.

    - Awaken one or more times per night to urinate (self-pep talk to awaken, practice feeling full bladder and emptying, alarm clock, clock radio, residential advisor awakening).

    - If awakened by wetting at night, get up and change to dry clothes and put dry towel over wet spot in bed.

    - Change wet clothing and bedding upon arising in the morning and thoroughly cleanse body to eradicate any odor of urine.

    - Bed-wetting alarms are effective (approximate cost $60 – $100), usually within 3-4 weeks, but may be inconvenient in a dormitory setting. A vibrating alarm may be preferable to avoid waking roommates.

2. Pharmacologic regimens include:

    - Desmopressin (DDAVP) can be administered intranasally or orally. Initial intranasal dose is 20 micrograms at bedtime (one 10 microgram spray per nostril). This can be increased by 10 micrograms per week to a maximum dose of 40 micrograms. Oral desmopressin 200 micrograms can be taken by mouth at bedtime and may be increased to 600 micrograms maximum if needed.

WHEN TO REFER TO THE CENTER PHYSICIAN

- If the student reports failure of the above regimens to control enuresis

- If there is daytime urinary incontinence

- If polydipsia and polyuria are present

- If there are any symptoms of urinary tract infection (urgency, frequency, dysuria, fever, abdominal pain)

TREATMENT GUIDELINES FOR HEALTH STAFF

OCULAR INJURIES

Authorized health and wellness staff may treat ocular injuries as follows:

1. Foreign bodies on the cornea, conjunctiva or inner eyelids may often be removed by using a squeeze bottle with ocular irrigating solution. Imbedded foreign bodies should be evaluated immediately by the center physician or emergency department.

2. Corneal abrasions, often associated with severe pain and photophobia, should be evaluated urgently by the center physician or emergency department. Patch the affected eye to reduce discomfort.

3. Chemical splash injuries to the eyes should be treated immediately with copious irrigation. If normal saline is not available, tap water may be used. Keep the eye open as wide as possible while irrigating. Continue irrigating for at least 15 minutes. All chemical splash injuries should be evaluated by the center physician or emergency department.

4. Trauma to the orbit and the eye is often related to sports injuries, fist fights and vehicular accidents. Apply a cold compress or ice pack without putting pressure on the eye. In cases of eye pain, reduced vision, swelling or bruising, seek emergency medical care. Any of these symptoms could indicate internal eye damage.

5. Penetrating foreign bodies may lacerate the eye or the eyelid. Do not irrigate the eye and do not try to remove any object that is imbedded in the eye. Cover the eye with a rigid shield without applying pressure. Seek emergency medical care.

WHEN TO REFER TO CENTER PHYSICIAN

- All significant ocular injuries should be discussed with the center physician at the time of the injury

TREATMENT GUIDELINES FOR HEALTH STAFF

ORAL HERPES INFECTION

Authorized health and wellness staff may treat herpes labialis (cold sores) as follows:

1. In a severe, acute episode, oral valacyclovir 2 grams po q 12 hours for 2 doses may reduce symptoms by one day if started during prodrome.

2. Recurrent episodes of herpes labialis (≥ 6 episodes per year) may be reduced by administering valacyclovir 1 gram po once daily or acyclovir 400 mg po twice per day. Reassess the need for continued prophylaxis by discontinuing therapy after 1 year.

3. Symptomatic treatment with oral or topical analgesics may be prescribed.

4. Contact precautions are indicated to prevent the spread of infection.

WHEN TO REFER TO THE CENTER PHYSICIAN

- If the student has HIV infection

- If the student has ocular lesions, referral to an ophthalmologist is indicated immediately

TREATMENT GUIDELINES FOR HEALTH STAFF

OTITIS EXTERNA

Authorized health and wellness staff may treat otitis externa as follows:

1. Administer Cortisporin Otic Suspension (hydrocortisone/neomycin/polymyxin), 4 drops in affected ear qid for 10 days, **or** ofloxacin 0.3% otic solution two drops bid for 10 days. (Shake container well before using.)

2. If the tympanic membrane is perforated, administer ofloxacin 0.3% otic solution two drops bid for 10 days. Do not administer Cortisporin Otic Suspension.

3. Avoid water in the ear canals by using ear plugs when showering, shampooing or swimming for 10 days.

4. Offer the student acetaminophen 650-1000 mg every 4 hours [MDD 4 g] **or** ibuprofen 400-600 mg every 6 hours [MDD 2400 mg] as needed for pain.

WHEN TO REFER TO THE CENTER PHYSICIAN

- If concern that the student has a perforated tympanic membrane

- If the student's ear pain or discharge is not resolved with the above treatment or recurs

TREATMENT GUIDELINES FOR HEALTH STAFF

OTITIS MEDIA

Authorized health and wellness staff may treat otitis media as follows:

1. Administer amoxicillin 875 mg po bid **or** 500 mg po tid for 10 days.

2. If allergic to penicillin, administer azithromycin 500 mg on day 1 and 250 mg on day 2 through day 5.

3. Instruct the student to return if ear pain or fever is not improved by day 3 of treatment or if pus begins to drain from the ear canal.

4. Offer the student acetaminophen 650-1000 mg every 4 hours [MDD 4 g] **or** ibuprofen 400-600 mg every 6 hours [MDD 2400 mg] as needed for pain.

5. Instruct female students that Candida vulvovaginitis may occur as a result of oral antibiotic therapy. (Refer to Candida Treatment Guideline)

WHEN TO REFER TO THE CENTER PHYSICIAN

- If the student has a perforated tympanic membrane
- If the student also has otitis externa

TREATMENT GUIDELINES FOR HEALTH STAFF

PAP SMEAR ABNORMALITIES

Pap smear screening is indicated only for students ≥ 21 years of age. Note that the recommendations below apply only to women 21 to 24 years of age. Authorized health and wellness staff may arrange for follow-up of Pap smear abnormalities as follows:

- Students with a normal Pap smear, with endocervical cells present, should have a Pap smear repeated every three years.
- Students with a Pap smear demonstrating absent endocervical cells, inadequate cellularity, or obscuring artifact should have a Pap smear repeated in 2-4 months to obtain an adequate specimen.
- Students with a Pap smear demonstrating inflammation should be evaluated for infection and treated as indicated by the results of testing.
- Students with a Pap smear demonstrating atypical squamous cells of undetermined significance (ASC-US) should have a Pap smear repeated in 12 months.
- Students with a Pap smear demonstrating Low-grade Squamous Intraepithelial Lesions (LSIL) should have a Pap smear repeated in 12 months.
- Students with a Pap smear demonstrating High-grade Squamous Intraepithelial Lesions (HSIL) should be referred for colposcopy.
- Reflex HPV testing is not indicated in this age group.

WHEN TO REFER TO THE CENTER PHYSICIAN

- All students in need of colposcopy
- If the student has questions about her Pap smear abnormalities and the indications for follow-up
- If the student has questions or anxiety about her colposcopy referral
- If a student under 21 years of age has HIV infection or an abnormal Pap result from the past

Reference: 2012 Updated Consensus Guidelines for the Management of Abnormal Cervical Cancer Screening Tests and Cancer Precursors
http://www.asccp.org/Guidelines-2/Management-Guidelines-2

TREATMENT GUIDELINES FOR HEALTH STAFF

PELVIC INFLAMMATORY DISEASE (PID)

Authorized health and wellness staff may treat clinically confirmed pelvic inflammatory disease as follows:

1. Ensure that laboratory specimens have been sent for chlamydia and gonorrhea testing. Do not wait for results prior to starting treatment. Over 50% of diagnosed PID tests negative for chlamydia and gonorrhea.

2. Administer one of following combined intramuscular and oral options:

   a. ceftriaxone 500 mg IM* in a single dose plus doxycycline** 100 mg po twice daily for 14 days with metronidazole 500 mg po twice daily for 14 days

   OR

   b. cefoxitin 2 g IM in a single dose and probenecid 1 g po concurrently in a single dose plus doxycycline** 100 mg po twice daily for 14 days with metronidazole 500 mg po twice daily for 14 days

   * ceftriaxone 1 g IM for persons weighing ≥ 150 kg
   ** doxycycline is contraindicated in pregnancy

3. Instruct student to return for re-treatment if vomiting occurs within 4 hours of any dose of oral medication.

4. Student should be instructed to abstain from intercourse until therapy is completed and partner(s) has been treated. Discuss contact treatment.

5. All women with PID should be tested for HIV infection. Discuss screening for other STDs as appropriate, health department reporting requirements, and prevention of STDs and pregnancy (offer condoms and contraception as appropriate).

6. Schedule a follow-up visit for clinical reexamination in 24 to 48 hours.

7. If a woman has an IUD, it does not need to be removed with the diagnosis of PID.

WHEN TO REFER TO THE CENTER PHYSICIAN

- If the student is pregnant: Because of the high risk for maternal morbidity, fetal loss and preterm delivery, pregnant women with suspected PID should be hospitalized and treated with parenteral antibiotics

- If the diagnosis of PID is uncertain or tubo-ovarian abscess is suspected

- If the student has fever ≥ 101°F or fever with chills or vomiting

- If the student has not responded clinically to oral antibiotics in 24 to 48 hours

TREATMENT GUIDELINES FOR HEALTH STAFF

PNEUMONIA AND BRONCHITIS

Authorized health and wellness staff may treat pneumonia and bronchitis as follows:

1. Evaluate the student's ability to breathe without pain or respiratory distress. Stridor, retractions, use of accessory muscles, gasping, blue color, and other signs of acute distress suggest that immediate attention is needed. Call 911. Administer oxygen by facemask if available.

2. For fever, offer the student acetaminophen 650-1000 mg every 4 hours [MDD 4 g] **or** ibuprofen 400-600 mg [MDD 2400 mg] every 6 hours as needed. Encourage oral hydration.

3. For cough, offer the student cough syrup in a dose containing 30 mg of dextromethorphan [MDD 120 mg], for use primarily at bedtime, but no more often than every 6 hours. Again, encourage oral hydration.

4. While most often viral in etiology in the Job Corps age group (and thus not usually requiring antibiotics), bronchitis and pneumonia can be caused by *Mycoplasma* and other bacteria. Appropriate antibiotic choices include doxycycline 100 mg po bid for 7 days **or** azithromycin 500 mg po on day 1, followed by 250 mg po once daily for 4 more days.

WHEN TO REFER TO THE CENTER PHYSICIAN

- If the student is short of breath or has a fever >101°F
- If cough is unresponsive to dextromethorphan
- If the student has a history of asthma
- If pertussis is suspected, such as paroxysmal cough associated with vomiting

TREATMENT GUIDELINES FOR HEALTH STAFF

PUBIC LICE (PEDICULOSIS PUBIS)

Authorized health and wellness staff may treat pubic lice as follows:

1. Pharmacologic regimens include:

   - Permethrin 1% creme rinse (Nix) applied topically to infested area until entirely wet, then thoroughly washed off after 10 minutes.

   OR

   - Pyrethrins with piperonyl butoxide (Rid) applied topically to infested area until entirely wet, then thoroughly washed off after 10 minutes.
   - Alternative regimen: Ivermectin 250 µg/kg po once with food, repeated in 7-14 days.
   - Petrolatum ointment (Vaseline) applied topically twice daily for 10 days for infestation of the eyelashes.
   - Oral antihistamines (diphenhydramine/Benadryl **or** hydroxyzine/Atarax, Vistaril) can be given to reduce itching.

2. Non-Pharmacologic regimens include:

   - Bedding and clothing recently worn should be decontaminated (either machine-washed in hottest water and machine-dried on hottest cycle for 20 minutes or dry-cleaned). Items that cannot be washed should be stored in a sealed plastic bag for 2 weeks. Fumigation of living areas is **not** necessary.
   - Although the nits/eggs are dead, they may stay tightly adherent. Wet hair with warm vinegar and water 50:50 mixture. After 30 minutes, rinse hair and then mechanically remove nits with a fine-toothed comb.
   - Sexually active students with pediculosis should also be evaluated for other STDs and educated to avoid sexual contact until both they, and their sexual partner(s) have been successfully treated. Sex partners within the last month should be treated for lice and also evaluated for other STDs. (It may take 2-3 weeks for adult lice to appear after exposure.)
   - Follow up with students after 1 week to see if symptoms persist. Retreatment with an alternative regimen is indicated if lice are found or if new nits/eggs are observed at the hair-skin junction.

Notes: (1) These treatment guidelines apply to head lice as well as pubic lice.
(2) Lindane is no longer recommended for treatment of pediculosis.

Reference: https://www.cdc.gov/parasites/lice/pubic/treatment.html

WHEN TO REFER TO CENTER PHYSICIAN

- If above treatments fail to resolve lice infestation
- If there is a need for other STD evaluation

TREATMENT GUIDELINES FOR HEALTH STAFF

SCABIES (SARCOPTES SCABIEI)

Authorized health and wellness staff may treat scabies as follows:

1. Pharmacologic regimens include:

    - Permethrin 5% cream (Elimite) applied topically in a thin layer to the entire body from the neck down and washed off after 8-14 hours.

    OR

    - Ivermectin 200 µg/kg po once with food, repeated in 14 days.

    - Oral antihistamines (diphenhydramine/Benadryl **or** hydroxyzine/Atarax, Vistaril) can be given to reduce itching. Cool baths (Aveeno) and topical 1% hydrocortisone cream topically may also relieve itching.

    - Topical or systemic antibiotic therapy is indicated ONLY for secondary bacterial infection of excoriated lesions.

2. Non-Pharmacologic regimens include:

    - Bedding and clothing recently worn should be decontaminated (either machine-washed in hottest water and machine-dried on hottest cycle for 20 minutes or dry-cleaned) or placed in a sealed plastic bag for 72 hours. Fumigation of living areas is **not** necessary.

    - The rash and itching are due to an allergic reaction and thus patients should be informed that these symptoms may persist for up to 2 weeks after treatment.

    - If patients are still symptomatic after 2 weeks, they may be retreated with an alternative regimen.

    - Sexual contacts should also be treated. Symptoms may take 30 days after exposure to develop.

WHEN TO REFER TO THE CENTER PHYSICIAN

- If the above treatment fails to resolve the scabies infestation
- If there is a need for other STD evaluation

TREATMENT GUIDELINES FOR HEALTH STAFF

SEIZURE DISORDER

Authorized health and wellness staff may treat seizures as follows:

1. All students with newly diagnosed seizures and all newly enrolled students who report that they have seizures should be referred to the center physician as soon as possible. If the center physician is not on center at the time of the discovery of a history of seizures, he/she should be called in order to discuss what is known about the student and get any orders prior to the appointment.

2. Each student with seizures should have a chronic care management plan developed which includes at least the following:

    - The anticonvulsant medication dose and administration schedule
    - Any limitation to physical activities or exercise programs
    - The schedule of follow up in the health and wellness center
    - The medical monitoring plan, including anticonvulsant blood levels if indicated
    - Need for follow up by neurologist
    - Documentation of which staff have been notified about the student's diagnosis
    - Specific plan for how non-health staff will manage any break though seizure on center (see Seizure Disorder Symptomatic Management Guideline.)

WHEN TO REFER TO THE CENTER PHYSICIAN

- If seizure activity occurs on or off center
- If student does not adhere to anticonvulsant therapy
- If student is pregnant

Refer to the Seizure Disorder Chronic Care Management Plan for additional guidance.

TREATMENT GUIDELINES FOR HEALTH STAFF

SEXUAL ASSAULT

Authorized health and wellness staff may treat to prevent sexually transmitted infection (STI) and pregnancy following a sexual assault as follows:

1. Forensic examination and laboratory testing should be conducted at the designated sexual assault site or Emergency Department prior to initiating treatment according to the center's Sexual Assault Response Team (SART) protocol. Clothing and laboratory specimens should be secured while preserving chain-of-custody.

2. For STD prophylaxis: administer ceftriaxone 250 mg IM in a single dose, plus azithromycin 1 gram po in a single dose, plus metronidazole or tinidazole 2 grams po with fluids or snack in a single dose.

3. For hepatitis B prophylaxis: if the student's hepatitis B vaccination status or immunity cannot be confirmed, administer the first dose of hepatitis B vaccine at the initial examination, and administer the second and third doses of hepatitis B vaccine at appropriate intervals. Hepatitis B immune globulin (HBIG) is not indicated unless the assailant is known to be HBsAg positive.

4. For HIV prophylaxis: assess risk for HIV infection in assailant and consider offering antiretroviral post exposure prophylaxis according to the latest Centers for Disease Control (CDC) recommendations: *MMWR Recomm Rep*. Jan 21, 2005;54(RR-2):1-28. Center physicians may also seek expert consultative services from the National Clinician's Postexposure Prophylaxis Hotline (PEP line) at 888-448-4911, available from 9 a.m. to 9 p.m. ET, seven days a week.

5. For pregnancy prevention: offer the student at risk emergency contraception with levonorgestrel 1.5 mg, administered po once, as soon as possible, but no later than 120 hours after the assault.

6. Initiation or completion of the HPV vaccination series is recommended for all victims of sexual assault.

7. Instruct student to return for re-treatment if vomiting occurs within 4 hours of any dose of oral medication.

8. Caution student to avoid alcohol ingestion during metronidazole or tinidazole therapy and for 48 hours after the last dose.

9. Schedule retesting for STDs following CDC recommended intervals, if initial test results were negative.

Reference: https://www.cdc.gov/std/tg2015/sexual-assault.htm

WHEN TO REFER TO THE CENTER PHYSICIAN AND MENTAL HEALTH CONSULTANT

- All students who have experienced sexual assault

TREATMENT GUIDELINES FOR HEALTH STAFF

SPRAINS/DISLOCATIONS

Authorized health and wellness staff may treat sprains and dislocations as follows:

1. Assess the extent of injury and any associated injuries.

2. If deformity, severe pain or inability to bear weight is present, refer for immediate evaluation.

3. Apply basic first aid for musculoskeletal injury: Rest, Ice, Compression, Elevation (RICE)

    - Rest – limit use of affected area for 48 hours
    - Ice – apply ice pack to affected area for 20 minutes four times a day
    - Compression – apply flexible elastic wrap if indicated
    - Elevation – for extremities as needed

4. Administer ibuprofen 400-600 mg every 6 hours [MDD 2400 mg] as needed for pain.

WHEN TO REFER TO CENTER PHYSICIAN

- If pain worsens or does not diminish with ibuprofen treatment within 48 to 72 hours

- If student is unable to participate in activities or has persistent limited range of joint motion for 48 to 72 hours

TREATMENT GUIDELINES FOR HEALTH STAFF

SYPHILIS (PRIMARY AND SECONDARY)

Authorized health and wellness staff may treat laboratory-confirmed syphilis infection as follows:

1. Administer benzathine penicillin G 2.4 million units in a single intramuscular (IM) dose once.

   Note: This must be long-acting benzathine penicillin (Bicillin L-A) only.

2. If student is allergic to penicillin, prescribe doxycycline 100 mg po bid for 14 days.

   Note: Doxycycline is contraindicated in pregnancy. Desensitize pregnant women and treat with benzathine penicillin G.

3. Discuss contact(s) treatment, screening for other STIs as appropriate, health department reporting requirements, and prevention of STIs and pregnancy (offer condoms and contraception as appropriate).

4. All students with syphilis should be tested for HIV infection.

5. Persons exposed within 90 days of the diagnosis of syphilis in a sexual partner should be treated presumptively, even if seronegative.

6. Schedule repeat serological testing for syphilis at 6 and 12 months after treatment. Failure of titers to decline fourfold within 6 months of treatment for syphilis indicates probable treatment failure.

WHEN TO REFER TO THE CENTER PHYSICIAN

- If the student has symptoms suggestive of another sexually transmitted infection
- If syphilis serology titers have not declined at least fourfold 6 months after treatment
- If student is allergic to penicillin and pregnant, desensitize and treat with penicillin

TREATMENT GUIDELINES FOR HEALTH STAFF

TUBERCULIN SKIN TESTING AND LATENT TUBERCULOSIS

Authorized health and wellness staff may evaluate tuberculin skin test results and treat latent tuberculosis as follows:

Note:

- Patients with a previous history of tuberculosis or positive tuberculin skin testing should not receive a repeat tuberculin skin test.

- In patients with a history of BCG vaccination, Interferon Gamma Release Assay (IGRA) blood testing is preferred instead of tuberculin skin testing.

Tuberculin skin tests should be interpreted 48-72 hours after intradermal placement according to the following CDC guidelines:

- **<** 5 mm induration – consider negative

- **≥** 5 mm induration – consider positive in a patient with HIV infection, recent contacts of active TB patients, patients with fibrotic changes on chest radiograph consistent with prior TB, patients with organ transplants, and other immunosuppressed patients

- **≥** 10 mm induration – consider positive in recent immigrants (within the last 5 years) from high-prevalence countries, injection drug users, patients with clinical conditions that place them at high risk: diabetes mellitus, chronic renal failure, some hematologic disorders (e.g., leukemias and lymphomas), other specific malignancies, malnutrition with weight loss of **≥**10% of ideal body weight, jejunoileal bypass, and adolescents exposed to adults at high-risk of TB infection

- **≥** 15 mm induration – consider positive in a patient with no known risk factors for TB

Note that induration, not erythema, is measured in mm. Tuberculin skin test results should be interpreted without regard to a prior history of BCG vaccination.

A patient with a tuberculosis skin test (TST) conversion as defined above must have a chest x-ray to exclude active pulmonary tuberculosis. If the radiograph is either normal or reveals only granulomas or calcification in the lung and/or regional lymph nodes, then the patient is considered to have Latent Tuberculosis Infection (LTBI).

1. Pharmacologic management of latent tuberculosis infection includes:

Isoniazid & Rifapentine* (3HP) INH 15 mg/kg (max 900 mg) & RPT (rifapentine) ≥50 kg-900 mg (max 900 mg)	3 months	Once per week** with direct observation therapy (DOT) or self-administered therapy (SAT)	Preferred regimen with strong recommendation. Treatment recommended for individuals: • ≥2 years of age • In persons who have HIV infection, including AIDS*** Not recommended for individuals who are: • pregnant or expect to become pregnant within 12 weeks**** • presumed infected with INH or RIF-resistant TB
Rifampin RIF 10 mg/kg (max 600 mg)	4 months	Daily	Preferred regimen with strong recommendation. Pregnancy Category C

Three additional regimens have conditional recommendations and require daily dosing for 3, 6, or 9 months.

* Prescribing providers or pharmacists who are unfamiliar with rifampin and rifapentine might confuse the two drugs. They are not interchangeable, and caution should be taken to ensure that patients receive the correct medication for the intended regimen.

** Health care providers can choose the mode of administration as either DOT or SAT. Given ease of DOT in Job Corps setting, this will likely be the preferred option for centers.

*** 3HP is the recommended treatment of LTBI in persons with HIV infection including AIDS, who are otherwise healthy and not taking antiretroviral medications or are taking antiretroviral medications with acceptable drug-drug interactions with rifampin

**** In pregnancy, consider delaying treatment until after delivery unless high risk for progression to active disease (recent TB exposure, HIV infected)

Ref: MMWR 69(1) February 14, 2020
https://www.cdc.gov/mmwr/volumes/69/rr/rr6901

2. Educate students about potential side effects and the need to notify a health provider immediately if experiencing flu-like symptoms or other reactions such as nausea, vomiting, abdominal pain, loss of appetite, yellow skin or eyes, dark urine, fever, rash, numbness of hands or feet.

Rifapentine can reduce the effectiveness of hormonal contraceptives; therefore, women who use hormonal contraceptives should add or switch to a barrier method or a long-acting reversible option.

3. Pyridoxine (vitamin B6) supplements need not be given with isoniazid in otherwise healthy youth, unless pregnant.

4. Baseline liver function testing is not routinely necessary in healthy students with no history of liver disease and taking no medications that may alter liver function. Testing is recommended at baseline for students with liver disease, HIV infection, regular alcohol use, and pregnancy. It can be considered for students taking chronic medications that may alter liver function.

5. At any time during treatment, students reporting symptoms suggestive of liver disease should have monitoring of liver function tests.

6. If the original chest film was considered negative and the patient remains asymptomatic, no repeat x-ray is needed at the conclusion of therapy.

7. Record completed treatment regimen in the student health record, and report same to the state or local Public Health Department so the patient will not have to undergo tuberculin testing and LTBI therapy again.

Note: Many local health departments provide evaluation and treatment services for reactive tuberculin skin tests, including chest x-rays and monthly medication at no cost to the center. Some health departments are beginning to utilize IGRA blood tests to guide decision making. Please defer to recommendations from your local health department.

WHEN TO REFER TO THE CENTER PHYSICIAN

- If measurements of skin test induration are uncertain
- If the student has an abnormal chest x-ray
- If the student has a history of liver disease, pregnancy, HIV infection, or concern regarding potential exposure to a resistant tuberculosis strain
- If the student does not adhere to therapy
- If the student develops symptoms of cough, chest pain, fever, chills or night sweats

TREATMENT GUIDELINES FOR HEALTH STAFF

TRICHOMONIASIS

Authorized health and wellness staff may treat confirmed trichomoniasis as follows:

1. Recommended regimen for women: Administer metronidazole 500 mg po twice daily for 7 days directly observed therapy with fluids or snack.

2. Recommended regimen for men: Administer metronidazole 2 g po once as single dose.

3. Alternative regimen for women and men: Administer tinidazole 2 g po once as a single dose.

4. Pregnant students who are symptomatic may be treated with metronidazole 2 g in a single oral dose. Metronidazole use during pregnancy is not associated with teratogenic or mutagenic effects in infants. Tinidazole should not be used during pregnancy or breastfeeding.

5. Instruct student to return for re-treatment if vomiting occurs within 4 hours of treatment.

6. Discuss contact(s) treatment, screening for other STIs as appropriate, health department reporting requirements, and prevention of STIs and pregnancy (offer condoms and contraception as appropriate).

7. Consider expedited partner therapy (EPT) if permitted by state law. A summary of state EPT laws can be found at: http://www.cdc.gov/std/ept.

8. Instruct student to abstain from sexual intercourse for 7 days and until all sex partners have been treated.

9. Note that oral metronidazole and tinidazole are the only effective drugs for the treatment of trichomoniasis, and that topical regimens are not effective.

WHEN TO REFER TO THE CENTER PHYSICIAN

- If vaginal symptoms or dysuria persist despite treatment

TREATMENT GUIDELINES FOR HEALTH STAFF

URI, PHARYNGITIS, SINUSITIS

These are among the most common illnesses to occur on Job Corps centers, and are usually of viral etiology. Authorized health and wellness staff may treat URI, pharyngitis, and sinusitis as follows:

1. For fever, offer the student acetaminophen 650-1000 mg po every 4 hours [MDD 4 g] or ibuprofen 400-600 mg po every 6 hours [MDD 2400 mg] as needed. Encourage oral hydration.

2. For cough, offer the student cough syrup in a dose containing 30 mg of dextromethorphan, for use primarily at bedtime, but no more often than every 6 hours [MDD 120 mg]. Again, encourage oral hydration.

3. For sore throat, offer the student analgesic throat lozenges or throat spray for relief of symptoms, in addition to the medications listed in #1 above.

4. Students with sore throat should be evaluated by the clinician for possible strep testing. Rapid streptococcal antigen test or throat culture should be obtained prior to treatment. The majority of patients with sore throat in this age group have a viral etiology. This can include mononucleosis and inappropriate treatment with antibiotics can precipitate a rash (Refer to Infectious Mononucleosis Treatment Guideline). Only students with a positive strep test or culture should be treated with penicillin VK 500 mg po bid for 10 days or cephalexin (Keflex) 500 mg po bid for 10 days in non-allergic patients.

5. For sinus pain, offer saline nasal spray OR nasal decongestant spray OR pseudoephedrine (Sudafed) 30 mg - 60 mg every 8 hours until evaluated by the clinician for possible antibiotic and/or nasal steroid spray prescription. Between 90% and 98% of rhinosinusitis cases are viral and antibiotics may not be effective even if the causative agent is bacterial. Note that nasal decongestant spray should not be used for more than 3 days.

6. For earache, offer the student medications listed in #1 above, and refer to the clinician for further evaluation. (Refer to Otitis Media Treatment Guideline)

WHEN TO REFER TO THE CENTER PHYSICIAN

- If the student has a persistent fever $\geq$ 101°F for more than 48 hours
- If the student has a persistent or worsening sore throat
- If the student has a rash
- If the student has a persistent sinus pain or earache

TREATMENT GUIDELINES FOR HEALTH STAFF

URINARY TRACT INFECTION (UTI)

Authorized health and wellness staff may treat **lower urinary tract infection (cystitis)** as follows:

1. Base treatment on history of dysuria, frequency, voiding small volumes, and urgency in the absence of flank pain, fever, or vaginitis. Urinalysis or dipstick with positive nitrites and leukocyte esterase supports the diagnosis of UTI.

2. Administer nitrofurantoin (Macrobid) 100 mg po twice daily for 5 days OR one trimethoprim 160 mg/sulfamethoxazole 800 mg double strength tablet (Bactrim DS) po twice daily for 3 days*.

3. Fluoroquinolones (i.e. ciprofloxacin) should not be used as first line agents for cystitis. Reserve for suspected bacterial resistance or upper urinary tract infection.

4. Obtain urine culture if student has recurrent urinary tract infections or antibiotic use within past 3 months.

5. Encourage hydration with copious fluids. Instruct student to return for re-treatment if vomiting occurs within 4 hours of any oral medication dose.

6. If new sexual partners, screen for CT and GC infection.

* Use of trimethoprim/sulfa use should be based on local patterns of E coli resistance; use only if local resistance is <20%.

WHEN TO REFER TO THE CENTER PHYSICIAN

- If the student has a history of recurrent UTI
- If the student has fever ≥ 101°F or fever with chills
- If the student has flank pain
- If the student is pregnant
- If the student has symptoms suggestive of a sexually transmitted infection
- If the female student has pelvic pain suggestive of PID
- If the student's symptoms have not resolved within 48 hours of initiating treatment
- If a male student has documented UTI (not urethritis)
- If the student has an allergy or other contraindication to listed medications and the use of a fluoroquinolone antibiotic needs to be considered

Reference: https://www.accp.com/docs/bookstore/psap/p2018b1_sample.pdf

TREATMENT GUIDELINES FOR HEALTH STAFF

VULVOVAGINAL CANDIDIASIS

Authorized health and wellness staff may treat confirmed vulvovaginal Candidiasis as follows:

1. Administer fluconazole 150 mg po once as a single dose directly observed therapy with fluids or snack.

   WARNING: Fluconazole is not recommended for use during pregnancy.

2. An alternative treatment is intravaginal and external topical treatment with an antifungal cream such as butoconazole 2%, clotrimazole 1%, miconazole 2%, or terconazole 0.8% once daily for the duration specified by the manufacturer. May be used during pregnancy.

3. Instruct student to return for re-treatment if vomiting occurs within 4 hours of treatment with oral regimen.

4. Discuss screening for STDs as appropriate, health department reporting requirements, and prevention of STDs and pregnancy (offer condoms and contraceptives as appropriate).

5. Caution student that many vaginal creams are oil-based and may weaken latex condoms and diaphragms.

6. Routine treatment of sex partners is not recommended.

WHEN TO REFER TO THE CENTER PHYSICIAN

- If symptoms persist or recur within 2 months of initial treatment

- If maintenance therapy is needed in an immunocompromised student, e.g., with HIV infection

TREATMENT GUIDELINES FOR HEALTH STAFF

WARTS (COMMON)

Authorized health and wellness staff may treat common warts on skin surfaces as follows:

1. Most non-genital warts eventually regress spontaneously but may persist for months or years.

2. Apply a topical salicylic acid preparation according to the manufacturer's instructions.

3. An alternative treatment is topical cryotherapy as directed by the center physician; may need to be treated every two weeks until resolution.

4. The student should be instructed to soak the warts in warm water daily and gently debride the surface of the wart with an emery board.

WHEN TO REFER TO THE CENTER PHYSICIAN

- If the student has extensive non-genital warts
- If the student has flat warts (tretinoin therapy may be indicated)
- If the student has not responded to topical therapy or cryotherapy within 4 weeks

TREATMENT GUIDELINES FOR HEALTH STAFF

WARTS (EXTERNAL GENITAL)

Authorized health and wellness staff may treat external genital warts as follows:

1. Student-administered imiquimod 5% cream (Aldara) applied once daily at bedtime three times per week for up to 16 weeks. Instruct student to wash treated areas with soap and water 6-10 hours after treatment or next morning. Instruct student to discontinue treatment and return for evaluation if skin irritation or rash occurs.

2. Alternative treatments include provider-administered:
    - Trichloroacetic acid (TCA) 80%-90%, repeated weekly as necessary
    - Cryotherapy
    - Surgical excision/curettage/laser

3. Discuss contact(s) treatment, screening for other STIs as appropriate, health department reporting requirements, and prevention of STIs and pregnancy (offer condoms and contraceptives as appropriate).

4. Pregnant students with genital warts should be referred to an obstetrician-gynecologist for treatment, as cesarean delivery may be indicated.

5. Sex partners with no visible genital warts should be counseled but need not be treated.

WHEN TO REFER TO THE CENTER PHYSICIAN

- If the student has symptoms suggestive of another sexually transmitted infection
- If the student has warts on the vagina, cervix, anus, rectum, or urethral meatus