

ATTENTION: Parents of Students Entering  
Kindergarten



# Take Home Packet

This packet contains information regarding the Medical and Dental examinations that are required for every kindergarten student. This also contains information on medications in school and head lice.

**Williamsport Area School District  
Office of Student Services  
Department of School Health Services**

Dear Parent/Guardian:

Some children tend to be apprehensive about using the bathroom at school. When this happens, many children will soil clothing. This can happen to any child until they become familiar with the school and their teacher.

In order to care for your child, we ask that all children have an extra pair of pants and underwear in their backpacks. We will be glad to assist your child in changing their clothes in the health room if necessary. Providing clothing for your child will prevent you from making unnecessary trips to the school. If your child does not have clothes available, we will attempt to reach you.

Sincerely,

Health Services Team

**Williamsport Area School District  
Department of School Health Services**

**MANDATED MEDICAL EXAMINATIONS**

Dear Parent/Guardian:

**The Pennsylvania School Health Law, Act 404, Section 1407, mandates that all children have a medical examination on original entry into school, sixth and eleventh grade.**

School health services are a supplement to the care your child receives from a personal physician. Therefore, you are strongly urged to have this required medical examination completed by the child's physician to ensure continued, coordinated and consistent medical care. Most parents elect to have this examination completed during the summer to be certain that their child begins the school year free from physical problems.

As immunization requirements for school attendance have changed frequently, you are encouraged to discuss your child's immunization status and needs with the physician at the time of the physical examination. You should provide the school nurse with the date of any immunizations the child receives as part of the required examination.

The following immunizations are required by law for all students entering school. Students will not be permitted to attend school without required immunizations. The only exceptions to immunizations are religious/philosophical, moral, ethical (parents must sign statement) or medical exemption (parent must have a signed statement from physician). Students in grades K-12 will be excluded from school until proof of required immunizations are received.

- a.) **Diphtheria/Tetanus/Pertussis & Polio** – 4 or more properly spaced doses with a fourth dose administered on or after the fourth birthday.
- b.) **Measles (Rubeola), German Measles (Rubella), Mumps** – 2 properly spaced doses of each vaccine or MMR 1 & 2 with the first dose administered at 12 months of age or older. Proof of immunity by laboratory testing is acceptable. Written documentation from a physician may be submitted for proof of mumps.
- c.) **Hepatitis B** – 3 properly spaced doses.
- d.) **Chickenpox (Varicella)** – 2 properly spaced doses of the vaccine or proof of disease. The first dose must be administered on or after 12 months of age. Written documentation from a physician may be submitted for proof of disease.

Please note only those examinations done after July 1 of the year prior to entry into the designated grade are acceptable under the Pennsylvania School Health Law. As this examination is required by law, we urge you to make certain the medical evaluation is completed prior to the beginning of school.

The completed Private Physician's Report should be returned to the School Nurse as soon as possible.

**The following immunizations are due by the first day of school for students entering these grades:**

**7<sup>th</sup> Grade: Tdap (must be age 11 or 12 years)  
Meningococcal (MCV) (must be age 11 or 12)**

**12<sup>th</sup> grade: 2<sup>nd</sup> dose of Meningococcal (MCV)  
[note: if the 1<sup>st</sup> dose of MCV was given at age 16 or later,  
a 2<sup>nd</sup> dose will not be required]**

**Students will not be permitted to attend school without  
these immunizations.**

2/2023



Bureau of Community Health Systems  
Division of School Health

**Private or School  
PHYSICAL EXAMINATION  
OF SCHOOL AGE STUDENT**

**PARENT / GUARDIAN / STUDENT:**

Complete page one of this form before student's exam. Take completed form to appointment.

Student's name \_\_\_\_\_ Today's date \_\_\_\_\_

Date of birth \_\_\_\_\_ Age at time of exam \_\_\_\_\_ Gender:  Male  Female

**Medicines and Allergies:** Please list all prescription and over-the-counter medicines and supplements (herbal/nutritional) the student is currently taking:

\_\_\_\_\_

Does the student have any allergies?  No  Yes (If yes, list specific allergy and reaction.)

Medicines  Pollens  Food  Stinging Insects

Complete the following section with a check mark in the YES or NO column; circle questions you do not know the answer to.

GENERAL HEALTH: <i>Has the student...</i>	YES	NO
1. Any ongoing medical conditions? If so, please identify: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infection Other _____		
2. Ever stayed more than one night in the hospital?		
3. Ever had surgery?		
4. Ever had a seizure?		
5. Had a history of being born without or is missing a kidney, an eye, a testicle (males), spleen, or any other organ?		
6. Ever become ill while exercising in the heat?		
7. Had frequent muscle cramps when exercising?		
HEAD/NECK/SPINE: <i>Has the student...</i>	YES	NO
8. Had headaches with exercise?		
9. Ever had a head injury or concussion?		
10. Ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
11. Ever had numbness, tingling, or weakness in his/her arms or legs after being hit or falling?		
12. Ever been unable to move arms or legs after being hit or falling?		
13. Noticed or been told he/she has a curved spine or scoliosis?		
14. Had any problem with his/her eyes (vision) or had a history of an eye injury?		
15. Been prescribed glasses or contact lenses?		
HEART/LUNGS: <i>Has the student...</i>	YES	NO
16. Ever used an inhaler or taken asthma medicine?		
17. Ever had the doctor say he/she has a heart problem? If so, check all that apply: <input type="checkbox"/> Heart murmur or heart infection <input type="checkbox"/> High blood pressure <input type="checkbox"/> Kawasaki disease <input type="checkbox"/> High cholesterol <input type="checkbox"/> Other: _____		
18. Been told by the doctor to have a heart test? (For example, ECG/EKG, echocardiogram)?		
19. Had a cough, wheeze, difficulty breathing, shortness of breath or felt lightheaded DURING or AFTER exercise?		
20. Had discomfort, pain, tightness or chest pressure during exercise?		
21. Felt his/her heart race or skip beats during exercise?		
BONE/JOINT: <i>Has the student...</i>	YES	NO
22. Had a broken or fractured bone, stress fracture, or dislocated joint?		
23. Had an injury to a muscle, ligament, or tendon?		
24. Had an injury that required a brace, cast, crutches, or orthotics?		
25. Needed an X-ray, MRI, CT scan, injection, or physical therapy following an injury?		
26. Had joints that become painful, swollen, feel warm, or look red?		
SKIN: <i>Has the student...</i>	YES	NO
27. Had any rashes, pressure sores, or other skin problems?		
28. Ever had herpes or a MRSA skin infection?		

GENTOURINARY: <i>Has the student...</i>	YES	NO
29. Had groin pain or a painful bulge or hernia in the groin area?		
30. Had a history of urinary tract infections or bedwetting?		
31. FEMALES ONLY: Had a menstrual period? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: At what age was her first menstrual period? _____ How many periods has she had in the last 12 months? _____ Date of last period: _____		
DENTAL:	YES	NO
32. Has the student had any pain or problems with his/her gums or teeth?		
33. Name of student's dentist: _____ Last dental visit: <input type="checkbox"/> less than 1 year <input type="checkbox"/> 1-2 years <input type="checkbox"/> greater than 2 years		
SOCIAL/LEARNING: <i>Has the student...</i>	YES	NO
34. Been told he/she has a learning disability, intellectual or developmental disability, cognitive delay, ADD/ADHD, etc.?		
35. Been bullied or experienced bullying behavior?		
36. Experienced major grief, trauma, or other significant life event?		
37. Exhibited significant changes in behavior, social relationships, grades, eating or sleeping habits; withdrawn from family or friends?		
38. Been worried, sad, upset, or angry much of the time?		
39. Shown a general loss of energy, motivation, interest or enthusiasm?		
40. Had concerns about weight; been trying to gain or lose weight or received a recommendation to gain or lose weight?		
41. Used (or currently uses) tobacco, alcohol, or drugs?		
FAMILY HEALTH:	YES	NO
42. Is there a family history of the following? If so, check all that apply: <input type="checkbox"/> Anemia/blood disorders <input type="checkbox"/> Inherited disease/syndrome <input type="checkbox"/> Asthma/lung problems <input type="checkbox"/> Kidney problems <input type="checkbox"/> Behavioral health issue <input type="checkbox"/> Seizure disorder <input type="checkbox"/> Diabetes <input type="checkbox"/> Sickle cell trait or disease Other _____		
43. Is there a family history of any of the following heart-related problems? If so, check all that apply: <input type="checkbox"/> Brugada syndrome <input type="checkbox"/> QT syndrome <input type="checkbox"/> Cardiomyopathy <input type="checkbox"/> Marfan syndrome <input type="checkbox"/> High blood pressure <input type="checkbox"/> Ventricular tachycardia <input type="checkbox"/> High cholesterol <input type="checkbox"/> Other _____		
44. Has any family member had unexplained fainting, unexplained seizures, or experienced a near drowning?		
45. Has any family member / relative died of heart problems before age 50 or had an unexpected / unexplained sudden death before age 50 (includes drowning, unexplained car accidents, sudden infant death syndrome)?		
QUESTIONS OR CONCERNS	YES	NO
46. Are there any questions or concerns that the student, parent or guardian would like to discuss with the health care provider? (If yes, write them on page 4 of this form.)		

I hereby certify that to the best of my knowledge all of the information is true and complete. I give my consent for an exchange of health information between the school nurse and health care providers.

Signature of parent / guardian / emancipated student \_\_\_\_\_ Date \_\_\_\_\_

STUDENT'S HEALTH HISTORY (page 1 of this form) REVIEWED PRIOR TO PERFORMING EXAMINATION: Yes  No

Physical exam for grade: K/1 <input type="checkbox"/> 6 <input type="checkbox"/> 11 <input type="checkbox"/> Other <input type="checkbox"/>	CHECK ONE			*ABNORMAL FINDINGS / RECOMMENDATIONS / REFERRALS
	NORMAL	*ABNORMAL	DEFER	
Height: ( ) inches				
Weight: ( ) pounds				
BMI: ( )				
BMI-for-Age Percentile: ( ) %				
Pulse: ( )				
Blood Pressure: ( / )				
Hair/Scalp				
Skin				
Eyes/Vision Corrected <input type="checkbox"/>				
Ears/Hearing				
Nose and Throat				
Teeth and Gingiva				
Lymph Glands				
Heart				
Lungs				
Abdomen				
Genitourinary				
Neuromuscular System				
Extremities				
Spine (Scoliosis)				
Other				

TUBERCULIN TEST	DATE APPLIED	DATE READ	RESULT/FOLLOW-UP

MEDICAL CONDITIONS OR CHRONIC DISEASES WHICH REQUIRE MEDICATION, RESTRICTION OF ACTIVITY, OR WHICH MAY AFFECT EDUCATION  
 (Additional space on page 4)

Parent/guardian present during exam: Yes  No

Physical exam performed at: Personal Health Care Provider's Office  School  Date of exam \_\_\_\_\_ 20\_\_\_\_

Print name of examiner \_\_\_\_\_

Print examiner's office address \_\_\_\_\_ Phone \_\_\_\_\_

Signature of examiner \_\_\_\_\_ MD  DO  PAC  CRNP

**HEALTH CARE PROVIDERS:** *Please photocopy immunization history from student's record – OR – insert information below.*

**IMMUNIZATION EXEMPTION(S):**

Medical  Date Issued: \_\_\_\_\_ Reason: \_\_\_\_\_ Date Rescinded: \_\_\_\_\_

Medical  Date Issued: \_\_\_\_\_ Reason: \_\_\_\_\_ Date Rescinded: \_\_\_\_\_

Medical  Date Issued: \_\_\_\_\_ Reason: \_\_\_\_\_ Date Rescinded: \_\_\_\_\_

**NOTE:** The parent/guardian must provide a written request to the school for a religious or philosophical exemption.

VACCINE	DOCUMENT: (1) Type of vaccine; (2) Date (month/day/year) for each immunization				
Diphtheria/Tetanus/Pertussis (child) Type: DTaP, DTP or DT	1	2	3	4	5
Diphtheria/Tetanus/Pertussis (adolescent/adult) Type: Tdap or Td	1	2	3	4	5
Polio Type: OPV or IPV	1	2	3	4	5
Hepatitis B (HepB)	1	2	3	4	5
Measles/Mumps/Rubella (MMR)	1	2	3	4	5
Mumps disease diagnosed by physician <input type="checkbox"/>	Date: _____				
Varicella: Vaccine <input type="checkbox"/> Disease <input type="checkbox"/>	1	2	3	4	5
Serology: (Identify Antigen/Date/POS or NEG) i.e. Hep B, Measles, Rubella, Varicella	1	2	3	4	5
Meningococcal Conjugate Vaccine (MCV4)	1	2	3	4	5
Human Papilloma Virus (HPV) Type: HPV2 or HPV4	1	2	3	4	5
Influenza Type: TIV (injected) LAIV (nasal)	1	2	3	4	5
	6	7	8	9	10
	11	12	13	14	15
Haemophilus Influenzae Type b (Hib)	1	2	3	4	5
Pneumococcal Conjugate Vaccine (PCV) Type: 7 or 13	1	2	3	4	5
Hepatitis A (HepA)	1	2	3	4	5
Rotavirus	1	2	3	4	5
<b>Other Vaccines: (Type and Date)</b>					



**Williamsport Area School District  
Division of Student Services  
Department of School Health Services**

**School Dental Program**

Dear Parent/Guardian:

The **PENNSYLVANIA SCHOOL HEALTH LAW**, Act 404, Section 1407, requires all children to receive a dental exam upon **entering school for the first time**, as well as those entering **third grade and seventh grade**. Please note only those examinations done **after July 1** of the year prior to entry into the designated grade are acceptable under the Pennsylvania School Health law.

We encourage you to have your child's teeth examined by your family dentist, as he best knows your child's dental history. Many parents choose to have this examination completed over summer vacation. The expense of this examination is, of course, the parent's responsibility. If your child is unable to receive a dental examination from a family dentist, he/she is eligible to participate in the school dental program conducted yearly in the early spring.

When your child receives the dental examination, please ask your dentist to complete the attached **FAMILY DENTIST REPORT**. This completed form should be returned to the school nurse or school nurse practitioner when school resumes.

We appreciate your cooperation.



COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF HEALTH

**PRIVATE DENTIST REPORT**  
**OF DENTAL EXAMINATION/SCREENING OF A PUPIL OF SCHOOL AGE**

NAME OF SCHOOL \_\_\_\_\_ DATE \_\_\_\_\_ 20\_\_

<u>NAME OF STUDENT</u>	<u>DATE OF BIRTH</u>	<u>GRADE</u>	<u>SECTION/ROOM</u>
_____ Last                      First                      Middle	_____	_____	_____
<u>ADDRESS</u>			

\_\_\_\_\_  
 No. and Street              City or Post Office              Borough/Township              County              State              Zip

**REPORT OF EXAMINATION/SCREENING**

		<u>TOOTH CHART</u>																
		<u>RIGHT</u>								<u>LEFT</u>								
		<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>	<u>8</u>	<u>9</u>	<u>10</u>	<u>11</u>	<u>12</u>	<u>13</u>	<u>14</u>	<u>15</u>	<u>16</u>	
<u>UPPER</u>					<u>A</u>	<u>B</u>	<u>C</u>	<u>D</u>	<u>E</u>	<u>F</u>	<u>G</u>	<u>H</u>	<u>I</u>	<u>J</u>				<u>Upper</u>
<u>LOWER</u>		<u>32</u>	<u>31</u>	<u>30</u>	<u>29</u>	<u>28</u>	<u>27</u>	<u>26</u>	<u>25</u>	<u>24</u>	<u>23</u>	<u>22</u>	<u>21</u>	<u>20</u>	<u>19</u>	<u>18</u>	<u>17</u>	<u>Lower</u>
<u>EXAM</u>	<u>UPPER</u>																	<u>Upper</u>
	<u>LOWER</u>																	<u>Lower</u>

Untreated Decay:                      No              Yes

Treated Decay:                      No              Yes

Sealants on Permanent Molars              No              Yes

Treatment Urgency:                      None              Early              Urgent

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Dental Provider                      Print Name of Dental Provider

\_\_\_\_\_  
Address of Dental Provider

**Williamsport Area School District  
Department of School Health Services**

**Protocol for the Administration of Medication During School Hours**

The Williamsport Area School District recognizes that parents have the primary responsibility for the health of their children. The district strongly recommends that medication be given in the home; although, it realizes that the health of some children requires that they receive medication while in school.

Parents should confer with the child's physician to arrange medication time intervals to avoid school hours whenever possible. When medication absolutely must be given during school hours, certain procedures need to be followed to help ensure the child receives their medication correctly as ordered. ***Failure to follow the guidelines will result in your child not receiving prescribed medication.*** These guidelines cover all children in grades K-12.

**For Prescription Medications:**

1. The physician must complete and sign **PHYSICIAN'S ORDER FOR PRESCRIPTION MEDICATION** (Side A), the prescription order form. The label on the outside of the bottle is NOT a physician order, nor is the medication printout from the pharmacy.
2. The parent must sign **PARENTAL AUTHORIZATION AND INDEMNIFICATION FOR THE GIVING OF MEDICINE** (Side B), the consent form for administering prescription medication.
3. Any medication to be given during school hours should be delivered directly to the school nurse, the health room technician or the school principal's designee by the parent or a responsible adult. Parent may be asked to sign **MEDICATION RECEIPT AND DISCARD FORM**.
4. The medication must be brought to school in the original pharmaceutically dispensed and properly labeled container (may not be written on by parent). Medications sent in Tupperware containers, envelopes or plastic bags will not be given. If the dosage on the bottle does not match the dosage on the order form, 30 days will be given for the parents to obtain a correct bottle/label. Parents may request a new label from the pharmacy before a refill. After 30 days, the medication will NOT be given until a correct bottle is received.
5. Medication that is ordered three times a day may be given before school, after school and at bedtime unless the physician indicates on the prescription order form that it must be given at lunch time.
6. Narcotic pain relievers may not be stored on the premises of the school. If your child requires a narcotic pain reliever, please contact the school nurse.
7. In the absence of the school nurse, the health room technician or the principal's designee will oversee the administration of medication.
8. Prescription medication will be kept locked in the nurse's office.
9. A log will be kept for any child receiving prescription medication during school hours.
10. Medication may be given either 60 minutes before or 60 minutes after the time ordered.
11. Students in grades 6-12 will be responsible for reporting to the nurse's office at the time the medication is to be given. In K-5, individualized plans will be made for the administration of medication by the school nurse or the school nurse's designee.
12. The first dose of any prescription medication must be given at home 24 hours before requesting the medication to be given at school. Parents should observe for side effects or any reactions.

13. If tablets must be cut, the parent is responsible for cutting tablets and bringing the correct dosage to school. The tablets should be prepared at home and brought to school in the correct form.

### **For Non-Prescription Medication:**

Due to rulings by the State Board of Nursing, the Williamsport Area School District will not dispense over-the-counter non-prescription medication at the parent's request.

1. Students are not permitted to bring over-the-counter non-prescription medications to school ***unless accompanied by a doctor's order.***
2. Acetaminophen, Tums and calamine lotion will only be given in accordance with the treatment protocol established by the school physician. Unless certain conditions are met for administering these items and parents have signed the permission card or indicated permission electronically, these items will not be offered to the students. The authorization shall be effective from the date of signing until graduation or revoked by parent/guardian in writing.

### **For Inhalers:**

1. Students requiring inhalers during school hours must follow all guidelines for prescription medications.
2. Students who wish to carry their inhaler must follow the WASD policy regarding inhalers. Please contact the nurse's office for specific information. Students who wish to carry their inhaler must submit written consent from their health care provider.

### **Unused/Expired Medication:**

1. Unused/expired medication will be returned to the parents for disposition.
2. Parents will be requested to pick up unused/expired medication via written notice.
3. The date, time, amount and name of medication being sent home will be recorded on the **MEDICATION RECEIPT AND DISCARD FORM**. Parent should co-sign form.
4. If the parent does not pick up the medication by the last day of school, the school nurse will destroy/discard any unused/expired medication. This act will be witnessed if the medication to be discarded is a controlled substance.

Other: Non-FDA approved products, herbal/dietary products, medications purchased from foreign countries, medical marijuana, or nontraditional preparations (including but not limited to: vitamins, supplements, homeopathic remedies, and essential oils) may not be administered by school personnel.

### **Additional information regarding medication administration:**

1. Morning medications will **NOT** be given on days in which there is a delay unless the prescribing physician specifically writes that it may be given 2 and or 3 hours later.
2. Medications will not be given if parents have forgotten or a parent refuses to give the medication.
3. Each health office will have a designated red zone for medication administration. There will be no interruptions permitted when the nurse is in the red zone.
4. Due to Confidentiality laws, parents will not be permitted in the health office while the nurse is caring for a student.

**Williamsport Area School District**  
**Division of Student Services**  
**Department of School Health Services**

Dear Parent,

Every year, many children throughout the United States become infected with head lice. Head lice will always be a part of our society. Since there are many misconceptions about head lice, we are attempting to provide you with the most accurate scientific information available. If you would like additional information, there are additional references below or you may contact the school nurse.

**What are Head Lice?** Head Lice are tiny wingless insects that are about the size of a sesame seed. They have six legs with claws on each leg. Since they do not have hind legs, they can not jump or hop. Although they are able to crawl quickly, they are unable to cover great distances.<sup>3</sup>

The female louse may live for 30 days and lays approximately 10 eggs (nits) per day. The eggs are attached to the hair by a glue-like substance. The heat from the human body incubates the eggs which will hatch in 10-14 days. Once hatched, the nymph grows for 9-12 days, mate and lay eggs. Untreated, this cycle will repeat itself every three weeks.<sup>2</sup> For pictures of head lice, please visit the web site <https://identify.us.com-are.html>

**Medical Implications:** Head lice are an infestation not an infection. Head lice do not cause or spread any diseases and therefore, do not pose any significant threat to one's health.<sup>3</sup>

**Societal Reactions:** Head Lice will always be present in the community at any given time. For years, the mere mention of lice caused people to react negatively. Research regarding head lice did not exist. Instead, myths were developed and spread from one generation to the next. Well meaning individuals have communicated myths (which have no scientific basis) to others and this has resulted in many misconceptions about head lice. Fortunately, with research, many past practices and myths can now be abolished. Instead of seeking the source or someone to blame, parents, schools, and communities need to work together to incorporate the most appropriate recommendations that are based on the latest scientific research.

**Prevention/Early Detection:** Prevention of head lice is best attainable through education. Parents and school staff need to educate children to avoid sharing hats, combs, brushes, scarves and avoid direct head to head contact.<sup>1</sup>

**Home Control Measures:** At least twice a week, parents should check their children's heads. This will provide parents with the opportunity to talk to their children about head lice and allow parents to detect any early infestation.

**School Control Measures:** Currently, there is no scientific evidence that indicates that mass screenings are effective in reducing head lice transmission. Research studies recommend that schools provide families with information on head lice.<sup>1, 2, 3, 4</sup>

**What should parents do when head lice are discovered?**

1. **Don't panic.** Remember, head lice do not cause any diseases.
2. Seek assistance from your physician, PA Department of Health, or the school nurse and follow their instructions. Lice are easily treated if ALL instructions are followed carefully.

- a. Apply a special medicated shampoo or crème rinse which can be purchased at the drug store.
- b. Apply the shampoo/crème rinse according to the directions on the bottle. Do **not** use on eyebrows or eyelashes.
- c. Wait the specified length of time for the shampoo to be effective, and then wash the hair thoroughly with warm water and regular shampoo. If using crème rinse, follow directions on bottle.
- d. Using a fine-toothed steel comb, comb the infested area to assist in the removal of the dead lice and eggs (nits). In some cases, you may have to use your fingernails to rid the hair of nits. It is best to be free of all nits.
- e. Inspection for and treatment of head lice should be carried out with a light shining directly on the hair.
- f. As treatment can be accomplished in an afternoon or evening, children should return to school the next day.
- g. All bedding, clothing, towels, etc. should be washed in hot water (130°F) with detergent and machined dried.
- h. Special sprays, available in drug stores, are not necessary. Simple vacuuming of these areas is also effective, provided they are vacuumed thoroughly. **(DO NOT SPRAY PEOPLE, ANIMALS OR UNDER CLOTHING.)**
- i. Lice do not hide in wall crevice or floor cracks. Treatment of these areas is useless.
- j. Bag any unwashable items for 10 days.

**Please do not spend any energy on trying to locate the source of your child's infestation.** It is virtually impossible to identify the exact source. Your time and energy should be used to treat and educate your child.

**Reinfestation:** Currently, there are no products that are 100% effective in killing all of the nits. There are several measures that can be done to keep lice from coming back.<sup>1,3</sup>

#### To Keep Lice from Coming Back

- ✓ Inspect all family members periodically for any new lice infestation. It is especially important to check hair every day for two weeks after lice have been found and initially treated.
- ✓ After the first shampoo, re-wash the hair with the special medicated shampoo after 9-10 days to insure adequate treatment. If using crème rinse, follow directions on the bottles. Do not re-treat before the 9 days.
- ✓ Instruct your child not to borrow personal items such as combs, brushes, hats, clothing, and towels from other people.
- ✓ Disinfect combs, brushes and similar items by washing with the special shampoo.<sup>1</sup>

Note: If searching the web, please beware of sites that contain nonscientific recommendations. Trusted web sites include the following:

<https://identify.us.com/idmybug/head-lice/head-lice-FAQS/index.html>  
<https://www.cdc.gov/parasites/lice/head/parents.html>

#### References:

<sup>1</sup> Burgess, Ian; Pollack, R. & Taplin, D. Cutting Through Controversy: Special Report on the Treatment of Headlice, 2003; 3-13

<sup>2</sup> Frankowski, Barbara L. and Leonard Weiner. Headlice Pediatrics. 2002 110 (3) 638-642.

<sup>3</sup> Pollard, Richard J. HeadLice Information. Harvard School of Public Health. 1-15

<sup>4</sup> Williams, L. K., Reichert, A., MacKenzie, W., Hightower, A., Blake, P. Lice, Nits, and School Policy. Pediatrics 107 (5) 1011-1015.