Section 1003.25, F.S. requires that each school principal maintain a permanent cumulative record for each student enrolled in a public K-12 school. Student cumulative health records are part of the student’s education cumulative record. The DH3041-CHP-07/2013 may be used as part of the cumulative health record. If cumulative health records are kept in students’ permanent educational record, which are accessed by school academic and support staff, it is important that the school health staff ascertains that the school closely follows the privacy provisions of s. 1002.22, F.S. and the Family Educational Rights and Privacy Act (FERPA), and that the information is easily and quickly accessible for health emergencies. A Department of Education technical assistance paper – *The Family Educational Rights and Privacy Act* – clarifies FERPA’s relationship with the Health Insurance Portability and Privacy Act (HIPAA) is available at: http://sss.usf.edu/resources/format/taps/2009/2009_103.pdf

Records maintained at school as part of the cumulative health record (Ch. 64F-6.005, F.A.C.) for students are:

- Certificate of Immunization (DH680) with immunization status and exemptions if relevant;
- School Entry Health Exam (DH3040-CHP-07/2013);
- Documentation of school health screenings, rescreenings, results/referral, follow-up and referral outcome (documented on or in the DH3041-CHP-07/2013 folder, or paper or electronic record in other location specified on the cover of the the folder);
- Documentation of subsequent physical examinations;
- Other health history regarding chronic or complex health conditions;
- Physician’s treatment plan or medical management plan;
- Documentation of injuries and/or episodes of sudden illness referred for sick-care or emergency health care;
- Documentation of nursing assessments, individualized healthcare plan (IHP), emergency action plan (EAP)/emergency care plan (ECP), general and child-specific training of unlicensed assistive personnel delegated and trained by the registered nurse (RN);
- Health counseling;
- Documentation of any consultations with school staff, students, parents/guardians or service providers about a student’s health problem, recommendations and results;
- Documentation of physician’s orders and parental permission to administer medication or medical treatments given in school; and
- Documentation of health services provided to the student (treatment log and/or medication administration record).

The DH3041-CHP-07/2013 folder should contain at a minimum:

- Certificate of Immunization (DH680) with immunization status and exemptions if relevant;
- School Entry Health Exam (DH3040-CHP-07/2013); and
- Documentation of school health screenings, rescreenings, results/referral, follow-up and referral outcome (documented on or in the DH3041-CHP-07/2013 folder, or paper or electronic record in other location specified on the cover of the the folder).

Other student cumulative health records should be maintained so they are always accessible to the school clinic, clinic staff and school staff designated by the school principal (and trained by the RN) to provide school health services.

For guidance on student health records retention, refer to General Records Schedule GS7 For Public Schools Pre-K – 12 and Adult an Career Education, available at: http://dlis.dos.state.fl.us/barm/genschedules/GS7.pdf