Colorado Department of Education
FAST FACTS
EXCEPTIONAL STUDENT SERVICES UNIT
School Nursing
May/2005

School Health Record Retention

The people responsible for records in my district say that health records are not considered to be part of a student's academic record. Is this true? What records should be maintained in the health file for schools? How long should these records be retained?

Student health records are defined in federal legislation (Family Educational Rights and Privacy Act – FERPA) to be part of the academic record and thus must be retained in the same way as the academic record.

The Colorado Division of State Archives and Public Records mandates that districts develop policies that define how long student academic records must be retained (24-80-103 C.R.S.). It authorizes school officials to purge immunization and other health records from the student academic file after the student has graduated or left the district provided that they have a records retention schedule approved by the State Archives.

The student cumulative health record (CHR) should be retained along with other academic records. The only part of the CHR that is required by the Division of State Archives and Public Records to be retained is the immunization record for students who have withdrawn, but not yet graduated. The following records may be requested by students who have left the school, could be useful in protecting schools against liability if health-related questions arise and should also be considered for retention:

Student record card with health history, summary of relevant health office interactions including significant accidents and illnesses, and summary of medications given,

- Individualized health care plan,
- Immunization record,
- Results, recommendations, and follow-up related to all screening,
- Other information that is deemed relevant by the school nurse.

"Relevant" health office visits, accidents, and illnesses do not mean every interaction. Consideration should be given to those situations that could have a long term impact on the student's physical or mental well being or ability to achieve optimally in his/her academic program.

Summary of medications given should be entered on the CHR when the medication is started and ended, at the end of the year, at the end of a course of medication, or when the dose changes. i.e. 1/5/02 – "Ritalin 10 mg daily. " 5/20/02 – "Ritalin 10 mg daily stopped per MD order." OR "Ritalin 10 mg daily from 8/15/2001 to 1/10/02; Ritalin 20 mg daily from 1/11/02 to 5/12/02." Once this information has been recorded, prescriber orders may be discarded.

The most recent health care plan should always be retained. The school nurse should decide whether earlier health care plans contain information that might have a long term impact on the student. Some may; others may not.

Referrals are part of follow-up and should be retained for mandated screening and for "relevant" illnesses and injuries.

The student's most recent immunization card should contain all immunizations the child has received. If this is not currently the case, a system should be implemented by which the school nurse or health aide transfers immunization information so that it is contained on one card.
For more information, please contact:

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